Drug Use in Canada: Opportunity Lost

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By David Zitner

Canadians spent $15 billion dollars for drugs last year, not including spending on complementary medicines such as herbal remedies. Yet, strange to tell, no one knows how many people were helped or hurt by this massive ingestion of pharmaceuticals.

Remember the last time you bought prescription (or non-prescription) medicines? At best your doctor or pharmacist might have told you in general terms what the drug was meant to do and possible harms. Why don't they know how many people take the drug and are helped or hurt by it? Turn the question around: when was the last time your doctor or drug plan administrator called to learn if you were dead or alive, healthier or sicker as a result of taking prescribed drugs?

Despite huge government investments in health information, no one bothers to ask about changes in health associated with drug use. Governments are totally preoccupied with health care costs, but seem not to want to know what the outcomes of care are for patients. Barriers are put in place to discourage the prescribing of expensive drugs, but not the prescribing of cheap but potentially harmful ones.

Drugs and the Canadian Institute for Health Information:

The Canadian Institute for Health Information (CIHI) collects information about each patient discharged from hospital, as well as collecting $95-million from Ottawa and untold millions more from the provinces in free data collection. Chart reviewers capture demographic information, diagnoses, surgical procedures, length of stay, and whether the patient was discharged dead or alive. Nothing is collected about anyone's health status (comfort, function, likelihood of dying) at admission or at discharge, and no information is gathered about the drug treatments received by each patient. Consequently, it is impossible to link the benefits (and harms) of care with drug treatments. It is also impossible to know if those prescribers who appear to have expensive prescribing habits, compared to colleagues, are providing better value by more effective treatment and reduction in sick days and hospitalization, or if more expensive prescribers are merely mischievous medical spendthrifts.
Routine monitoring for outcomes can save lives by informing clinicians about the results of the care they provide, and by early detection that a drug might be causing harm. Baycol (Cervistatin) a cholesterol-lowering drug was removed from the market when doctors at the Mayo Clinic happened to notice that some patients who took it suffered and died from muscle breakdown causing severe pain and kidney failure. The failure to routinely capture outcome information means that some people needlessly suffered the complications of treatment.

Cylert (Pemoline) a drug used for attention deficit disorder in children was removed from the market because it results in liver complications. In the thalidomide story, the drug caused congenital anomalies in the children of mothers who took it. Routine surveillance and early detection would have protected many people from harm.

Systems are available to record reports of drug complications. Unfortunately, no Canadian province has routine systems to systematically inquire and learn about the outcomes of drug treatment. Reporting systems exist, but doctors, pharmacists and hospitals often fail to recognize an illness as a reportable complication of drug treatment, and when it is recognized often don't report it.

Auto repair shops, computer service technicians, and many other industries routinely contact people to learn if service was satisfactory. Why do health organizations, hospitals and pharmacists so rarely inquire about your comfort and function after treatment? And if they don't, how are we to learn when prescriptions have been beneficial or harmful or when to change prescribing patterns?

Surveying Patients:

In Nova Scotia, medicare's administrators routinely survey a representative sample of patients to learn if they actually received the services a doctor billed for. The letter informs the patient about the payment, and only asks if the patient actually saw the doctor.

A polite and commercially conscious operation would be concerned with more than just whether a service was in fact offered. They might write a revolutionary (for our health care system) letter saying: "We hope you benefited from your doctor's visit. Did you feel better after taking the treatment? Did you feel worse? Was your function better? Worse? How long did you wait for care? Was it too long?"

All Canadians are worried about the costs of health care and no one can afford to pay for treatments that are useless or harmful. Unless we ask we will not be able to learn about the benefits and harms of care and will be unable to reduce superfluous or harmful activity.

Our failure to learn about the outcomes of care means we are squandering an important opportunity provided by our current single payer, monopoly health care system.

Drugs and the Canada Health Act:

Many Canadians support the Canada Health Act and its basic principles, that Canadians should have universal access to comprehensive care and that coverage
should be portable across the country (the other principle, public administration, refers to a process and not a result). Yet in spite of these fine principles, access to necessary drugs is limited for some because public coverage for necessary drugs is neither comprehensive, nor portable, nor universal.

Variations in provincial drug policy provide a clear indication of the practical workings of the Canada Health Act. The working poor are often not covered by public or private drug insurance programs. At the same time many of us have excess and redundant protection because the public systems pay for services we could buy ourselves, many of which are valuable, some less so. Surely we would be a more compassionate community if we used our limited public resources to protect the poorest among us by diverting public resources away from individuals who can afford service.

The Mazankowski Report on health care in Alberta has invited us to think more deeply about what we mean by comprehensiveness in health care, and this is nowhere more urgently needed than in the field of pharmaceuticals.

Drugs are going to play an ever-larger role in health care. Yet we don't gather the information to allow us to distinguish useful ones from the useless or harmful. And access to medically necessary drugs is capricious, irrational and unfair under Canadian medicare. Canadian drug policy is a microcosm of the confusion, ignorance and moral ambiguity that plague our health care system.

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