For the record

Working for health care

The average American is shouldering an ever greater portion of employer-sponsored health insurance plans, according to a study conducted by the Commonwealth Fund.

Moreover, they're paying more for less, as deductibles (the amount someone must pay out-of-pocket before his insurance kicks in) keep spiralling upward, according to the report, *State Trends in Premiums and Deductibles, 2003–2010: The Need for Action to Address Rising Costs* (www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2011/Nov/State%20Trends/1561_Schoen_state_trends_premiums_deductibles_2003_2010.pdf).

"Rising employer insurance premiums have meant that many working families have seen little or no growth in wages as they have, in effect, traded off wage increases just to hold onto their health benefits," the study states. "[I]n state after state, premiums have increased as a share of median household income, making it difficult for many families to save for education or retirement — or simply to meet day-to-day living expenses."

The average total premium for family coverage in 2010 was US$13 871, an average increase of 50% from 2003. The highest growth rate (70%) occurred in Mississippi. Premiums increased by less than 40% in only six states, with Idaho (33%) experiencing the lowest growth rate. The five lowest cost states (between US$11 379 and US$12 409) were Idaho, Arkansas, Hawaii, Montana and Alabama, while the five highest cost states, along with the District of Columbia, which had the highest premium at US$15 206, were New York, Rhode Island, Connecticut, Florida and New Hampshire. In 16 states, total premiums topped $14 000 per year in 2010.

If the growth rate of insurance premiums continues at the same pace, the average premium for family coverage will be US$23 793 by 2020, the study says. But that may be reduced as a result of US President Barack Obama's health care reforms including the "creation of state-based health insurance exchanges, the introduction of new insurance market rules and consumer protections, and the expansion of state and federal oversight of industry practices." If those measures combine to reduce the growth rate by 1%, the average premium would be US$2161 less.

In parallel with the increase in premiums, employers are demanding that their employees pay a higher share of costs, either through higher premiums, higher deductibles, increased copayments, or reductions in the level of benefits, at a time when the median household income declined in 34 states, the study notes.

"The resulting increase in employee shares of premiums combined with rising premiums resulted in an average 68 percent increase in annual costs of premiums for employees for a single-person plan and 63 percent increase for a family plan across states from 2003 to 2010. In 2003, employee annual costs for their share of family plan premiums averaged $2,283. By 2010, employee annual costs for their share of family plan premiums averaged $3,721 (median of $3,685), ranging from an average of $2,988 in the five states with the lowest employee annual premium costs of family coverage (Michigan, Montana, Vermont, Pennsylvania, and Kentucky) to an average of $4,479 in the five states with the highest employee annual premium costs for family coverage (Delaware, Maine, Virginia, Texas, and Florida)," the report states.

The average deductible, meanwhile, for a family plan rose 83% over the same time period to US$1975 from US$1079, and 98% for a single-person plan to US$1025 from US$518. For people working in firms with fewer than 50 employees, the family rate rose to an average US$2857 from US$1575, while the single person rate rose 106% to US$1447 from US$703.

The number of uninsured or underinsured adults in the US rose to 81 million from 61 million. — Wayne Kondro, *CMAJ*

Paving the path to personalized medicine

Genome Canada, the Canadian Institutes of Health Research (CIHR) and the Cancer Stem Cell Consortium will collectively contribute $67.5 million toward a "personalized medicine" research initiative that the federal government lauds as having the "potential to transform the delivery of healthcare to patients."

"The potential to understand a person's genetic makeup and the specific character of their illness in order to best determine their treatment will significantly improve the quality of life for patients and their families and may show us the way to an improved health care system and even save costs in certain circumstances," Health Minister Leona Aglukkaq stated in a press release (www.genomecanada.ca/en/about/news.aspx?i=407).

"Personalized medicine is not a household term," Aglukkaq told a press conference. "But we think it will be soon."

Genome Canada will contribute $40 million, the Canadian Institutes of Health Research $22.5 million and the Cancer Stem Cell Consortium (a partnership that includes the Canada Foundation for Innovation, Genome Canada, CIHR, the Ontario Institute for Cancer Research, the Stem Cell Network and the Michael Smith Foundation for Health Research) $5 million toward research projects that fall under the umbrella of the initiative. The three funding bodies will collectively invest a maximum of $5 million in any one project, which must obtain a minimum of

© 2012 Canadian Medical Association or its licensors

50% of its funding from another party such as a provincial government, private company, university trust fund or international foundation (www.genomecanada.ca/en/portfolio/research/2012-competition.aspx). Each of the three also has various specific and differing eligibility requirements that must be met before it will fund a project.

Genome Canada, for example, will fund large-scale "applied research" projects that "demonstrate how genomics-based research can contribute to a more evidence-based approach to health and improving the cost-effectiveness of the health-care system," in such areas as:

- "Development of molecular markers that can inform dietary or behavioural choices in disease prevention strategies and the related understanding of how these choices may be presented to, understood, and be acted upon by, individuals;
- Development of monitoring diagnostic tools for screening programs for diseases and investigation of relevant regulatory pathways and/or relevant policies and practices that would accelerate the integration of new diagnostic tools in Canadian laboratories;
- Development of molecular markers to monitor disease progression and/or response to treatment and studies that would result in development of best practices for addressing related psycho-social implications for patients and families;
- Development of biomarker panels to stratify patients so that more targeted treatments can be offered that address the molecular pathology of the particular disease;
- Development of computational methods that will enable translation of genomic discoveries to the clinic and studies that would result in recommendations for facilitating the uptake of electronic health records by clinicians; or,
- Pharmacogenomic approaches to improve safety and efficacy of existing drugs resulting in an eventual label change for an adverse drug reaction, and related regulatory oversight."

Genome Canada will also ultimately support three genomics-related ethical, economic, environmental, legal and social projects such as "studies, including economic modeling, to assess more comprehensively the social and economic benefits that are derived from genomics research and its integration into the health-care system; (and) studies relying on methods such as health technology assessment, comparative effectiveness (including cost-effectiveness, clinical utility, and/or real-world effectiveness studies) or health outcome assessments related to the integration of genomics-based practices or technologies, including risk stratification, new diagnostic and screening tools, and associated therapeutic modalities, as well as studies into the understanding across health-care practitioners and segments of the Canadian population of these practices or technologies, to inform decision-making by governments or other stakeholders."

CIHR's $22.5 million contribution represents the first phase of the granting council's "Personalized Medicine Signature Initiative" (www.cihr-irsc.gc.ca/e/43707.html). CIHR funding for the projects will be provided through its institutes. The CIHR Institute of Infection and Immunity, for example, will "consider" contributing $2.5 million toward projects in the areas of "transplantation; antimicrobials resistance; inflammation; human microbiome; clinical auto-immunity; preparing for and responding to emerging threats; and vaccines."

The Cancer Stem Cell Consortium will contribute $5 million to one project, i.e, the "highest-rated" cancer stem proposal in the forthcoming personalized medicine competition. That project "must be focused on the study of cancer stem cells with the goal of developing cancer stem cell based therapy or biomarkers with the specific aim of improving cancer treatment." — Wayne Kondro, *CMAJ*

Ontario vows shift to patient-centred care

Political foes immediately dubbed it as vague and administrative but Ontario's Minister of Health and Long-Term Care Deb Matthews lauded the province's plan to retool its health care system as transformative and vital to ensuring sustainability.

The plan "is obsessively patient centred, and will invest health dollars where patients need them most," Matthews said while unveiling the scheme in an address to the Toronto Board of Trade (www.health.gov.on.ca/en/news/speech/2012/sp_20120130.aspx). Health care spending in Ontario must be shifted "to where we get the highest value. And health care is overflowing with opportunities for reform," she argued.

Among measures in Ontario's *Action Plan for Health Care* (www.health.gov.on.ca/en/ms/ecfa/healthy_change/docs/rep_healthychange.pdf) are proposals to place management of family doctors who are part of the province's 200 family health teams under the umbrella of Ontario's 14 Local Health Integration Networks (regional authorities that oversee health care delivery) and to allow the creation of more specialized clinics to perform unspecified but "routine" medical procedures. (There are currently 18 such clinics in Ontario performing cataract surgery, mammography, ultrasound, fluoroscopy, magnetic resonance imaging, computed tomography scans, X-rays, dialysis or bone mineral density tests).

Matthews also said in her address that the plan will "accelerate the transition from provider-centred funding model towards a patient-centred funding model, where funding is based on the services provided."

That will essentially entail a reduction in operational block funding for hospitals and more payment based on actual treatments provided to patients. "Care providers should be rewarded for ensuring better patient outcomes," the plan states. "Funding must follow the patient. That is why we will accelerate the move to patient-based payment, as patients move through our health care system."

Among other proposals in the reform package are ones to provide more house calls and to substantially bolster financial support for home care programs so as to reduce "strain on hospitals and long-term care homes."

Ontario now spends 35% of its

$47.1 billion health budget on hospitals, 23% on physician compensation, 8% on drugs, 8% on long-term care, 6% on community care and the remainder on "other" activities such as public health initiatives, Matthews said in her speech. "There's a strong consensus that we don't have this balance right — that we need to put more into community care to help our growing number of seniors. The demographic pressure demands it."

She also signaled that the province believes physician compensation is a major part of the imbalance. "We need to make trade-offs. And that's what we wrestle with throughout the budget process. Let me give you an example. A 1% increase in physician compensation could buy home care for 30,000 seniors. And a 1% increase in hospital budgets could buy over 5 million more hours of home care. If we have more seniors to care for … and if fiscal pressures demand we keep costs down … then we have to address physician compensation. Because every precious new dollar we put into the system must benefit the health of patients — first, last and always."

Matthews also affirmed earlier indications that the province is looking to adopt a more evidence-based approach in determining what medical services will be covered under the Ontario Health Insurance Plan or what drugs will be covered by its provincial drug plan. "We will strengthen Health Quality Ontario [an agency created to promote evidence-based standards of care] so that we increasingly shift funding to services that are known to get the best results for patients. This year alone, evidence-based changes have allowed us to re-invest $125 million towards more effective patient care. Likewise, we will continue to fund drugs only when the best clinical evidence tells us they benefit patients." — Wayne Kondro, *CMAJ*

Coalition urges funding for psychologists

Payments to psychologists should be covered in provincial health insurance plans so as to improve Canadians' access to psychological services, according to the Canadian Mental Health Association, the Mood Disorders Society of Canada and the Canadian Psychological Association.

"The services of psychologists are not funded by provincial health insurance plans which make them inaccessible to Canadians with modest incomes or no insurance" stated Peter Coleridge, national CEO of the Canadian Mental Health Association in a statement issued by the three groups to mark Psychology Month in Canada (www.cpa.ca/docs/file/Media/PsychologyMonth JointRelease(ENFR).pdf). "This is in spite of the fact that some of the most effective treatments for common mental disorders — depression and anxiety — are psychological ones like cognitive behaviour therapy."

"It is vitally important that we look to the needs of the community when it comes to mental disorders and health promotion and that we respond to those in ways that are effective," added Dave Gallson, associate national executive director of the Mood Disorders Society of Canada. "Our research has found that the lack of insured services prevents a majority of individuals with mental illnesses from seeking the support they need."

The groups urged that Canada follow the lead of Australia, which in 2006 began covering services provided by registered psychologists in public health insurance plans, as mental disorders have a $51 billion per year impact on the economy.

"Psychological services are proven effective in helping Canadians to manage and overcome psychological problems and disorders," said Dr. Karen Cohen, CEO of the Canadian Psychological Association. "Canada's private health care insurance plans and publicly funded programs don't do enough to ensure Canadians have equal and adequate access to needed psychological service. Canada's governments and employers must do more to ensure all Canadians — regardless of income — can access the psychological care they need."

Psychology Month was established in 2005 in a bid to elevate awareness about the need to improve mental health services in Canada (www.cpa.ca/psychologymonth/). The Canadian Psychological Association and the Canadian Alliance on Mental Illness and Mental Health assert that "two out of three people with a diagnosable mental disorder in Canada do not receive seek or receive care. Many factors influence the low utilization of service but these include the stigma involved in seeking help for a mental health problem and the availability and accessibility of needed treatments" (www.cpa.ca/psychologymonth/facts/). — Wayne Kondro, *CMAJ*

***CMAJ* 2012. DOI:10.1503/cmaj.109-4120**