Plans afoot for national network of for-profit urgent care centres

Dr. Mark Godley plans to set up private, for-profit urgent care centres across Canada, including, possibly, Ontario Aboriginal reserves. Just days after he and 3 partners opened Canada’s first such centre on the bottom floor of their False Creek Surgical Centre in Vancouver, on Dec. 1, Godley told CMAJ his plans include a national network of centres capable of caring for 20 000 to 30 000 patients annually.

He said he wants to change the way urgent medical care is delivered in Canada, and won’t stop “until I’ve gone across the whole country.”

Godley intervened in the successful 2005 legal challenge in the Supreme Court of Canada by Dr. Jacques Chaoulli. The court ruled that Quebec’s ban on private health insurance for medically necessary services violated provincial human rights law. Godley says he’s operating within the law.

Godley’s Vancouver centre triggered a massive public backlash, with critics arguing that it threatened universal medicare. The BC health ministry said it would seek a court order to shut it down. Late on Dec. 1, Godley and the province made a deal: the clinic agreed to bill the provincial Medical Services Plan for covered treatments, instead of charging private fees.

Details were still to be worked out, and the controversy continued, with provincial NDP health critic Adrian Dix accusing the clinic of “holding the government to ransom.” Godley says emergency care in Canada is in crisis, and while medicare is “ideologically noble,” he says, the lack of prompt service already violates the Canada Health Act and “the patient has no bill of rights.” Godley argues that private businesses like his can respond faster than government to the changes that are needed, and medicare is not threatened because “you can still have a single-payer system and competitive delivery units.”

Godley admits that his project is risky, and noted that in the 2 weeks before the Vancouver centre opened, “I lost 10 pounds.”

Godley, who emigrated from South Africa 17 years ago, modeled the Vancouver centre on 800 urgent care centres in the US. The clinic is staffed daily from 8 a.m. to 11 p.m. by emergency physicians who also work at public hospitals, and serves ambulatory patients who do not require an overnight stay. Facilities include a radiology lab, speedy blood diagnosis equipment used by the military, a slit lamp to diagnose nose eye injuries and an operating room for day surgery.

Godley said the clinic will be more efficient at diagnosing and diverting patients with life-threatening conditions such as heart attacks or strokes to the nearby Vancouver General Hospital, where they can go directly for treatment without waiting in the emergency department. He estimates that urgent centres like his could care for 57% of emergency department patients.

Next up? Godley hopes to open a surgical centre with diagnostics in Surrey, BC. — Deborah Jones, Vancouver

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Auditor-General slams regulatory regime

Health Canada’s management of its 3 primary regulatory programs is so haphazard that it is impossible to ascertain whether “it is fully meeting its responsibilities as the regulator of drug products, medical devices and product safety,” Auditor-General Sheila Fraser says.

Moreover, the department’s process and principles for oversight of the 3 regulatory programs is so incoherent that it hasn’t even “determined the level of activities the programs must carry out to meet the Department’s regulatory responsibilities, or the level of resources they would need to do so,” Fraser said in a Nov. 28 report to Parliament.

The inevitable consequence is inadequate protection of Canadians’ health and safety, which even program managers admit is likely now at risk, and sets the stage for “increased risk of liability to the Crown,” Fraser noted. “The Department needs to decide what it is trying to achieve, what its priorities are, and direct resources toward programs and services that help Canadians.”

While casting all aspects of Health Canada’s regulatory process as generally lax, the report sketches a lengthy list of areas in which oversight is particularly deficient, including conduct-
The agency will “get the right information to the right people at the right time.” — Jeff Lozon, chair of the Canadian Partnership Against Cancer

Ottawa creates clearing house for cancer information

Cancer treatment inequities across the nation should eventually be mitigated by a new federal plan, funded to the tune of $260 million over 5 years, to disseminate “best practices” information about prevention, detection and treatment, according to the chairman of the newly-minted, arm’s-length Canadian Partnership Against Cancer.

There’s often a lag on the order of 10 to 15 years between what we know works and actually applying it to cancer care, says Jeff Lozon, president and chief executive officer of St. Michael’s Hospital in Toronto. “If we can contribute to reducing that lag time, we’ll have done a good job.”

Getting evidence-based information out to clinicians should invariably improve outcomes, Lozon added. “We want to get the right information to the right people at the right time, so that care can be delivered faster and, perhaps, more effectively. It’s lending national support to helping them do their jobs.”

The primary purpose of the agency will be to “serve as a clearing house for state-of-the-art information about preventing, diagnosing and treating cancer,” Prime Minister Stephen Harper said while unveiling the initiative in Montréal. “Its job is simply to make sure that the best cancer care practices and guidelines; establishment of a national plan for strategic investments in priority areas of research; and establishment of a national cancer data collection system.

Seven “action groups” have been struck to develop specific measures to achieve the CSCC’s objectives, Latierre says. They’re expected to report early next year with their initial recommendations.

The CSCC’s business plan notionally allocated $40.3 million for administration, as well as specific pots of money for each of the 7 working groups, as follows: primary prevention ($40.3 million), standards ($12.3 million), clinical practice guidelines ($13.8 million), re-balance focus (i.e., information for patients) ($20.1 million), human resources ($16.1 million), strategic research ($6.9 million), surveillance ($20.1 million), and guidelines ($7.9 million). — Wayne Kondro, CMAJ

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