



Accessible health care

I commend Meridith Marks and Robert Teasell for drawing attention to the problems faced by Canadians with disabilities in accessing the health care system.¹ However, I believe the most fundamental threat to the well-being of these patients resides in the potential for expansion of the private health care insurance industry in this country.

By stipulating that health care must be accessible, universal and publicly administered, the Canada Health Act de facto ensures that people with disabilities are not denied health care coverage or do not have their coverage loaded (i.e., higher premiums to reflect greater actuarial risk). Although health care funding in Canada is not calculated actuarially, its costs are shared by all Canadians through their taxes.

Private insurance companies operate on a for-profit basis. They employ actuarial methods to screen applicants for conditions that represent an insurance risk. People with disabilities or other pre-existing medical conditions who applied for private coverage would therefore face higher, perhaps unaffordable, premiums or would be denied coverage altogether. The publicly funded health care system would have an uncertain future in a 2-tiered scenario, but people with disabilities and chronic conditions would be completely dependent on it.

I believe that guaranteed and affordable insurance is the cornerstone of

health care access for patients with disabilities and chronic conditions. All Canadian physicians should work to ensure that such insurance is not jeopardized.

Richard D. Cohen
Department of Medicine
University of British Columbia
Vancouver, BC

REFERENCE

1. Marks MB, Teasell R. More than ramps: accessible health care for people with disabilities [editorial]. *CMAJ* 2006;175(4):329.

DOI:10.1503/cmaj.1060188

Local thoughts on global actions

Unfortunately, William Cameron is correct to claim that the next milestone to be attained in HIV management is unlikely to be the delivery of medical care to the poorest people.¹ I recently saw 2 patients in Ottawa who had been exposed to HIV outside an occupational setting. Both patients sought medical care in a timely manner and were eligible for postexposure prophylaxis for HIV infection. When they learned that the cost of the 4-week regimen was Can\$50 to Can\$100 per day, both patients declined the therapy.

With appropriate treatment, HIV infection can now be considered to be a chronic disease. The cost of hundreds of courses of postexposure prophylaxis to prevent 1 seroconversion is not trivial, but neither is the cost of decades of care for people infected with HIV because of a lack of access to prophylactic medicines.

Even in countries that are far from the poorest in the world or the hardest hit by HIV, access to essential medicines is hardly universal. Certainly, the injustices concerning access to HIV medicines in Canada pale in comparison to those in Africa. However, my 2 Canadian patients felt the same despair

as patients in Africa do. This despair comes with the realization that their wallets are too thin to give their families the best chance to live free of HIV infection. Eliminating the financial barrier to medicines, thereby reducing the burden of disease, is paramount and is a milestone that is well within our reach.

Matthew J. Schurter
Resident, Family Medicine
Ottawa, Ont.

REFERENCE

1. Cameron DW. Twenty-five years of AIDS [editorial]. *CMAJ* 2006;175(3):225.

DOI:10.1503/cmaj.1060194

Diabetes care in developing countries

In a recent Analysis piece in *CMAJ*,¹ Venkat Narayan and colleagues noted that accurate data on the costs of treating diabetes are not available for most developing countries but that extrapolation from information gathered in developed countries is possible. We examined trends in the amount and cost of medications and monitoring equipment for diabetes prescribed in England between 1991 and 2004. Data on all prescriptions dispensed in the community for diabetes treatment were obtained from the Prescription Cost Analysis system, which compiles data for England's Department of Health.

The number of prescriptions (medicines and monitoring) rose from 7 613 000 in 1991 to 24 325 640 in 2004, an increase of more than 300%. Total expenditures increased by 650%, from £68.5 million to £448.6 million (the current exchange rate is about Can\$2.10 to £1). Insulins were the biggest contributor to costs (£196.8 million) followed by monitoring equipment (£131.5 million) and oral medications (£120.3 million). Insulins ac-

counted for over 60% of the cost of drugs but comprised only 23% of prescriptions. Metformin accounted for 40% of prescriptions but comprised only 7% of the total medication bill. Since 1991, the proportion of total prescribing accounted for by metformin has doubled, while that for sulphonylureas has decreased by almost half. In 2004, spending on glitazones (£50.6 million) was higher than on metformin (£22.6 million) or sulphonylureas (£40.1 million).

Even in a very affluent country, such large increases in spending place considerable pressure on health service budgets. Developing countries would have considerably more difficulty in covering such high prescribing costs, even though hypoglycemic agents are essential in controlling the complications of diabetes. In recent years antiretroviral drugs have been made available to patients in developing countries at low cost, representing a great advance in the management of HIV infection. Perhaps the time has come for a similar scheme for drugs to manage diabetes and its complications in developing countries.

Josip Car

Clinical Lecturer
Department of Primary Care and
Social Medicine
Imperial College London

Hitesh Patel

Janakan Srishanmuganathan
Chelsea and Westminster Hospital
Azeem Majeed

Professor
Department of Primary Care and
Social Medicine
Imperial College London
London, UK

REFERENCE

1. Narayan KMV, Zhang P, Williams D, et al. How should developing countries manage diabetes? *CMAJ* 2006;175(7):733.

DOI:10.1503/cmaj.1060209

Caring for young adults with diabetes

The recent *CMAJ* lead editorial on the challenges of caring for young adults

with chronic diseases in the adult health care system is timely.¹ Young adults aged 20–29 years with type 1 diabetes are 4 times more likely to die than their peers without diabetes, a rate that is higher than at any other age.² These deaths are largely due to preventable causes: diabetic ketoacidosis and suicide.³ Failure to adhere to the rigours of daily diabetes care can lead to chronic poor glycemic control and microvascular complications before 40 years of age.

Up to 50% of young patients with diabetes have reported difficulties with the transition to adult health care, and 25%–35% are lost to medical follow-up in the first few years after they move into the adult system.⁴ Much discordance exists between the developmental tasks of young adults with diabetes (such as moving away from home and starting a career and a family) and the expectations of the systems involved in their care. These patients can feel overwhelmed by the demands of coping with the many changes that occur during the transition to adulthood, and often the result is inadequate self-care and negative attitudes toward their disease and treatment.

In August 2002, the Diabetes Education Resource for Children and Adolescents at the Winnipeg Children's Hospital established a program (Building Connections: The Maestro Project; www.maestroproject.com) that uses a systems navigation model to facilitate the transition from pediatric to adult diabetes care for young adults in Manitoba. The project coordinator maintains contact with the young adults in the program to address any issues that arise during their transition and provides referrals for community services. If we are to reduce morbidity and mortality in young adults with diabetes, new dedicated, flexible systems are required in adult health care to meet the needs of these patients.⁵

Heather Dean

Catherine MacDonald

Department of Pediatrics & Child
Health
Winnipeg Health Sciences Centre
Winnipeg, Man.

REFERENCES

1. MacDonald N. Finding the way — meeting the needs of adults with childhood-acquired illnesses [editorial]. *CMAJ* 2006;175(7):717.
2. Health Canada. *Responding to the challenge of diabetes in Canada*. First report of the National Diabetes Surveillance System. Ottawa: Health Canada; 2003. Cat no H39-4/21-2003E.
3. Warner DP, McKinney PA, Law GR, et al. Mortality and diabetes from a population based register in Yorkshire 1978–93. *Arch Dis Child* 1998;78:435–8.
4. Pacaud D, Yale JF, Stephure D, et al. Problems in transition from pediatric care to adult care for individuals with diabetes. *Can J Diab* 2005;29(1):13–8.
5. Wolpert HA, Anderson BJ. Young Adults with diabetes: need for a new treatment paradigm. *Diab Care* 2001;24:1513–4.

DOI:10.1503/cmaj.1060226

Quality of care evaluation in France

Monitoring and enhancing physician performance is a major challenge. Several countries have developed programs for maintenance of certification, which may include written tests of medical knowledge, tests of clinical skills, and ratings by patients and peers, among other elements. The importance of self-regulation and of the independence of physicians has been stressed.¹

In France, physicians are viewed to be personally responsible for providing good care. A program to promote professional development with a focus on performance in practice was introduced in 1998, and physicians in private practice were encouraged to join it on a voluntary basis. The program was a success (in our province, 1 of every 5 physicians in private practice joined the program) and since 2005 it has been mandatory for every physician. It is regulated by an independent body that is also responsible for the accreditation of hospitals.

We are seriously concerned about the increasing involvement of payers in the evaluation of quality of care. In September 2004, the main regional care trust (a regional council of the national public health insurance system) in France, l'Union régionale des caisses d'assurance maladie (URCAM) Ile-de-France, which operates in Paris and its suburbs, published an audit concerning the treatment of colon cancer that used clinical practice guide-