FOR THE RECORD

Published at www.cmaj.ca between Mar. 26 and Apr. 15

Data on wait times remain spotty, CIHI says

Five years after Canada's health ministers reached an agreement to reduce wait times in five designated priority areas (cancer, cardiac bypass surgery, diagnostic imaging, joint replacement and sight restoration), measurement of progress toward achieving reductions remains problematic because of ongoing problems in data collection, the Canadian Institute of Health Information (CIHI) says.

In two of the areas, radiation therapy and cardiac bypass surgery, "provinces encountered challenges using the common definitions, and it is less clear whether differences in reported wait times by province are related to variations in definitions or to real differences in waits," CIHI states in its fifth annual report on wait times, *Wait Times Tables — A Comparison by Province, 2010.*

"Many provinces recently made changes to the way they collect and report wait time data. While these changes improved the quality and comparability of the information, they limited the ability to assess whether meaningful reductions in wait times were made," added the report (http://secure.cihi.ca/cihiweb/products/wait_times_tables_2010_e.pdf).

In the area of bypass surgery, for example, the provinces agreed to benchmarks that vary according to the level of urgent care required (Level I: within two weeks; Level II: within six weeks; and Level III: within 26 weeks). But only three of seven reporting provinces use a common scale and each appears to differently apportion patients to each level, so data on cardiac bypass surgery is "not yet comparable by urgency level." Similarly, there "are no pan-Canadian benchmarks for angioplasty or for magnetic resonance imaging (MRI) and computed tomography (CT) scans."

Despite the many methodological and data collection issues, CIHI says that some conclusions can be drawn:

- At least three-quarters of hip-fracture surgeries are completed within the benchmark of 48 hours across the country. But the number of patients receiving hip replacements within the 182-day benchmark varies significantly by province from 51% to 100%.
- In seven provinces, fewer than 75% of patients receive knee replacement surgery within the 182-day benchmark.
- 75% of cataract surgery patients in seven provinces are treated within the 112-day benchmark.
- 88% of patients in eight provinces receive radiation therapy within 28 days.
- In the four provinces reporting radiation therapy data, patients wait longer for MRIs than CT scans. — Wayne Kondro, *CMAJ*

Ontario hospitals get 1.5% budget increase

A 1.5% increase in hospital budgets, a ban on payments to pharmacies for providing shelf space for generic drugs and linking hospital executives' pay to performance outcomes are among measures unveiled in Ontario Finance Minister Dwight Duncan's blueprint for fiscal year 2010/11.

The 1.5% increase in hospital budgets is less than the 2.1% received in fiscal 2009/10 but the Ontario Hospital Association indicated it is too early to know what impact it will have on the province's 154 hospitals.

Ontario hospitals have said that the rising costs of salaries and medical supplies tend to add up to 4% to hospital expenses per year, and some health experts say making up for the shortfall may lead to staff reductions, service cuts, surgery delays and bed closures (*CMAJ* 2010. DOI:10.1503/cmaj.109-3154).

Ontario Hospital Association President and Chief Executive Officer Tom Closson expressed disappointment with the 1.5% increase to base funding but said that "many critical details about hospital funding in 2010-11 remain unknown."

"The Budget does not provide information about funding sources other than the base operating increase and as a result, it is premature to assess potential impacts on services and staff," he said in a news release (www.newswire.ca/en/releases/archive/March2010/25/c5369.html).

Other budget measures included a vow to reduce the cost of generic drugs under the Ontario Drug Benefits Plan by introducing legislation to ban drug manufacturers from paying allowances to pharmacies in return for shelf space. Pharmaceutical firms paid $750 million in such allowances in fiscal year 2008/09.

The budget also contained details about how the government is "committed to improving the quality and accountability of the health care system" through measures such as: facilitating lower prices for generic drugs, increasing support for rural pharmacies, supporting the expansion of clinical services provided by pharmacists, reviewing the Public Hospitals Act, creating an independent body of experts to advise on clinical practice guidelines and creating a committee to address hospital working capital deficits.

Duncan said in his Mar. 25 budget that the Ontario government will attempt to curtail health care spending, which is ballooning in the province due to an aging population and investments in expensive medical technology (www.fin.gov.on.ca/en/budget/ontariobudgets/2010).

"Today, health sector spending accounts for about 46 cents of every program dollar," the budget states. "If left unchecked, cost drivers could push health care spending to 70 cents of every program dollar in 12 years. The

Province will continue to face challenges in managing the growth in health care spending without crowding out other priorities such as investing in schools, helping the vulnerable, protecting the environment, and investing in infrastructure and economic development." — Roger Collier, *CMAJ*

Quebec proposes fee for medical visits

The government of Quebec will dip deeply into the pockets of health care users, Finance Minister Raymond Bachand announced in a budget for fiscal year 2010/11 that introduces a universal "health contribution tax" and proposes a "deductible" fee for medical visits.

The health contribution tax, which will be levied on income tax returns, is pegged at $25 per adult this year, $100 in 2011 and $200 in 2012. "These revenues will be paid into a dedicated fund that will provide direct financing to health-care institutions on the basis of their productivity and results. The health contribution will stimulate efficiency," Bachand said in his budget speech (www.budget.finances.gouv.qc.ca/Budget/2010-2011/en/documents/BudgetSpeech.pdf).

A $25 fee per medical visit is under consideration as a means of influencing "the behaviour of health-care providers and users," Bachand said. "A modulated deductible would encourage Quebecers to make rational use of the services available to them, in particular by directing them to the most appropriate resource in the circumstances. It would also encourage institutions to be more efficient so as to be able to treat more patients. The revenues from the deductible would be distributed to the institutions where the services were provided."

"This form of funding with an orienting effect is used successfully in several European countries," Bachand said, adding that the government would consult its "partners" in the coming months on the best means of implementing a deductible fee.

The deductible would apply to each consultation that a patient has with a physician who performs a medical act, so if someone went to a medical facility and eventually saw two doctors, there would be a $50 charge, according to a budget document, *For a more efficient and better funded health-care system*.

Such a fee, first proposed by a provincial Task Force on the Funding of the Health System, might be capped at 1% of a family's income (www.budget.finances.gouv.qc.ca/Budget/2010-2011/en/documents/MoreEfficient.pdf). It would not be payable at the time a medical service was received, but rather the following year as part of an individual's income tax return. All households would receive an annual statement from the government indicating the number of medical visits that are subject to the fee.

The budget documents argue that such a deductible would not constitute a violation of the Canada Health Act because it would not be a user fee that would restrict accessibility of the health care system. "What is sought is an orienting effect, not a moderating effect: the purpose is to encourage delivery of the right care at the right place."

Bachand indicated that health care spending, at $28 billion, will account for 45% of all government program spending in 2010/11 and that drug costs are the fast rising component of the health budget, rising an average 10.7% a year over the course of the past decade.

Bachand also said the government will move forward with measures to promote more efficient management of the health care system and better organize the use of information technologies, including "rationalizing technological and computer infrastructures." — Wayne Kondro, *CMAJ*

Private clinics precluded from recommending bariatric surgery

The government of Ontario will prohibit private weight management clinics from recommending patients for bariatric surgery.

The independent clinics, as with family physicians, will have to refer their patients to one of five designated assessment centres, which will determine whether surgery is warranted after patients have participated in a multidisciplinary weight management program of at least three months' duration and failed, says Ministry of Health and Long-Term Care spokesman Andrew Morrison.

"We're working on a centralized referral function that is coming online soon," Morrison says. "They can refer patients to a referral centre which will then assess them, which could prove they are ready for surgery or it could prove they just need more dieting or general counselling."

The changes in the referral process are part of a provincial bid to reduce the cost of bariatric surgeries performed on Canadians in the United States by expanding the number of surgeries performed within the province to 1470 from 244 a year (*CMAJ* 2010. doi:10.1503/cmaj.109-3147).

The latest referral rule will make it harder for physicians and patients to access care, argues Dr. Yoni Freedhoff, director of the Bariatric Medical Institute, a privately run weight management centre in Ottawa, Ontario. "It is yet another hurdle for people with weight management issues to jump. And now the hurdle is being extended to physicians who have specifically made it their practice to care for and treat this very underserviced population."

Freedhoff adds that patients will be obliged to duplicate efforts they've already undertaken at private clinics. "Despite going through our clinics, the ministry is saying our patients also have to go through these regional assessment centres, which themselves have education programs and therefore all of these patients who are well-educated are going to be re-educated." — Becky Rynor, Ottawa, Ont.

Pharmaceutical sales increased during recession

Canadians found many ways to tighten their belts during the economic recession but it appears spending on pharmaceuticals is an area in which few skimped.

Sales at Canadian retail pharmacies rose 6.1% to $22.9 billion in 2009, while the number of prescriptions filled by pharmacies rose 5.5% to 483 mil-

lion, according to the pharmaceutical industry market intelligence firm IMS Health.

The IMS data also indicate that generic drugs comprise 54.3% of the pharmaceutical market, as compared to 51.8% in 2008 (www.imshealth.com/deployedfiles/imshealth/Global/Americas/North%20America/Canada/StaticFile/IMS_Canada_2009_Charts_En.pdf). That trend is expected to continue as 42% — worth roughly $7.1 billion in sales — of branded medications will lose patent protection through the year 2014.

Hypertension was the top reason for visits to physicians in 2009, according to the IMS data. It accounted for 20.6 million visits to physicians and was followed by: routine medical exam (10.49 million), diabetes (9.74 million), depression (8.58 million), anxiety (6.36 million), acute upper respiratory infection (6.29 million), normal pregnancy supervision (4.95 million), hyperlipidemia (4.74 million), unknown cause of morbidity (4.5 million) and surveillance of contraceptive methods (3.52 million).

Canadians filled an average 14 prescriptions, spending $680 per capita, at pharmacies in 2009. That ranged from a high of $820 and 25 presciptions in Quebec, to a low of $518 and 10 prescriptions in British Columbia.

Cardiovascular drugs were the highest prescribed therapeutic class, with nearly 75 000 prescriptions written for a value of $3.27 billion, a 4% increase over 2008. They were followed by (according to number of prescriptions within a therapeutic class): psychotherapeutics (61 233 prescriptions valued at $2.36 billion), gastrointestinal/genitourinary (33 542 prescriptions, $1.87 billion), cholesterol agents (31 839 prescriptions, $2.59 billion), hormones (26 147 prescriptions, $1.02 billion), analgesics (25 252 prescriptions, $1.02 billion), anti-infectives, systemic (24 738 prescriptions, $887 million), diabetes therapy (21 360 prescriptions, $908 million), neurological disorders (20 008 prescriptions, $1.09 billion) and diuretics (17 524 prescriptions, $181 million).

Pfizer earned the most of any pharmaceutical company in Canada, with purchases from pharmacies and hospitals tallying $2.54 billion, followed by Apotex ($1.6 billion), AstraZeneca ($1.39 billion), Novopharm ($893 million), GlaxoSmithKline ($841 million), Novartis ($799 million), Schering-Plough ($743 million), Roche ($673 million), Janssen-Ortho ($610 million) and Merck Frosst ($551 million). — Wayne Kondro, *CMAJ*

When should dementia patients be allowed to drive?

Doctors should trust their instincts in determining whether patients with mild dementia should be allowed to continue driving, according to updated guidelines from the American Academy of Neurology.

"Because there is no test result or historical feature that accurately quantifies a driving risk, clinicians are only capable of making qualitative estimates of driving risk," the academy says (www.neurology.org/cgi/rapidpdf/WNL.0b013e3181da3b0fv1.pdf).

The academy conducted a full-test review of 422 studies in making its recommendations for an update of the 2000 American Academy of Neuology practice parameters on driving and dementia. The systematic review indicated that there is no definitive or conclusive test or tool that can determine if a patient with mild dementia should be precluded from driving.

Some tools or characteristics, however, may be more useful than others in helping doctors make their determination, the academy said. The most useful may be a patient's score on the Clinical Dementia Rating scale, which measures cognitive abilities such as memory, judgment and problem solving. The scale ranks patients from zero (no dementia) to three (severe dementia). Patients scoring higher than two on the scale should "probably" surrender their driving licences, the academy said.

The second-highest-rated characteristic that may be useful to doctors is "a caregiver's rating of a patient's driving ability as marginal or unsafe."

Other characteristics that may be useful to clinicians are: a history of traffic citations (one in the previous two to three years); a history of crashes (one crash in the previous one to five years); reduced driving mileage; self-reported situational avoidance (driving at night or in the rain); Mini-Mental State Examination scores of 24 or less; and "aggressive or impulsive personality characteristics."

The academy added that characteristics that are not useful in making a determination of an unsafe driver are "a patient's self-rating of safe driving ability and lack of situational avoidance."

The guidelines also noted that "there is insufficient evidence to support or refute the benefit of neuropsychological testing, after controlling for the presence and severity of dementia, or interventional strategies for drivers with dementia." — Wayne Kondro, *CMAJ*

Global life expectancy rises

Global life expectancy reached 68 years between 2005–2010, a 21-year rise since 1950–1955, according to a United Nations report.

It's a direct function of a shift in the burden of disease from communicable to noncommunicable diseases, states the *Report of the Secretary-General on health, morbidity, mortality and development*.

"Marked increases in longevity have resulted from controlling the spread of communicable diseases and using effective medicinal drugs to treat them. An epidemiological transition has thus occurred whereby the causes of death have passed from being preponderantly communicable diseases to being dominated by non-communicable diseases. Comcomitantly, the distribution of deaths by age has shifted to older ages and life expectancy has reached unprecedently high levels," adds the report (http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N10/222/24/PDF/N1022224.pdf?OpenElement).

But while the life expectancy gap between income groups and geographic areas has narrowed, "major differences persist," the report adds. Life expectancy

in high-income developed countries rose to 80 years between 2005–2010 from 67 years between 1950–1955. Over the same time period, it rose to 78 from 49 years in high-income developing nations; to 70 years from 57 years in upper-middle-income countries; to 72 from 43 years in lower-middle-income countries; and to 60 from 38 years in low-income countries.

The report adds that 31% of all deaths in the world resulted from communicable diseases, such as infections, while 60% were attributable to noncommunicable diseases, such as cancer and heart attacks, and 10% to injuries.

Those totals varied significantly by geographic area. In North America and Europe, the proportion was 6% communicable, 87% noncommunicable and 7% injury. Noncommunicable diseases were also the primary cause of death in Asia, Oceania and Latin America and the Caribbean. Only in Africa were more deaths caused by communicable diseases (64%) than noncommunicable diseases 28%) and injury (7%). That was largely the consequence of the AIDS epidemic, the report states.

Female life expectancy exceeds male life expectancy in all geographic regions and all income groups, the report adds. Globally, females have a life expectancy of 70 years, compared to 65 for males. That discrepancy is highest in Europe (13 years) and lowest in Africa (two years). Again, Africa's numbers were largely a function of the AIDS epidemic.

Over the 60-year period, there was also a 70% reduction in childhood mortality rates. Globally, mortality under age five dropped to 71 deaths per 1000 births in 2005–2010 from 233 per 1000 births in 1950–1955. — Wayne Kondro, *CMAJ*

DOI:10.1503/cmaj.109-3235