marketplace.” If we think we’re having trouble confronting costs, wait until we turn over more chunks of health care to the marketplace,” says Taft, author of *Clear Answers: the Economics and Politics of For-Profit Medicine*.

In April, the Alberta government plans to introduce a new Health Care Assurance Act, which would replace the Health Care Protection Act. The current legislation, once known as Bill 11, forbids privately-owned hospitals and alludes to the supremacy of the Canada Health Act. The new bill is expected to omit both. — Lisa Gregoire, Edmonton

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BC to reform health care

British Columbia is planning to enshrine the Canada Health Act’s 5 basic principles in provincial legislation that will also consider more private health care delivery models, Premier Gordon Campbell outlined in a Throne Speech on Feb. 14.

The speech also called for the addition of a sixth basic principle — sustainability — that would speak to the growing cost of delivering health care, which now accounts for 44 cents of every dollar the province spends.

“The need for sustainability is prompted by the major challenge that the fastest growing demographic in BC is 85-plus,” said BC Health Minister George Abbott. “In every corner of the health care budget we are under pressure,” he added, citing the demands of aging baby-boomers.

“We want to find the best alignment of public and private.” — BC Health Minister George Abbott

In the Throne Speech, the Campbell government questioned Canadians’ reluctance to consider other mixed delivery models, such as those in use in Europe.

“Does it really matter to patients where or how they obtain their surgical

treatment if it is paid for with public funds?” the speech asked. “Why are we so quick to condemn any consideration of other systems as a slippery slope to an American-style system that none of us wants?”

While the province has indicated that any changes it makes to the provincial system will be consistent with the Canada Health Act, Campbell also argued that the Act needs updating. “Accessibility, universality, portability, public administration and comprehensiveness are all things that we’ve embraced as Canadians,” the premier told reporters after his speech. “But as we point out in the Throne Speech, they are really largely undefined across the country.”

The Throne Speech also proposed establishing a Foundation for Health Care Innovation and Renewal to examine health models around the world, many of which incorporate a blend of public and private health care.

“We haven’t made any decisions with respect to what the model will be, but in BC we have 70 or 80 private clinics today so there is already a mix. We want to find the best alignment of public and private,” Abbott says. He and Campbell visited Sweden, Norway, France and the United Kingdom in March.

Some health care lobby groups, as well as the Opposition parties, questioned Campbell’s devotion to medicare given his emphasis on costs.

“Adding the word ‘sustainable’ to the Canada Health Act can mean only one thing: the government will decide what’s sustainable to cover under the public system. Anything beyond that, the government will strip from coverage under medicare and force patients

to pay out of their own pockets,” Debra McPherson, president of the BC Nurses’ Union, said in a statement.

In her response to the Throne Speech, NDP Leader Carole James said the province should invest more in

public health care. Instead, “the government has now embarked on an aggressive agenda to move to two-tiered health care.”

Earlier this year, a Conference Board of Canada report rated BC as having the best medical system in the country, despite low patient satisfaction rates.

There continue to be difficulties in the province’s system, including overly long wait times for orthopedic surgeries and problems in continuing care facilities, Abbott says. “In BC we do have to work on the public’s understanding, but there are areas where we need improvement,” Abbott says. — Andréa Ventimiglia, Ottawa

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Quebec included in

CaRMS match

For the first time in its 35-year history, the 2006 residency match included Quebec’s 3 francophone medical schools.

The addition of Laval, Sherbrooke and Montréal, makes the Canadian Resident Matching Service (CaRMS) truly national, says Director Sandra Banner. Previously, the 450 or so medical school graduates from these 3 institutions applied separately for residency spots in Quebec and the rest of Canada. Inclusion in CaRMS streamlines them. (McGill has always been part of CaRMS.)

First-round results announced on Feb. 22 show that 63% of Quebec students matched with their first choice of residency positions. Banner says she expects this to increase to 80% after round 2. The integration “went beautifully, we’re thrilled,” says Banner, who worked with the Fédération médicale étudiante du Québec and Canadian Federation of Medical Students on the change.

Across Canada, more than 80% of the 2052 applicants matched to one of their top 3 program choices. Of the 2101 available residency spots, 208 were still vacant after the first round; 20% more than in 2005.

This year’s match also marked the first time that Quebec international

medical graduates (IMGs) were allowed to apply in the first round; 102 Quebec IMGs applied and 45 were matched, 26 of these in family medicine.

After round one, 98 applicants remained unmatched, and will try again in the second round on April 3. In that round, Ontario-based IMGs will be allowed, for the first time, to compete for placement along with other IMGs from across Canada. Banner says more than 1000 IMGs will compete in the second round.

Of note in round one is a continuing rise since 2003 in interest in family medicine; 30% of applicants selected it as their first choice in 2006, up from 27% the previous year. Banner says the College of Family Physicians of Canada (CFPC) has been working with Health Canada on 2 programs to promote family practice among medical students.

Dr. Paul Rainsberry of the CFPC says he thinks the low numbers are due to “universities unconsciously undervaluing” this area of health care. He sees the programs as “an opportunity to try to give students a clearer sense of what family medicine is all about.”

It seems to be paying off. “It’s a small trend,” Banner says, “but we’re inching along.” — Andréa Ventimiglia, Ottawa

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Manitoba pharmacists’ association clarifies Plan B regulations

After meeting with the Manitoba government official responsible for privacy, the Manitoba Pharmaceutical Association is reminding its members that women requesting the levonorgestrol (Plan B) morning-after pill have the right to remain anonymous.

In a Feb. 2 notice to pharmacy managers and a “Commentary” released jointly with Manitoba’s Ombudsman, the association points out that Schedule 2 medication like levonorgestrol “does not require that a pharmacist record individuals’ personal health information.”

In April 2005, the association, along with other provincial associations, distributed the Canadian Pharmacists Association’s (CPhA) program on levonorgestrol to its members. That program included a screening form to record sensitive personal information, such as the names and addresses of women wishing to purchase levonorgestrol.

A news article last year (*CMAJ* 2005;173:1435-6) revealed that many pharmacists across the country were requesting and storing that information before dispensing the drug, posing a potential barrier to access.

In a meeting between Manitoba Ombudsman Irene Hill and the association’s registrar, “We talked about the current situation and what we could do to clarify that,” Hill said. During the meeting, she said she emphasized that personal information should not be collected unless absolutely necessary. Other than the need to collect names and addresses for insurance purposes, “there’s no requirement for the information to be collected.” The joint commentary reflects this stand.

Ontario’s Privacy Commissioner also met with the pharmacists’ regulatory body in that province in early December 2005. The Ontario association quickly developed new guidelines and instructed its members not to use the CPhA screening form.

The Manitoba association believes its documents were clear to begin with on the issue of pharmacists asking for this information, says Ron Guse, the registrar. “Our position is that the pharmacist may need that information, but the patient doesn’t have to supply it.”

Nor does the pharmacist have to dispense the medication, he added. The *Winnipeg Free Press* has reported that women in Steinbach, Man., have limited access to pharmacies that dispense levonorgestrol. Two pharmacies in Steinbach refused to dispense levonorgestrol when a *Free Press* reporter declined to answer screening questions.

If pharmacists are not going to provide the medication, “they need to provide information for the woman seeking it” on how to get it, says Hill.

In Massachusetts, the state’s pharmacy board upheld the complaint of 3 women who sued Wal-Mart Inc. for refusing to stock and sell levonorgestrol in

its 48 pharmacies. Their suit argued that the retail chain violated a Massachusetts’ law that requires pharmacies to stock all “commonly prescribed medications.”

In response to the suit, Wal-Mart had said that it has a corporate policy of declining to carry emergency contraception. Following the ruling, a spokesman said the company would comply.

Wal-Mart Canada Corp. in Mississauga did not respond to repeated calls requesting an interview about whether they stock levonorgestrol in the Canadian stores. — Laura Eggertson, *CMAJ*

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News @ a glance

Generic act: By summer, Médecins Sans Frontières (MSF) hopes to be able to ship the first order for an AIDS drug manufactured under a new Canadian law, known as the Jean Chretien Pledge to Africa Act. The 2004 Act allows for production of generic versions of drugs that are still under patent but are needed to address public health emergencies. The drug, being developed by Apotex Inc., is a fixed dose

combination, a one-a-day AIDS antiretroviral that combines 3 patented drugs. It must be approved by Health Canada and then licensed by the patent holders, either voluntarily or through a compulsory licensing process. MSF was one of several organizations that lobbied for the law, but the only one with extensive operations in the field, which is why it placed the first order, explains Rachel Kiddell Monroe, MSF’s Access campaign officer. “We are really hoping this order will open the floodgates, says Kiddell Monroe. “People need this drug, it can be a god-send. When the Canadian approval process is complete, the drug will also go to the World Health Organization for