UK needs 10 000 more therapists

One in 6 adults in the UK suffers from depression or chronic anxiety disorder, making mental illness the country's biggest social problem, reports the Centre for Economic Performance in London.

"We are not talking about the 'worried well'," the centre's report states. "We are talking about people whose lives are crippled by their distress."

In *The Depression Report: a New Deal for Depression and Anxiety Disorders*, the centre's Mental Health Policy Group says the 1 million UK residents who currently depend on state benefits because of mental illness now outnumber those who receive unemployment benefits. The Centre for Economic Performance at the London School of Economics is one of Europe's leading economic research groups.

Only 1 in 4 of those who suffer from depression or chronic anxiety is receiving any kind of treatment, the report states, and treatment generally consists of drugs prescribed by GPs.

The authors of the report state that the scale of the crisis is such that the health service can't deliver effective psychotherapy services. This means that recommendations in the clinical guidelines drawn up by the National Institute of Clinical Excellence (NICE) can't be implemented. Although depression and anxiety account for one-third of all disability, only 2% of the National Health Service funds are spent on such services.

"In reality, the waiting lists are enormous and the guidelines cannot be implemented. If the same happened with cancer services, there would be an uproar," the lead author of the report, Lord Professor Richard Layard, told CMAJ.

To solve the crisis, the report's authors are calling for 10 000 new therapists to be employed in a massive expansion of psychological therapy services. The authors say this would be cost-effective as people who receive psychotherapy for depression are less likely to relapse and can stay off state benefits for longer.

"Many patients want therapy but don't get any treatment because they don't want to take drugs. This is a huge hidden problem," Layard says.

The report was welcomed by the leading UK mental health charities, which said the NICE guidance on depression and anxiety should be implemented in full. — Colin Meek, Wester Ross, Scotland

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Changing family practice

Family physicians are providing less obstetrical care and inpatient care concludes a new study from the Canadian Institute for Health Information (CIHI). *The Evolving Role of Canada's Fee-for-Service Family Physicians, 1994 to 2003* updates a 2004 report with an emphasis on provincial data in 9 clinical areas for fee-for-service family physicians.

"Our goal was to give provinces the opportunity to look at the data in their own contexts. It is up to them to explain the results. This should help them to ask the right questions," said CIHI's director of Health Resources Information, Francine Anne Roy.

One of the most noteworthy findings is that the number of family physicians providing obstetrical care fell by nearly 50% since 1994. The percentage of male doctors doing obstetrics dropped from 26% in 1994 to 13.2% in 2003; among female physicians, the percentage fell from 27% to 15.7%.

In rural areas, the number of family doctors providing hospital inpatient care dropped from 80% in 1994 to 75% in 2003. Among urban doctors, 61% had provided inpatient care in 1994, but only 48% offered this service in 2003.

"Our college was not surprised by the findings," said Dr. Louise Nasmith, president of the College of Family Physicians of Canada. "The system has become more and more fragmented, and it is harder for doctors to access the care that they need from specialists. It makes it difficult to provide a seamless practice."

Nasmith added that "While there

are more family physicians in urban areas, doctors in rural areas are more likely to provide full-service care. As a result, they are burning out quickly, because they are on call all the time." — Margot Andresen, Ottawa

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News @ a glance

Flu vaccine delays: Production problems will delay delivery of the annual flu vaccine to provinces and territories by at least 1 month. The Public Health Agency of Canada is hopeful the vaccine will be available before the peak flu season, typically mid-December. Production was delayed because manufacturers had difficulty obtaining and then producing 1 of the seed strains (*A/Wisconsin-like*) that the World Health Organization has recommended for inclusion in this year's vaccine.

Digital Stock

Limit pharmacist prescribing: Alberta's move to allow pharmacists limited prescribing authority (CMAJ 2006;175[5]:463-4) provoked a strong reaction from delegates to the CMA Annual Meeting, Aug. 23 in PEI. They overwhelmingly approved (93%:7%) a resolution calling on the Alberta government to set conditions that pharmacists must abide by in order to prescribe. These include obtaining patient consent, maintaining a patient record, 24-hour availability, disclosure of potential conflicts of interest as both a prescriber and dispenser, and notifying physicians of changes to a prescription. "This is a strong precedent set in Alberta and it could happen in other jurisdictions," said Dr. James Bell of Alberta, who seconded the motion. "The

scope of practice afforded pharmacists is well beyond their scope of expertise and affects [physician] practice.”

No quick fix: The 2004 First Ministers Accord did not provide a “fix for a generation,” report 67% of respondents to a survey of members in the Association of Canadian Academic Healthcare Organizations. The association of 40 teaching hospitals, regional health authorities and research institutes released its survey, completed by 29 of its 43 member presidents and CEOs, in July. A majority of executives (58%) believe wait times will either stay the same or worsen in the next 3–5 years as a result of measures in the accord.

Northern exposure: An Ontario Medical Association survey of Northwestern Ontario physicians and their spouses/partners indicates that nearly one-third of them plan to leave for less remote practices over the next 5 years. Some 18% of doctors now practising in Thunder Bay are making long-term plans to move, while 44% of those practising outside the northern city intend to leave their current community. The survey indicates doctors have few complaints about the nature of their practices, other than an excessive amount of work, or their remuneration. They feel far more dissatisfaction about community, family and cultural factors, such as ease of travel in and out of a community. “Income alone is not sufficient to retain physicians in Northwestern Ontario over the long term,” the study argues. “Things that would improve retention were perceived to be: improving quality of life and educational/cultural opportunities for children; better employment opportunities for spouses/partners; more access to extended family (e.g., aging parents, siblings or adult children); physician having more time away from work to spend with the family; better orientation to their new community on arrival; and feeling more appreciated by the community.” — Compiled by Barbara Sibbald and Wayne Kondro, *CMAJ*

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PULSE

Government health care

outlays fall below OECD

average

Canadians have been asked to dig deeper into their own pockets to pay for private health insurance than their typical counterparts among other Organisation for Economic Co-operation and Development nations, according to the OECD's annual health data statistics.

Out-of-pocket payments and private insurance constituted 30% of Canadian health care spending in 2004, some 3 percentage points higher than the OECD average of 27%. Private insurance covers 13% of the Canadian health care bill, well above the OECD average of 6.5%. But out-of-pocket outlays account for 15% of Canadians' overall health bill, below the OECD average of 20%.

The disparity between Canadians and most of their OECD counterparts is most pronounced with respect to outlays for drugs. Private payments now constitute 62% of Canada's overall drug bill, as opposed to an OECD average of 39%. Canada's rate falls below Mexico and the United States (88% and 76%, respectively), but well above that of Ireland (the lowest, at 11%).

The OECD data also indicate that over the past 15 years, Canadian governments have been slowly offloading the burden of health care expenses onto private shoulders (Table 1). The public share of total health expenditures is now 69.8%, as compared to 74.5% in 1990. Moreover, Canada's public outlays now fall below the OECD average of 71.6%.

Canadian Institute for Health Information Vice-President Jean-Marie Berthelot says the shift is most pronounced with respect to private insurance payments.

“There has been a significant increase in Canada,” from about 8.1% in the early 1990s to nearly 13% in 2004.

Table 1: Public share of total health expenditures in OECD countries

Country	% of total expenditures on health	
	1990	2004
Australia	67.1	—
Austria	73.5	70.7
Belgium	—	—
Canada	74.5	69.8
Czech Republic	97.4	89.2
Denmark	82.7	—
Finland	80.9	76.6
France	76.6	78.4
Germany	76.2	—
Greece	53.7	52.8
Hungary	—	72.5
Iceland	86.6	83.4
Ireland	71.9	79.5
Italy	79.1	76.4
Japan	77.6	—
Korea	38.5	51.4
Luxembourg	93.1	90.4
Mexico	40.4	46.4
Netherlands	67.1	62.3
New Zealand	82.4	77.4
Norway	82.8	83.5
Poland	91.7	68.6
Portugal	65.5	71.9
Slovak Republic	—	—
Spain	78.7	70.9
Sweden	89.9	84.9
Switzerland	52.4	58.4
Turkey	61.0	72.1
United Kingdom	83.6	85.5
United States	39.7	44.7
Average	72.8	71.6

Note: OECD = Organisation for Economic Co-operation and Development.
Source: OECD Health Data, June 2006.

By contrast, the OECD average has remained unchanged at 6.5% over the same time period, while in nations similar to Canada, like Australia, the rate has declined to 7.4% from 11.4%. — Wayne Kondro, *CMAJ*

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