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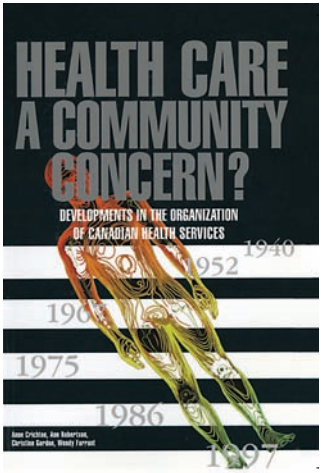

HEALTH CARE: A COMMUNITY CONCERN?
by Anne Crichton, Ann Robertson, Christine Gordon, and Wendy Farrant
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CHAPTER 10

Support Services for Physicians in General Practice

At one time family practitioners used to perform their own diagnostic tests and mix their own drugs but now they are dependent on external support services. As well in the past, most family doctors were prepared to work around the clock. Now most provide a telephone answering service after office hours and, as a result, some patients prefer to look for help from other sources. We shall now review these support services and their organization.

Diagnostic Services: Laboratories and Radiological Services

In recent years there has been extensive development of diagnostic services — laboratories and radiological services — which enable general practitioners to decide whether they can treat cases themselves or may need to seek further advice. The growing intensity of the use of diagnostic services and their increasing costs cannot be ignored (e.g., Elston 1987).

Laboratory development policies differ from province to province. The first well-developed laboratories were part of the government funded public health services concerned with controlling infectious disease. Then with the state funding of hospital insurance and the development of hospitals, most diagnostic tests for other conditions began to be carried out in hospitals. Community-based for-profit laboratories did a minor business until Medical Care Insurance provided for their doctors' fees to be paid by governments.

Most provincial governments have a laboratory advisory committee to help them to make decisions about the proportion of research funding versus service funding and how to balance profit and non-profit services (Crichton, Hsu and Tsang [1990] 1994). Some provinces have been more

ideologically committed to privatization of services and others to government provision of laboratories, so this has created differences in their approach to structuring.[1] Saskatchewan is at the government end of this continuum, Ontario at the other (Morrison 1984). In British Columbia, which lies somewhere in the middle, the private laboratories provide the bulk of the cheaper common tests for general practitioners and most laboratory companies have set up offices next to practice groupings in order to save patients' travel time. More esoteric tests are carried out in hospital or public health laboratories.

Similarly, radiologists have set up community-based offices. However, their office expansion has not been as extensive as the laboratory expansion. The provincial medical plans do not always approve the opening of new radiological service centres next to small group practice offices. While they may have been willing to permit private laboratories to do bulk testing at negotiated rates, they have usually baulked at paying the more entrepreneurial radiologists for expensive scans and have restricted many tests to the hospitals where they had more control over the purchase of equipment and so, its deployment.

Pharmaceutical Services

The organizational models for the manufacture and distribution of drugs lie in the private sector — the drug research and production companies and the local pharmacies which are required to employ qualified pharmacists to dispense prescription drugs are business organizations.

In treating patients, general practitioners rely largely on drug therapy. Studies of the need for prepaid insurance for drugs (e.g., Evans and Williamson 1978) showed that the chronically sick and elderly were most likely to need financial support for drug purchases. Universal insurance coverage was not recommended nor was it provided.[2]

Ronald Lang (1974) indicated that after the introduction of medical care insurance, at first the Canadian governments had been relatively successful in controlling the costs of drugs to all purchasers through promoting generic substitution or formulary policies. However, led by Saskatchewan (Harding 1981) in 1975, the provincial governments decided to introduce so-called Pharmacare or Prescription Drug Program schemes to provide subsidized drugs

1 Frances Pitcherack, personal communication, 1990.

2 The federal government did not develop matched grant programs for drugs. Although pharmaceutical products are not covered by government insurance schemes, an estimated eighty-five percent of the population is estimated to have some form of third party insurance (Canada 1990o).

for those over sixty-five years of age or who were chronically sick.[3] These schemes vary from province to province (Canada 1987a). As well, provincial governments looked for ways to reduce the cost of drugs, generally through facilitating generic substitutions for brand name drugs.[4] However after much pressure the Conservative federal government gave way to the drug companies on patent law (Canada 1985d). This led to protests by seniors and an attempt by the Liberal-dominated Senate to block the legislation.

Klass (1975), Harding (1981) and Lexchin (1984) have taken strong positions against the drug companies. Some articles by Lexchin (1987, 1988)[5] put the onus for excessive spending on pharmaceuticals on the drug companies and the medical profession:

> The Canadian medical profession has a long history of allying itself with the Canadian pharmaceutical industry. This alliance exists on two levels: medical associations and medical journals. As a result of the alliance the traditional emphasis on the primacy of the welfare of the patient has been subverted in favour of the profit motive of the drug industry. Elements of the medical profession promote useless pharmaceutical research, poor physician prescribing and physician involvement in educational activities controlled by the industry. Specific reforms to loosen the alliance are outlined, but ultimately the alliance will only be broken when the values of Canadian physicians change. (Lexchin 1988, 603; Lexchin 1990a,b)

Archer (1984) found it necessary to refute allegations that pharmacists, too, were involved in a "consumer rip-off," following studies of prescription drug use in Saskatchewan in 1983 and Alberta in 1984.

Recently the situation has become very difficult for the provincial governments. In British Columbia, for example, Pharmacare costs have doubled over the last five years. This led to studies of the situation by a review panel which has recommended the introduction of a provincial computer program (Pharmanet) to track prescription use by individuals. It is hoped that this will reduce inappropriate or dangerous drug use and prevent duplication and fraud in the use of prescriptions. There have also been recommenda-

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3 Saskatchewan provided subsidized drug services to ninety-four percent of its residents under two programs — the Medical Services Division and the Saskatchewan Aids to Independent Living. By using formularies, the cost of drugs was kept as low as possible (Saskatchewan 1990a). Manitoba also had a generous scheme. Other provinces have had more restrictive programs.

4 Lexchin (1989) thinks that governments might go further to provide formularies to be used by general practitioners. Their effectiveness has been demonstrated by groups such as the Saskatoon Community Clinic (Wolfe and Badgley 1972).

5 These articles have extensive bibliographies.

tions that patients should be charged according to their ability to pay but this has not yet been brought in (British Columbia Annual Report Ministry of Health, 1995).[6]

The executive director of the College of Pharmacists[7] attributed the escalating costs to skillful marketing by the drug companies and the lack of attention by doctors and patients to small changes in drug composition which has led to a lot of waste. There has also been much higher cost to the Pharmacare programs for new, more effective drugs.

In 1993–94 the distribution of Pharmacare expenditures in British Columbia was as follows: seniors 55.5%, social assistance 17.1%, families 13.3%, long term care 6.9%, medically dependent children 4.5%, home oxygen 2.5%, administration 0.4% (British Columbia Annual Report Ministry of Health, 1995).

The Science Council of Canada, having become aware of public concern at the rising costs of pharmaceuticals, called a conference in 1990 to discuss the issue. A background paper for the conference (Canada 1990o) put together the evidence available at the time:

> Not only do Canadians spend a larger proportion of their total health expenditures on drugs but they also consume more drugs than do residents of other industrialized countries. This is one conclusion of a report (Corruthers et al. 1987) on drug utilization that reviewed 2,500 current articles from the literature. (p. 4)
>
> Medication now accounts for a larger share of total health care expenditures than ever before. As health care resources stretch to cover more services, there is an increasing need to demonstrate that drugs are used appropriately, that benefits from medication are commensurate with costs and that health care providers have the information they need to better manage this health resource. Much of the necessary information and knowledge is already available but now there is need to share that information, to build on it and to act on it. (p. 2)

The Science Council of Canada conference was called in order to influence the development of a more coherent and comprehensive policy on drug use. The issues were identified as demographics: the aging of the population and the greater consumption of drugs by the elderly,[8] good health status of the population, problems of managing medical technological developments, costs of health care and uncontrolled demand.

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6 The charge to seniors and persons with disabilities for the filling of prescriptions in 1994 has been raised by fifty percent.

7 Bob Kushneran, talk to students at the University of British Columbia, 1994.

8 The National Advisory Council on Aging (Canada 1990l) has been concerned with overuse of medications by the elderly and has been trying to develop

Proposed shifts in health policy were listed, including the following, with immediate implications for control over pharmaceutical use:

1. Enhanced post-marketing surveillance involving the federal and provincial governments and a proposal for the continuous review of drug products as a condition of marketing
2. Formal drug utilization review studies for selected drugs
3. Research into criteria for cost-effectiveness evaluation as applied to drugs and other health care components
4. Improved information systems and the possible use of "smart card" and other technologies to track drug utilization
5. Analysis of the impact of user fees and co-payment schemes on drug benefit programs
6. Strategic links between universities, industry and governments for pharmaceutical R&D
7. National initiative on risk/benefit management of drugs

In May 1991 the federal government announced the creation of a National Advisory Committee on Pharmaceutical Research to advise the minister, particularly on the funding of research and development following further changes in patent protection for drugs. But the federal government had disbanded the Science Council of Canada and agreed to extend the years of patent coverage in return for some research jobs being set up by the drug companies.

Non-Medical Fee-for-Service Activities

Services which *may* be paid for by the medical plans other than medical services are chiropractic care, psychological counselling, nurse practitioners' services or physiotherapy.

The medical profession does not recognize the scientific basis of chiropractic and has tried to keep it out of the system of care but it has been able to survive because of public demand (Mills and Larsen 1981).

Psychological counselling and nurse practitioners' services, too, are not well liked by medical practitioners, many of whom see these professionals as competitors and may discourage the plans from paying fees to them. However, in the far north where doctors are unwilling to practise, there are nursing stations staffed by nurse practitioners.

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education programs to moderate behaviour. British Columbia held an invitational workshop on *Medication Use and Elderly People* (British Columbia 1989c) and has developed a number of programs to assist seniors in the management of drug use (British Columbia 1989e).

All provinces have private practice physiotherapists. They may work without a physician's referral in British Columbia and Quebec. They usually work in their own community-based offices. In British Columbia there is a ceiling on the number of treatments allowed for each patient by the medical plan; in Ontario there is a ceiling on the number of available billing numbers, but patients may pay for private care.

Hastings and Vayda (1986) list others — social workers, nutritionists and pharmacists — who are professionals in community health care, but they are likely to be salaried (not fee-for-service remunerated) unless they have their own businesses and set their own fees.

Twenty-Four Hour Coverage: Emergency Services

In general family practitioners do not offer office services on a twenty-four hour basis though there are some group practices which make exceptions to this rule. Most doctors offer telephone advice after working hours, although this advisory service may be staffed not by one of the practice group members but by an answering service doctor. In consequence hospital emergency departments are often sought out after hours, not only for real emergencies but for general counselling by those who cannot, or do not wish to, use the services of general practitioners during their office hours (Béland et al. 1990).

Emergency departments may also be used to bypass the regular referral system and its waiting lists, or as in Quebec, to make a new attempt to break into that system when regular channels are blocked (Steinmetz and Hoey 1978). The crisis in emergency service use in Quebec put pressures on the Minister to hasten restructuring of primary care (Quebec 1990b).

A Medline search of Canadian articles on utilization of emergency departments, over the period 1980 to 1990, has not been very revealing. The emergency departments of children's hospitals are most frequently studied (eight articles) while there is only one article each on use by elderly and mentally disturbed patients. Four articles deal with victims of abuse brought to emergency departments and two look at the handling of major disasters, while ten are concerned with spatial organization or stress among staff members. The appointment of salaried physicians to the larger hospital emergency departments during this decade seems to have relieved some of the pressures on the system (which were very severe in the early 1970s) and improved the response to demand. Crichton, Lawrence and Lee (1984) have discussed the information required to organize an effective emergency department. Garza (1992) has reviewed emergency services across Canada. It is clear from other studies (e.g., Stone 1994) that these services are not well coordinated with other clinical activities.

Voluntary Organizations Supporting the Medical Care System

Before the public health departments began to provide home care and other support services, help was usually provided by non-governmental organizations to those patients needing additional care which could not be given by family doctors, and many of these organizations continue to provide social supports.

Govan (1966) described the evolution of charitable organizations which were concerned with helping people who were diseased or disabled in Canada. At first these were organizations with a broad general approach such as the Red Cross, but from the late 1930s onwards, voluntary organizations associated with specific diseases began to emerge — the first being cancer societies. While some of these bodies may give priority to research over support to patients, many provide specialist treatments (e.g., Canadian Arthritis and Rheumatism Society), vocational counselling, help in resettlement into the community after medical treatment and peer group support, as well as engaging in advocacy activities.[9] There are now many mutual aid organizations. Current local listings are usually available in public libraries. Where there are Kinsmen societies they may coordinate information on support services for persons with disabilities and provide technical assistance.

Since the voluntary organizations have provided many support services, which are becoming more expensive, they have started to look to the provincial governments for financial assistance to carry on their work. In many instances this has been granted but in a totally uncoordinated way (sectors of the health departments would make grants or offer contracts as would social service departments, neither consulting with the other). Korbin (British Columbia 1993b) appointed by the province and Rekart (1994) have reviewed the situation in British Columbia, and Raines (1994) has made an inventory of Vancouver agencies. It is clear that coordination has been totally lacking there in the past but efforts are beginning to be made to change this.

Rescue Services, Ambulance and Other Transportation Issues

There are emergency services other than those based in hospitals — search and rescue services,[10] paramedic services (Copass and Eisenberg 1987) and road and air ambulance services (Garza 1992).

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9 In 1988 Saskatchewan Health, Mental Health Division developed a plan for cooperation with voluntary organizations (Saskatchewan 1988).

10 There are search and rescue services provided by different authorities in different situations. The Canadian Coast Guard provided information about its officer training plan, safety handbooks for inshore fishermen, for small fishing vessels, for safe boating and a summary of Search and Rescue (SAR) incidents,

Most cities now provide free transportation on small buses for registered persons with disabilities who want to get out and about, and parking spaces are reserved for disabled car drivers in many places.

However, although there are improvements, not all transportation problems have been solved, because there is no provision for subsidized travel from remote areas to see specialists about elective care nor is there transportation for families of these patients taken into hospitals for emergency care. However, to help with relocation problems, hostel accommodation may be provided for those who need intermittent treatment in tertiary care centres or for family members from out of town who have come to be with emergency admissions.

Summary

This chapter has dealt with the organization of support services required to assist primary care physicians in carrying out their work: laboratory testing, x-ray investigations, prescription drug availability, emergency services. There has been some concern on the part of provincial governments about the ever growing cost of these services and the failure of medical professionals to control this escalation.

The organization of laboratories and radiological diagnostic services varies from province to province. Some have been more willing than others to allow private laboratories to take on all the work, others want to keep diagnostic tests in the public sector. Some make compromises.

Pharmacy services are not insured but provincial governments subsidize drugs for seniors and chronic sick persons. Governments have struggled to control the costs of pharmaceuticals which have been growing rapidly in recent years. A Science Council of Canada conference in 1990 called for a national policy but this recommendation has not been followed through. Local efforts to control prescription drug overuse have not yet been very successful in cutting back rising costs.

Non-medical fee-for-service activities are listed here: chiropractic care, psychological counselling, nurse practitioner services and physiotherapy. Other community care services are salaried.

A review of emergency services indicates that these are not well coordinated with doctors' office services and may be used unnecessarily by some patients.

There are, as well, a large number of subsidized voluntary organizations which deliver services. These are not well coordinated with one another or with publicly provided services.

1989. Similarly there are land rescue programs to deal with emergency situations.