Funding medicare

In *CMAJ*'s first Controversy article Michael Gordon and associates say that our health care system should acquire additional funding by means of an alternative tax, through which heavy users of the system would pay more.[1] Steven Lewis counters by stating that this is what the Canadian system was created to prevent.[2]

Gordon argues that privatization is waiting in the wings with eager US support, but a greater risk is posed by several provinces that have jumped on the free-market bandwagon. However, that wagon is now low on propellant.

Gordon's group makes sound arguments against private health care, but they only had to note that it is a commercial enterprise. If profits are threatened, behaviour in this sector will not differ from that of any commercial operation trying to ensure profitability or survival. Why the market in health care would behave differently escapes me.

Lewis correctly questions whether additional funding is needed, while Gordon and associates present a long list of references saying that it is. However, more money leads to greater outlays and creates a need for yet more money. It has been so for 30 years.

The solution? A slice of the income tax pie dedicated solely to medicare should be collected with income tax but accounted for separately. Funding health care from general revenues is organically unstable.

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1. Gordon M, Mintz J, Chen D. Funding Canada's health care system: a tax-based alternative to privatization. *CMAJ* 1998;159(5):493-6.
2. Lewis S. Still here, still flawed, still wrong: the case against the case for taxing the sick. *CMAJ* 1998;159(5):497-9.

While reading the article by Gordon and associates[1] I found myself reaching for my pen as the tortured logic of the article became increasingly painful. Surely a brief letter to the editor was called for. My literary enthusiasm was dampened after I found the companion article by Steven Lewis.[2] My limited critical skills pale beside his refreshing prose.

However, Gordon and associates are to be congratulated for supporting public health care over privatization. They would prefer adding the amounts of estimated medicare costs to taxable income. I assume that in single-taxpayer families the taxpayer would receive the assignments for all family members. Lewis proposes that if more money is required it should come from the same place as before the cutbacks. I have some ideas of my own.

- eliminate fee-for-service payments in favour of a system that provides better incentives to promote health and reduce excessive utilization;
- use the approximately $1.1 billion the pharmaceutical industry spends annually on marketing to establish effective CME and academic detailing; and
- establish a means of communication for health care professionals, payers and patient representatives to avoid adversarial approaches and promote effective utilization of resources.

Now is the time for physicians to re-examine health care funding if medicare is going to survive.

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1. Gordon M, Mintz J, Chen D. Funding Canada's health care system: a tax-based alternative to privatization. *CMAJ* 1998;159(5):493-6.
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[Michael Gordon responds:]

As the letter writers note, we enthusiastically support publicly funded Canadian medicare.[1] However, the system is undergoing passive privatization,[2] and few Canadians have unimpeded access to dental care and other health care services. If governments supported the requisite funding and structural changes required to expand medicare and added proper accountability for patients and health care providers, funding changes might not be needed.

The fee-for-service system is often cited as a source of excessive costs

and services, but changing it to a capitation service will not necessarily result in financial savings or beneficial outcomes.[3] As well, the pharmaceutical industry is unlikely to transfer its marketing budget to finance neutral CME and academic detailing. Rather, government initiatives such as reference-based pricing may be beneficial.[4,5] Still, many of the newer and more effective drugs are more costly, and most Canadians pay, either personally or through workplace benefits, which become part of the cost of doing business.

The tax-based formula could be structured so that those eligible for GST rebates would not pay health care costs, and such costs would not necessarily be transferred to another family member. Therefore, a child or low-income earner with high medical costs could be exempt from payments even if another member of the family had a high income but low medical costs. The tax-based system could be used within a capitation or fee-for-service framework, as utilization could still be tracked and individual contributions determined. It could readily allow for enhancements in coverage.

Dr. Aldis is probably correct that the wholesale Americanization of health care is unlikely, but he notes that there is support for enhancing the private tier from some provincial governments and medical leaders.[6] Such calls resonate throughout the system and elicit public support, especially when medicare seems to be faltering because of apparent resource limitations.

Aldis does not appear to take seriously the risk of calls for a parallel private tier to solve a perceived funding crisis.[6] We do. Our tax-based formula should be considered as a serious alternative to such proposals.

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2. Rafuse J. Private-sector share of health spending hits record level. *CMAJ* 1996;155(6):749-50.
3. Conrad DA, Maynard C, Cheadle A, Ramsey S, Marcus Smith M, Kirz H, et al. Primary care physician compensation method in medical groups: Does it influence the use and cost of health services for enrollees in managed care organizations? *JAMA* 1998;279:853-8.
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5. Donald JB. Prescribing costs when computers are used to issue all prescriptions. *BMJ* 1989;299:28-30.
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Emergency stroke care

The supplement article on emergency management of acute ischemic stroke in Canadian hospitals, by Corinne Hodgson,[1] contained some apparent discrepancies.

The article states that "For both the urban and rural hospitals, the median time [between admission to the emergency department and] examination was 9.7 hours." However, data presented in Table 2 of the article indicate the 56.4% of all patients were examined within 3 hours of arrival. This suggests that the category "< 3 hours" must contain the observation identified with the 50th percentile. It follows that the median time to evaluation must have been less than 3 hours.

I also have some concerns about this treatment of the data. It would be reasonable to calculate the proportion of patients seen within 3 hours on the basis of the patients whose time to examination was known (i.e., 303/312 or 97%). However, the method of analysis offered assumes that every patient in the "unknown" group had examination times in excess of that for the patients for whom data were available.

Data for the interval between arrival at the emergency department and CT scanning indicate that the mean for urban patients was 4.5 hours and for rural patients 15.0 hours. One can infer that 165 (48.7% of 339) of the urban patients and 22 (11.1% of 198) of the rural patients underwent CT imaging, for a total of 187 patients. Combining these figures ([165 × 4.5] + [22 × 15]/187) yields an average wait of 5.7 hours, which appears inconsistent with the average time of 15.1 hours reported in the article.

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Reference
1. Hodgson C. Emergency management of acute ischemic stroke in Canadian hospitals. *CMAJ* 1998;159(6 Suppl):S15-8.

[The author responds:]

Dr. Picard has uncovered 2 unfortunate errors in this article.

The numbers in Table 2 are correct, but there was an error in reporting the mean time from arrival at the hospital to examination. The mean (not median) time to examination for both urban and rural hospitals was 0.7 hours (not 9.7 hours).

The second error concerns the waiting times by type of hospital. What is given as the mean waiting time (15.0 hours for rural patients and 4.5 hours for urban patients) is in fact the median. Nearly half (43.6%) of the urban patients underwent CT scanning within 3 hours of arrival in the emergency department (Table 1). Among rural patients, the proportion was 31.8%. Although 48.7% (165/339) of urban patients underwent CT scanning, for rural patients the proportion was much lower (22/198 or 11.1%).

There is also a typographic error in the paragraph on waiting times. The mean time between arrival and CT for ward patients should have been reported as 42.9 hours.

I apologize for the inconvenience caused by these errors.

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Table 1: Time between arrival in emergency department and CT scanning

	Waiting time; no. (and %) of patients			
Hospital setting	< 3 hours	3–6 hours	> 6 hours	Total
Urban	72 (43.6)	38 (23.0)	55 (33.3)	165
Rural	7 (31.8)	0 (0)	15 (68.2)	22

Psychobiology of stroke: a neglected area

The editorial by Antoine Hakim and colleagues[1] provides a comprehensive review of the human and financial burden of stroke on the Canadian health care system. The article also draws attention to the current state of disorganized stroke care in Canada and suggests remedies for this problem. However, we are concerned that both the editorial and the accompanying supplement[2] fail to address the psychological consequences of stroke and the importance of integrating psychiatric services into the treatment of stroke patients.

The prevalence of post-stroke depression in 2 rehabilitation hospitals in Canada was estimated at 36% to 50%.[3,4] Given that at any given time approximately 300 000 Canadians are suffering the consequences of stroke, at least 100 000 of these may be disabled by depression. Furthermore, depression after acute stroke was the only treatable condition independently associated with limitations in physical functioning.[5] This finding emphasizes that early recognition and effective treatment of depression after stroke may optimize rehabilitation potential and thereby reduce the hu-