FOR THE RECORD

Published at www.cmaj.ca between Nov. 2 and Nov. 16

Health spending nears $192 billion in 2010

Physicians will gobble up a larger chunk of the Canadian health care dollar in 2010 as the rate of growth in spending on doctors will rise faster (6.9%), than it does for drugs (4.8%) and hospitals (6.2%), according to the Canadian Institute for Health Information (CIHI).

Spending on physicians is projected to rise to $26.3 billion in 2010 (or 13.7% of the overall health pie) from $24.6 billion in 2009. Hospitals retain the largest share (28.9%) of outlays at $55.3 billion, up from $52.1 billion in 2009. Spending on prescribed and non-prescribed medications was projected to rise to $31.1 billion from $29.7 billion and now consumes 16.3% of total health expenditures. Spending on "other professionals" such as dentists, optometrists and chiropractors is pegged at $21.3 billion for 2010, while spending on "other institutions" such as nursing homes and residential care facilities is projected at $18.5 billion and "other health spending" such as research, transportation and hearing aids, was pegged at $12.2 billion. Spending on public health programs is forecast at $12.2 billion.

Overall, Canadian health care spending in 2010 is forecast at $191.6 billion, an annual increase of 4% (or 1.4% after factoring in inflation and population growth), says the report, *National Health Expenditure Trends, 1975–2010* (http://secure.cihi.ca/cihiweb/products/NHEX%20Trends%20Report%202010_final_ENG_web.pdf). That translates into 11.7% of Canada's gross domestic product and a per-capita rate of $5614, or $217 more than in 2009 and $460 more than in 2008.

The report also indicates that total health expenditure per capita varies significantly among the provinces. "In 2010, Alberta and Manitoba are forecast to spend more per person on health care than any other province, at $6,266 and $6,249, respectively. Quebec and British Columbia are forecast to have the lowest health expenditure per capita, at $5,096 and $5,355, respectively."

The report also pegs Canada as being among six countries with the highest rate of total health expenditure to gross domestic product in 2008. The United States led the pack, followed by France, Switzerland, Germany, Austria and Canada. Meanwhile, in an international comparison of total health expenditure per capita in 2008, the US again led the pack, followed by Norway, Switzerland, Luxembourg and Canada. — Wayne Kondro, *CMAJ*

British drug companies to reveal payments to doctors

The Association of the British Pharmaceutical Industry has approved amendments to its code of practice that will require pharmaceutical companies to publicly disclose the amount of money they pay to doctors and other health care professionals for speakers' fees, participation on advisory boards or consulting services such as chairing or attending meetings, (including registration fees, accommodation and travel). Companies are expected to commence publishing such data in 2013 for payments made in 2012.

But pharmaceutical firms need not disclose the names of individual doctors who receive payments, according to the consultancy amendments (www.pmcpa.org.uk/files/Final%20proposals%20agreed%20at%20the%20ABPI%20General%20Meeting%20-%20Appendix%203.pdf). "The information which must be disclosed is the total amount paid in a calendar year to all of the consultants who have provided services. The total number of consultants must be given. The names of the consultants need not be disclosed. Companies may of course give greater detail, for example by giving separate figures for different categories of service or by providing details of the maximum and minimum payments etc."

Nor is there an obligation to disclose "payments to consultants in relation to research and development work, including the conduct of clinical trials."

The amendments also preclude companies from providing branded promotion items to doctors, commencing Jan. 1, 2011, unless they are to be passed on to patients (www.pmcpa.org.uk/files/Final%20proposals%20agreed%20at%20the%20ABPI%20General%20Meeting%20-%20Clause%2018%20-%20Appendix%202.pdf).

"Many items given as promotional aids in the past are no longer acceptable. These include coffee mugs, stationery, computer accessories such as memory sticks, diaries, calendars and the like," the amendments state. "Items for use with patients in the clinic, surgery or treatment room etc are also no longer acceptable. These include surgical gloves, nail brushes, tongue depressors, tissues and the like. Items such as toys and puzzles intended for children to play with may no longer be provided."

"Items for use in the home or car remain unacceptable. Examples include table mats, coasters, clocks, desk thermometers, fire extinguishers, rugs, thermos flasks, coffee pots, tea pots, lamps, travel adaptors, toolboxes, umbrellas, neck cushions, plant seeds, road atlases and compact discs of music. Pharmaceutical companies can no longer give diaries and desk pads etc to health professionals and appropriate administrative staff but there is nothing to prevent them being given by other parties which are not pharmaceutical companies. In the past these have sometimes carried advertisements for prescription medicines but this is now not acceptable. Advertisements for prescription medicines must not appear on any items which pharmaceutical companies could not themselves give."

Simon Jose, president of the association, said the increased transparency is needed to restore consumer trust.

"We operate in a world where customers' and society's expectations of our industry have increased and it is only right that we adapt to this. Our members' vote in support of the changes to the Code recognises this need and also reflects the very supportive feedback from external organisations that these changes clearly resonate with health professionals. It is both important and absolutely right that we have a professional and meaningful relationship with healthcare professionals — these changes ensure that this will continue to be done in a transparent and appropriate manner," Jose stated in a press release (www.abpi.org.uk/press/press_releases_10/021110.asp). "We want to shift the debate to focus on how we can improve health outcomes for patients through science and innovation. This vote is a strong symbolic indicator of change and a positive step towards increasing trust in industry as a partner in the healthcare system." — Wayne Kondro, *CMAJ*

Overhaul of Nova Scotia emergency departments recommended

Many of Nova Scotia's small, rural hospitals should move away from offering 24–7 emergency services by adopting a "Collaborative Assessment Room for Emergency (CARE)" model under which primary care within a region is bolstered and major emergency care is efficiently handled by regional or provincial hospitals, a government-commissioned report recommends.

The province's emergency department system is now essentially "dysfunctional," Dr. John Ross, the province's provincial advisor on emergency care, states in a report, *The Patient Journey Through Emergency Care in Nova Scotia: A Prescription for New Medicine* (www.gov.ns.ca/health/emergencycarereport/docs/Dr-Ross-The-Patient-Journey-Through-Emergency-Care-in-Nova-Scotia.pdf). It is "a non-system if you will: multiple specialty groups that do not communicate with each other; multiple delays and handoffs; partial data; little accountability; and, in the end, limited evidence that all these investments and activities produce the desired outcomes."

If small hospitals embraced the CARE model, the report claims that it would reduce the number of emergency department visits, limit the random closure of those departments and reduce costs related to staffing emergency departments overnight for what is often just one or two patients.

Collaborative clinics could provide the care needed for minor emergencies, it states. "Major emergencies should be cared for and transported by Emergency Health Services directly to the most appropriate regional or provincial hospital in the shortest time possible. … Aside from services on-site, nurses working with Health Link 811 can provide advice on minor emergency care. As well, paramedics can provide basic care during home assessments, arrange clinic follow-up, or provide more advanced care while transporting patients to hospital. Developing innovative on-call systems by leveraging current technology must be part of the solution. This will free up more doctors to provide daytime care."

Among the other 26 recommendations in the report are ones calling for the adoption of province-wide standards for emergency care; the adoption of a performance-based pay scheme for physicians and other health workers; fast-track areas for X-rays and common tests in larger hospitals; and ensuring that at least 90% of patients admitted to emergency departments spend less than eight hours there.

Nova Scotia's New Democratic government, which previously pledged to keep all emergency rooms open 24–7, is reviewing the report and will respond "shortly." — Quentin Casey, Halifax, NS

Medication discrepancies still a challenge for Canadian health organizations

Compliance levels for "medication reconciliation" at patient admission and transfer points remained the lowest required organizational practices for the 236 Canadian health organizations that underwent an on-site Accreditation Canada survey in 2009, according to the non-for-profit, independent organization's annual report.

Just 46% of organizations conducted medication reconciliation at admission and just 44% at transfer, says the *2010 Report on Required Organizational Practices: Results from Canadian Health Organizations* (www.accreditation.ca/uploadedFiles/News_and_Publications/Publications/Report_on_ROPs/2010-Report-on-ROPs.pdf). Medication reconciliation is essentially the process by which health care providers obtain medication information about patients, whether during admission, discharge or change in care setting, service or level of care. Appropriate protocol dictates that any discrepancies or changes at any point in the process should be documented.

Compliance levels for medication reconciliation at admission improved from a 32% level in 2008, while those for reconciliation at transfer improved from a 38% level.

The report expressed optimism, though, that the situation will soon improve. "Enhancements were introduced into the Qmentum program [Accreditation Canada's review initiative, which focuses on five review areas: quality improvement, patient safety, risk assessment and mitigation, performance measurement, and accountability] in early 2010 and these will strengthen medication reconciliation compliance rates, thus closing the safety gap for client organizations and their patients. These revisions will ease the overall requirements on organizations and will focus and further specify the requirements in each service setting, including the emergency department, ambulatory care, and home care. Revisions include the use of the best possible medication history (BPMH) where appropriate, and keeping track of medications that are discontinued, altered, or changed."

Other required organizational practices for which there was a compliance rate of less than 75% in 2009 were: "Educates clients and families about their roles in promoting safety (73%); Evaluates compliance with hand hygiene practices (72%); Defines roles, responsibilities, and accountabilities for

client care and safety (71%); Implements a falls prevention strategy (70%); and Identifies abbreviations, symbols, and dose designations that are not to be used (66%)."

Compliance rates for tracking and sharing information on infection rates rose to 76% from 63%. Among other practices which demonstrated the largest gains in compliance rates were: Provides training on infusion pumps (up 17% to 81%); Conducts one client safety-related prospective analysis per year (up 26% to 81%); and Uses two client identifiers before administering medications (up 20% to 87%).

Required organizational practices that will come into effect in 2011 are: "surgical checklist; workplace violence prevention; home safety risk assessment; and venous thromboembolism prophylaxis." — Wayne Kondro, *CMAJ*

Fourteen specialists resign in Newfoundland and Labrador in wage protest

Fourteen salaried specialists in Newfoundland and Labrador have tendered their resignations in a wage dispute with the provincial government that they say is creating a two-tier pay structure for physicians.

The 14 physicians, who include six pediatric specialists, one general internist, a medical geneticist and a neurologist, object to the government's refusal to offer them the same 42% pay increase that was awarded to oncologists and pathologists following the province's breast cancer testing scandal.

"We're hoping it will wake government up," says Dr. Sandra Luscombe, incoming president of the Newfoundland and Labrador Medical Association (NLMA) and a developmental pediatrician with the Janeway Children's Health and Rehabilitation Centre in St. John's, who'll join 13 others in resigning, effective Feb. 4, 2011.

"The government has not engaged us in a dialogue to work this out," she says. "They're not listening to us."

The 14 physicians who are resigning want parity with the oncologists and pathologists but "it became clearer and clearer the government was not going to entertain any discussion to bring the salaries closer together," says Luscombe.

The government contends that its offer to the province's 1075 physicians, including 212 salaried specialists, is fair. "[They] are being offered a 31% increase to their salaries, which is a very generous offer that brings them to 98% parity with their Atlantic counterparts," Minister of Finance Tom Marshall said in a press release (www.releases.gov.nl.ca/releases/2010/exec/1105n09.htm).

But that notion of parity comes with strings attached, Luscombe says. The raise "would depend on shadow billing, a new concept," she says. "There is parity only if the results of the shadow billing met with the government's approval. Increases would be linked to shadow billing." (Editor's note: In other jurisdictions, shadow billing, also known as "dummy" or "evaluation" claims, has typically involved the submission of claims as a record of services provided, not as fee-for-service invoices).

"This is unheard of. I don't know of any other province that does this," she adds.

How the government plans to link shadow billing to pay raises is unclear but Luscombe says the NLMA has requested details from the government. She adds that she is concerned that if the government feels the level of shadow billing is too low, it will use that to justify not giving physicians the raise.

Luscombe contends the battle over bucks is actually a fight for more physicians. "We're all overworked" and the province will never attract enough specialists until they are paid appropriately, she says.

The government is now on the hunt for 14 replacements. Health Minister Jerome Kennedy has already instructed the regional health authorities "to begin recruitment immediately to fill these positions."

The government, which denied the NLMA's request for binding arbitration, has also sent letters to some of the physicians who resigned informing them it intends to file a complaint with the College of Physicians and Surgeons of Newfoundland and Labrador. — donalee Moulton, Halifax, NS

DOI:10.1503/cmaj.109-3733