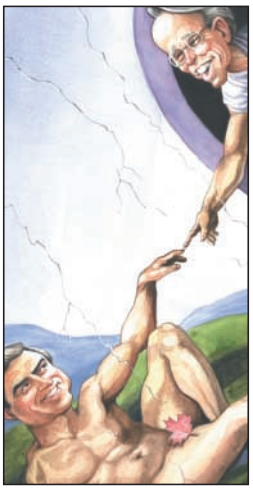
The debate on health care reform in Canada



Alan King

In this issue, we launch a series of essays on medicare, as Canadians continue to follow the deliberations of the Commission on the Future of Health Care in Canada headed by Roy Romanow. In the first essay, Steven Lewis argues that health care federalism is where durable solutions to medicare's woes lie.

Also in this issue, P.J. Devereaux and colleagues provide fodder for the current discussions about private for-profit health care delivery in Canada with a systematic review and meta-analysis of studies comparing mortality rates in private for-profit and private not-for-profit hospitals in the United States. They report that in the studies of adult populations, with adjustment for potential confounders, private for-profit hospitals were associated with an increased risk of death (relative risk [RR] 1.020, 95% confidence interval [CI] 1.003–1.038; $p = 0.02$). The one perinatal study with adjustment for potential confounders also showed an increased risk of death in private for-profit hospitals (RR 1.095, 95% CI 1.050–1.141; $p < 0.0001$). In separate commentaries, David Naylor and Donald Taylor discuss the relevance of these findings to the Canadian health care setting.
See pages 1389, 1399, 1416, 1418 and 1421.

Reducing the risk of osteoporotic fractures

Age-related bone loss is the main cause of hip and vertebral fractures in elderly people. A number of drugs have been used to slow down the progress of osteoporosis and to reduce the risk of fractures. The bisphosphonates are a new class of compounds that act by selectively inhibiting osteoclast function, and thus bone resorption, during the remodelling cycle of bone turnover. Randomized controlled trials have demonstrated gains in bone mineral density of 4.5%–8.3% at the lumbar spine and 1.6%–3.8% at the femoral neck for patients treated for 3–4 years with bisphosphonates. In this issue, Anthony Hodsman and colleagues evaluate the evidence to date that these increments in bone mineral density during bisphosphonate therapy translate into a reduction in observed fractures.
See page 1426

Family physician workloads

The challenges of physician resource planning are exacerbated by a lack of detailed information on the role played by family physicians, as indicated by practice variations across regions and demographic characteristics. Steve Slade and Nick Busing report the results of a national study of family physician practice patterns undertaken to allow regional-level comparisons of clinical workload and range of medical services offered. Solo practitioners reported 53.8 (95% confidence interval [CI] 52.7–55.0) total weekly work hours, whereas those practising in multidisciplinary clinics reported 45.0 (95% CI 43.2–46.8) hours. FP/GPs in the Atlantic and Prairie provinces reported 5.6 and 5.1 more weekly work hours, respectively, than the national average of 51.4 (95% CI 50.8–52.0) hours. FP/GPs who served inner-city populations reported 48.6 (95% CI 46.8–50.5) total weekly work hours, whereas those serving rural populations reported 57.0 (95% CI 54.7–59.2) hours. FP/GPs practising in less populated provinces and in rural areas reported the highest numbers of work hours, medical services offered and clinical procedures performed.
See page 1407

Pesticide exposure

Exposure to pesticides can affect human health in a variety of ways, from acute poisoning to chronic effects including dermatitis, neurobehavioural symptoms and cancer. In the fourth article in our series on identifying and managing adverse environmental health effects, Margaret Sanborn and colleagues review the common sources of exposure and discuss the epidemiology of pesticide poisoning. They provide clinical information on diagnosing and managing cases of pesticide exposure, identify groups who are occupationally or biologically vulnerable and offer advice on preventing exposure.

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