

Health Council calls for lower generic drug prices

The Health Council of Canada is encouraged by Ontario's recent move to cut the prices of generic drugs.

Ontario's new regulations come into effect July 1, cutting the prices of most generic drugs by at least 50 per cent and eliminating so-called "professional allowances" pharmacists receive from generic companies for stocking their products.

Other provinces appear to be poised to follow suit with Quebec's health minister scheduled to hold a news conference on the subject Friday. British Columbia is also expected to soon make a policy announcement on generic drug pricing and a new agreement with pharmacists.

This week, the Health Council released a report it commissioned from Secor Consulting that says the current way governments and others set generic prices leaves "too much money" with manufacturers, distributors and retailers that otherwise could create savings for the taxpayer or be used in other areas of health care.

"Canadians pay some of the highest prices in the world for generic drugs," Council CEO John G. Abbott said in a news release. "The paper

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Publication Change

Due to Canada Day falling on Thursday next week, we will post an abbreviated version of the newsletter on our www.healthedition.com website June 30 but it will not be sent by email. The July 9 newsletter will have these and other articles covering news for the two-week period.

Health Committee calls for Ottawa to do more on HHR

The federal government is being asked to step up its involvement in securing a stable supply of health professionals for Canada. In a report tabled in Parliament last Thursday, the Commons Health Committee said Ottawa, the provinces and territories

need to work together to address health human resource challenges, and federal funding is needed in primary care reform, and increasing the capacity of the health education system to train and integrate foreign-trained health professionals.

It also said the federal government should be doing more to address issues it has direct responsibility for, particularly increasing the number of aboriginal health human resources in the North.

The report was produced after a year-long study of health human resource or HHR issues. It held 12 hearings from April 2009 to May 2010 and included a fact-finding trip to Nunavut.

The Committee noted that the different levels of government have a long-standing working relationship on HHR stemming from federal-provincial-territorial health accords in 2003 and 2004.

For example, the federal-provincial-territorial Advisory Committee on Health Delivery and Human Resources has produced a Framework for Collaborative Pan-Canadian Health Human Resources Planning, although the Committee heard from some witnesses in its hearings that the Framework is not achieving expectations.

One particular criticism is that it contains no "hard targets" in increasing the supply of health care providers – something the Committee said should be addressed.

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More patient-focused care needed, Sask. report says

Quality of care in Saskatchewan is slightly better than it was three years ago, but the pace and scale of improvement must accelerate, the province's Health Quality Council says in a report this week.

The report, *Quality Insight 2010*, says there has been little change in how patients rate the care they receive in Saskatchewan hospitals. Approximately 30 per cent of patients rated the hospital where they received care as the "best possible hospital" -- a measure of the extent to which hospitals exceed patients' expectations. This has not changed appreciably since 2007.

The Council said this confirms the view of the Patient First Review of the province's health system last year that the health system needs to be reorganized and delivered around the needs of patients, not the other way around.

The new report does find an improvement in care for people with

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The federal government has also funded more than 32 interprofessional practice projects as part of Health Canada's Pan-Canadian Health Human Resource Strategy, but the Committee heard that these initiatives have not resulted in wide-spread change in health-care delivery.

The Committee heard appeals for an ongoing fund for primary care reform. This would potentially kick in after the expiry of the 10-year funding deal in 2004 health accord.

The Committee said it supports this view, and recommended the government "consider the possibility of establishing sustained funding mechanisms devoted to promoting interprofessional collaborative practice within the provinces and territories."

It also sees a role for the federal government in accelerating the integration of internationally-educated health care professionals in the Canadian health care system.

Among its eight recommendations just on this topic, the Committee said the government should provide targeted funding to increase the capacity of medical schools and teaching hospitals to get more of these foreign-trained professionals working in Canada.

It further reminded the government to keep its 2008 election promise to fund 50 new residencies a year over four years.

One of the nine chapters in the report is devoted to the unique challenges of the North, and, among other things, it called for "secure and stable funding for aboriginal health human resources.

The Committee's report can be found at http://www2.parl.gc.ca/Content/HOC/Committee/403/HESA/Reports/RP4631326/403_HESA_Rpt06_PDF/403_HESA_Rpt06-e.pdf. **HE**

Hansard Highlights

Debates in provincial legislatures and House of Commons

Only the **Newfoundland and Labrador** legislature was in session this week. On Tuesday, Opposition House Leader Kelvin Parsons said his party had received a number of complaints about delays in heart surgery. He pointed to the case of a 65-year-old man from Flower's Cove who had been waiting six weeks for emergency surgery. "Each time he was scheduled for surgery it has been cancelled at the last minute," he said, adding that the family was told the delays were due to the lack of beds in the intensive care unit at the St. John's Health Sciences Centre where cardiac procedures are done. Health Minister Jerome Kennedy said the province is doing well in terms of cardiac bypass surgery — the type of surgery this man required — and "it is my understanding that we try to have the surgeries completed within the benchmark of 180 days." However, he said he recently met with department officials and "told them I was not satisfied with the progress we were making on wait times, and I wanted to see further

progress and new ideas brought forward." The man from Flower's Cove received his surgery on Wednesday.

The **Manitoba** legislature adjourned for the summer last Thursday. Progressive Conservative MLA Leanne Rowat brought up the issue of rural health care services, and said the government has treated people in rural and northern areas as "second-class citizens." She said the health minister has closed 17 rural ERs and has "forced Manitoba seniors to leave their communities to go live in personal care homes away from their family and friends, and patients of all ages are forced to travel long distances for even the most basic medical appointments because this minister can't keep rural and northern facilities staffed." Health Minister Theresa Oswald replied that there has been a 20 per cent increase in the number of rural physicians since 1999, when the NDP came into power, and 2,000 more nurses overall. "We're going to continue to keep investing in rural Manitoba," she said.

Alberta adding 3,000 continuing care beds

Alberta Health Services is adding 3,000 continuing care beds over the next three years. This includes 1,017 new beds announced earlier this year, and will bring the province's inventory to 22,500. Wait times for a bed have gone up 20 per cent since 2008, but AHS expects wait times to go down significantly as a result of the building program.

Some 1,100 beds, a third of the total, will be opened this year with 293 slated for Calgary where, according to the *Calgary Herald*, some 244 patients a day are in a hospital bed waiting for a spot in continuing care to open. Edmonton is getting 471 beds

where 257 hospital patients a day, on average, are waiting for placement.

No details have been provided on the type of continuing care that will be provided with the new beds. An AHS news release simply said it is committed to providing a range of living options, including home care, supportive living and long-term care.

There has been resistance in some quarters to the strategy of lessening reliance on long-term care. "Three thousand beds sounds great, but they are the wrong kind of beds and they're taking us in the wrong direction," NDP Leader Brian Mason told the *Herald*. **HE**

.. Briefly .. News Shorts .. Briefly .. News Shorts .. Briefly

Alberta and Newfoundland and Labrador are promising to provide more timely wait-time information.

The two provinces were singled out for criticism in last week's report from the Wait Time Alliance, a consortium of medical groups. The Alliance said both provinces post information which is more than six months old. Alberta Health Minister Gene Zwozdesky said the wait-time website was reporting on data collected by the former nine health regions, and now that there is one agency running the show it was necessary to take the site offline to make the necessary changes. He expects it to be up-and-running in the fall. Newfoundland and Labrador Health Minister Jerome Kennedy said more people are being assigned to work on wait times in his department. (*Calgary Herald*, June 18; *St. John's Telegram*, June 23)

Newfoundland and Labrador pharmacists may now refill, extend or adjust prescriptions

following changes to pharmacy regulations. When extending a prescription or making any change to a prescription, the pharmacist must notify the original prescriber. While the standards are now in effect, pharmacists are required to educate themselves fully on the standards and submit a declaration form to the Pharmacy Board before providing these services to patients. News release at <http://www.releases.gov.nl.ca/releases/2010/health/0623n03.htm>

Quebec has reached a contract agreement in principle with yet another health sector union group.

Currently, some three-quarters of health and social service workers are now covered by a tentative deal. Of these, 20 per cent are nurses or respiratory therapists but do not include the 58,000 members of the Fédération interprofessionnelle de la santé du Qué-

bec (FIQ) — the largest nursing union in the province. FIQ leaders rejected the government's offer last week. Meanwhile, the government and labour federations are inching closer to a deal on a new public sector wage package that has so far been excluded from contract talks. Premier Jean Charest met with labour leaders Tuesday and has promised a final global offer by the weekend. The government had originally proposed a five per cent increase over five years but had said this could be increased if economic growth is higher than expected. The unions are after 11.25 per cent over three years. (*La Presse*, June 23; News release) ... **The Quebec Order of Nurses has licensed 795 new members.** Some 1,105 candidates sat for the exam in March. Of these, 419 were there for their second or third time. As of the end of March, the Order had 71,371 members. (*Le Soleil*, June 23)

Manitoba nurses have ratified a tentative contract agreement that provides a one-time, lump-sum payment of two per cent followed by a four per cent increase in year three of the deal. It also includes a two per cent wage bonus after 20 years of service, and provides indexed pensions beginning in 2018. The deal was endorsed by 89 per cent of the union membership. (News release)

All Saskatchewan hospital operating rooms will be using surgical safety checklists by next March, Health Minister Don McMorris said this week. The surgical safety checklist is used before, during and after surgical procedures. Surgical team members verbally confirm information such as the patient's identity, the procedure being performed, surgical equipment required, and potential complications arising from the patient's health history

or condition. Following surgery, they confirm instrument counts and review any equipment issues or unexpected issues encountered during the surgery. News release at www.health.gov.sk.ca under What's New.

New Brunswick's billing number system for physicians is coming under review.

A physician resource management committee will be looking at the issue which the Medical Society says is an impediment to attracting new physicians. A physician needs a billing number in order to get paid for his or her services. There are 57 unused numbers for the province, and are divided among different communities based on assessed need. The Medical Society says the billing number system is also a roadblock for establishing more collaborative care practices in the province. (*Fredericton Daily Gleaner*, June 21)

Only a third of Nova Scotia physicians have computerized their patient records

even though a \$4 million government program was set up five years ago to help them do this. However, it is tied to the use of one particular system and the head of Doctors Nova Scotia says physicians want more choice. A family physician in the Halifax area told the CBC that a number of physicians feel that there is no point switching from paper records because they are within 10 years or so from retirement (cbc.ca) ... **Expanded community resources for seniors could take 1,100 of the 3,700 seniors waiting for a nursing home bed in Eastern Ontario off the list,** a study for the Champlain Local Health Integration Network (LHIN) has found.

Wait lists for a space in one of the 7,440 beds in the region have grown significantly and the average wait is 237 days, more than double the 105-day provincial average. (*Ottawa Citizen*, June 18)

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we are releasing today should help policy makers and people across the country move forward to curtail the cost of generic drugs for both public and private plans while maintaining access and quality of service.”

The paper offers six suggestions:

- Drug insurance plans could revisit their maximum reimbursement prices since a body of evidence suggests that Canadian prices are too high
- Reimbursement prices could be set at the pharmacy level
- The use of alternative and competing distribution channels could be encouraged
- Using the pharmacist to provide additional paid services would moderate the impact of reducing generic-drug prices and benefit the healthcare system
- Drug plans, including employer-sponsored plans, could use tiered formularies to encourage their beneficiaries to use low-cost drugs
- Provincial and territorial drug plans could ensure that newly approved drugs are listed on their formularies in a timely manner.

Last week, the annual report of the Patented Medicine Prices Review Board (PMPRB) was tabled in Parliament. It found that the prices of patented drug products rose 0.3 per cent from 2008 to 2009, in line with the inflation rate. Research spending by patent holders was \$1.2 billion (7.5 per cent of sales), three per cent lower than in 2008.

Generic Drug Pricing and Access in Canada: What are the Implications? can be found at www.healthcouncilcanada.ca. The PMPRB report can be found at www.pmprb-cepmb.gc.ca. **HE**



Editorials & Commentary

Slow progress

The *Regina Leader-Post* (June 24) comments on the report from the Health Quality Council (HQC) this week saying there has been only slight improvement in Saskatchewan health care in the last three years. “With a new focus on data and measurement, spearheaded by the HQC, the health system is better able to identify where it is winning and losing. However, we wonder where the incentive will come from to fulfill the HQC’s plea to “accelerate” change, since patients are stuck with a single government-run provider. Patients have a right to expect the system to pick up the pace.”

Handwashing

An editorial in the *Victoria Times-Colonist* (June 18) is perplexed by the finding of a recent audit by the Vancouver Island Health Authority that most health care workers do not wash their hands before visiting a patient. The one-day audit found only 30 per cent of all health care workers do so, but the rate dropped to 18 per cent for physicians. Nanaimo Regional General Hospital experienced an outbreak of *C. difficile* in July 2008 that prompted a renewed emphasis on

good housekeeping and personal hygiene. However, the audit found a compliance rate at the hospital of only 41 per cent and it was as low as seven per cent in the perinatal unit according to coverage of the story in the *Times-Colonist*.

The editorial said “It is hard to understand the reluctance of health-care professionals to practise one of the most important ways of reducing the spread of disease ... If the people who deal with illness every day don’t see the need for keeping their hands clean, they cannot be expected to lead the rest of us — the great unwashed, one might say — to a higher level of awareness. Simple hand-washing can keep us out of the sick bay and keep health-care costs down. Doctors know that. It’s time for them to put that knowledge to good use.”

Health Edition is published by Kysgar Communications Inc. **Merck has made this copy of *Health Edition* available as part of its commitment to foster constructive dialogue about health reform in Canada.** You can contact *Health Edition* at info@healthedition.com. ISSN 1492-627X

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chronic conditions. “More heart attack patients are getting the right drugs and fewer seniors are on potentially dangerous medications,” it says, and more diabetes patients are being prescribed blood pressure drugs.

However, it says the health system has a long way to go. Heart attack patients are still not getting all the drugs they need after leaving hospital, and nearly half of diabetes patients do not have ideal control of their condition.

It also calls on the government to speed up implementation of an electronic health information system, to give managers and health care providers faster, easier access to the information they need to improve care for patients.

“Timely – ideally real-time – information is critical if we are to use data to improve how we organize and deliver care,” the report says.

Quality Insight 2010 can be found at www.hqc.sk.ca. **HE**