Income-based health premium centrepiece of Kirby report

When Liberal Senator Michael Kirby released his Senate committee's report on medicare Oct. 25, the critics were out in force. One said it may disappear into oblivion as soon as Roy Romanow's own much-anticipated report appears this fall. Others said it should be banished to one of the Senate's dustiest shelves because it promotes more private delivery of services. And yet more skeptics were wondering whether Ottawa has the resolve to adopt its centerpiece recommendation: that taxpayers pay a new health premium ranging from 50 cents to $4 per day.

But Kirby insists that the report prepared by his 11-member committee, entitled *The Health of Canadians — The Federal Role*, contains the prescriptions needed to stave off the development of a parallel, private system. Two-tier medicine is "the inevitable consequence of failing to reform the system now," he said. The report concludes that public funding is the most efficient way to fund health care, but more of the service delivery could be done privately.

To that end, the committee urged the adoption of a new health premium to fund new measures, such as a national pharmacare program. It also urged the federal government to earmark a revenue source — possibly half of its GST revenue — to ensure the long-term sustainability of federal cash transfers to the provinces for health care.

The health premium would be levied according to existing tax brackets, starting at 50 cents per day for those with taxable incomes under $31 000 and rising to $4 per day for those earning more than $103 000. Kirby says the measures would generate $5 billion a year to expand and restructure the system.

At the core of reforms lie recommendations to promote more competition in the delivery of services by devolving authority for managing care — including all funding for physicians, hospitals and, possibly, prescription drugs — to regional health authorities (RHAs). Under this plan, hospitals would receive allocations according to the number of services provided. Physicians, or groups of physicians, could contract with an RHA on a capitation basis, or they could work entirely outside the system.

Kirby conceded it is a trifle inconsistent to recommend a type of fee-for-service for hospitals while urging capitation for physicians. But rather than consistency of principles, he said the senate committee sought incentives to encourage "volume" within hospitals. "Secondly, fee-for-service will allow us to determine which hospitals are efficient and which aren't."

Service-based hospital funding would also improve accountability, added Senator Wilbert Keon, a Progressive Conservative. "It makes you perform up to standards and if you don't do the work they take the money back at the end of the year, and that's the way it should be."

Kirby (right) and CMA Past President Peter Barrett: Will anybody listen?

Canadian Health Coalition spokesman Mike McBane says the unstated objective is privatization "by stealth. … That's an Arthur Andersen approach to medicare — governments are bad, markets are good."

Canadian Healthcare Association President Sharon Sholzberg-Gray said the debate is somewhat moot because the federal government cannot tell provinces how to spend money on hospitals or physicians.

CMA President Dana Hanson was more upbeat, saying that Kirby's report helps "set the stage for a truly comprehensive national health care plan." Kirby's report is available at **www.parl.gc.ca/37/2/parlbus/commbus/senate/com-e/soci-e/rep-e/repoct02vol6-e.htm**. — *Wayne Kondro*, Ottawa

New medical school offers cadaver-free anatomy lessons

There weren't any cadavers, let alone a dissecting room, when the first students arrived at the Peninsula Medical School in Plymouth and Exeter, UK, this fall. The brand-new school had become the first in the UK to teach anatomy without using cadavers.

School spokesperson Dr. John McLachlan, who says modern medical imaging techniques have made the change possible, thinks students will benefit. "The dissecting room can be a traumatic experience for first-year students, and perhaps it is not the best introduction to the whole issue of death and dying."

Anatomy will be taught using a combination of techniques, supported by models and 3-dimensional images and reconstructions. McLachlan thinks students will adapt easily because of their exposure to technology. At a more advanced stage, although probably not in the first year, the university will employ sophisticated simulations that will allow students to employ methods similar to those used to train airline pilots.

McLachlan disagrees with critics who maintain that dissection is a necessary part of medical training. "A cadaver does not bear much resemblance to a living body. To the uninitiated, it would be difficult to distinguish between a nerve fibre and a blood vessel." As well, he says chemicals used to preserve cadavers, when combined with post-mortem changes, make the consistency of the tissue and organs quite different from that encountered in live patients.

The General Medical Council (GMC), which is responsible for setting standards for undergraduate education, says its main concern involves outcomes, not the teaching process. However, GMC personnel will visit Peninsula to ensure that standards are maintained.

Peninsula is 1 of 2 new schools to open in the UK this year. They are part of a plan to increase intake by 1100 medical students a year by 2005. — *Cathel Kerr*, Fife, Scotland