Letter from . . . Canada

What is a private patient?

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What is a private patient? Our National Health Insurance has had the effect of making all Canadians into private patients. By subsidising the premiums of the poor, the governments in Canada have promoted them to a plateau of medical equality. We have a one-tier system. All patients can choose their own doctor and their own specialist. Professional fees are paid out on their behalf according to what is done for them. For a few extra dollars, it is still possible to purchase more privacy within a hospital, but the talents of the medical staff and the total facilities of the hospital are shared by all. Waiting lists are relatively short, depending on the physical facilities available and, of course, emergency cases receive immediate priority.

But, however egalitarian the concept, some will always be more equal than others. Prominent citizens and those with political power will always receive priority. This is a fact of life. The judgment point of any system is how it looks after the poor, the working poor, and now the new poor.

From the patient's viewpoint the Canadian system, while not perfect, works very well. But this does not mute the cacophony of our own Barbarbarians who wish to scrap it and institute a full-time salaried service. Their main motive is control and their main argument has always been that the fee-for-item is too expensive, and that a salaried system would be cheaper. The simple pragmatists of the profession, conscious of the frailty of human nature, have remained sceptical. The best laid plans fail to work without a certain amount of coercion, either by carrot or clout. In Canada the controlled carrot seems a happier solution. The fee schedule is negotiated. This leaves the profession unregimented but also free to pay their own overheads, their retirement pension, and whatever fringe benefits they think necessary. Those who derive large incomes have the pleasure of paying most of it back to the Government. The treadmill of long hours, little security, inflationary overheads, and increasing taxes leads some to join those doctors necessarily paid by salary, but an entrenched medical hierarchy is not the norm. Doctors are paid for what they do. Committee work is done in their own time and any work delegated to juniors, except in some university centres, means that they, the juniors, get paid. This is borne out very strongly by the figures of the Federal Government, comparing the net incomes of doctors derived from fees to their age group (table I; Federal Government statistics for 1971).

British readers will be fascinated by two points in this table: firstly, the watershed appears at the early age of 50 and, secondly, there is no compulsory retirement at 65, although the pace of earnings is much slower. Cynics will at once assume that by 45 most Canadian doctors can afford to spend their time golfing and skiing, depending on the season. To refute this, table II shows the doctors' total, non-professional earnings. These reach

TABLE I—Comparison of net incomes of doctors derived from fees to their age group in 1971

Age (years): Income(s)*:	<35 28 282	35-44 43 599	45-54 43 776	55-64 38 132	≥65 21 190
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*At the time of writing 1 \$ (Canadian) = 45p.

TABLE II—Doctors' total, non-professional earnings (dollars) in 1971

Age (years): Earnings (\$):	<35 + 137	35-44 - 354	45-54 + 426	55-64 + 2751	≥65 + 5535
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any sizable proportion only at 65, when pension plans become available.

The minus figure between 35 and 44 is debt. All doctors can practise for a few years and then take more specialist training. This makes for good, practical specialists and consultants and round pegs usually finish up in round holes. Some debt is usually acquired in this transition; hence the minus figure.

Body blow for the prophets

The effect of this non-rigid system of piecework is that nobody gets paid too much for doing too little and nobody gets paid too little for doing too much. Nevertheless, the obvious faults of a fee-for-service system coupled with the absolute aversion of any trade unionist for piecework, where payment is related to production, leads to continuing pressure for a salaried service. The example that is usually paraded before us is that of the union-backed community clinics where the fiscal input is by capitation and the payment is by salary. This year their vociferous advocates have received a considerable set-back in the form of the Roth Report.¹ Dr Burns Roth, a professor of public health and hygiene at the University of Toronto, was commissioned by the Government of Ontario to compare the overall medical costs of patients treated by the Sault Ste Marie Clinic and the St Catherine's Clinic with the cost for the rest of the citizens of Ontario. The report was written, but it was only after considerable probing that the figures were made public and the reason is not hard to see. The prophets of the socialised millennium have received a body blow. The average cost per person in Ontario for all hospital and medical services was \$126, the average cost per person in Sault Ste Marie Clinic was \$133, and the average cost per person in St. Catherine's Clinic was \$141.

Even worse, the Roth Report calculates that had these services within the clinics been financed on a fee-for-service basis, the cost per person in Sault Ste Marie would have been \$123 and in St Catherine's only \$121. You may imagine that these figures are as welcome in the bureaucratic sparrow's nest as a large cuckoo egg and you may rest assured that a considerable effort will be expended to discredit them. For instance, the report does show that the number of surgical hospital days utilised by the patients in the clinics was fewer than the average for the

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people of Ontario. This has naturally led to an emotional discussion on whether everybody in Ontario is getting too much surgery, or whether the patients within the clinic are getting too little, and rational solution is unlikely. But the overall cost figures cannot be lightly exorcised. It would appear that the fee-for-item payment, even before the tax rip-off, is a cheaper way of paying for doctors' services. The Canadian taxpayer at the present time would appear to be getting good value for his tax money.

And this makes me wonder. As a burnt out negotiator for the profession, was I taken in by a deep Machiavellian plot?

Would we all have been better off on salary? And as I sit at my desk and write out the monthly cheques for my staff, and for my overheads, I contemplate the happiness of hierarchy for a few heretical moments. But not for long. Individual and professional freedoms are progressively conditional—and conditions always cost.

Reference

¹ Korcok, M, *Canadian Medical Association Journal*, 1974, 111, 1347.

Today's Treatment

Diseases of the central nervous system

Myasthenia gravis

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Myasthenia gravis is a disorder of neuromuscular function due to a defect in synthesis or storage of acetylcholine at the nerve ending. The muscle weakness is characteristically worse after effort and improved by rest. The patient starts to comb her hair and is unable to finish, or halfway through a meal finds that she can chew no longer. Myasthenia gravis occurs at all ages but the modal age of onset is about 20 years. There is a tendency to early remission but complete remissions are not prolonged. The muscle weakness has a characteristic distribution, the extraocular, bulbar, and neck muscles, limb girdles, distal limbs, and trunk muscles being affected in that order. The myasthenia responds to cholinesterase inhibitors, which enhance the effects of the limited supply of acetylcholine at a neuromuscular junction, and the quick-acting anticholinesterase edrophonium (Tensilon) provides a useful diagnostic test for myasthenia gravis. Patients with the purely ocular form of myasthenia gravis (Benign ocular myasthenia) do not usually develop generalised myasthenia if symptoms remain confined to the extraocular muscles for more than a year.

Myasthenia may be a feature of certain intrathoracic tumours, particularly the oat cell carcinoma, and this disorder must be distinguished from myasthenia gravis. This syndrome is known as pseudomyasthenia, the myasthenic syndrome, or the Eaton-Lambert syndrome and is due to impaired release of acetylcholine from the nerve ending with distinct clinical and therapeutic features. Cholinesterase inhibitors are of little benefit in this disorder but the response to guanidine (250 mg three times a day) is often good.

Medical treatment

The principal agents used to treat myasthenia gravis are the reversible anticholinesterase compounds. They act by inhibiting

cholinesterase, the enzyme that breaks down acetylcholine, thereby increasing the effective concentration of acetylcholine at the motor end-plate. Neostigmine and pyridostigmine are the drugs of choice. Ambenonium is occasionally used. Edrophonium has no place in treatment as its period of action is so short. These drugs are watersoluble and hence do not cross lipid barriers readily. They are thus distributed in the extracellular space and do not enter the central nervous system. These drugs are active by mouth but may if necessary be given parenterally. When given at regular intervals during the day muscle strength can usually be restored to an adequate even if not a normal level. It is important to establish the dose of anticholinesterase drug which gives the maximum therapeutic response.

Most myasthenic patients can be improved only up to a certain level. Increasing the drug dosage above the maximum response level if in the forlorn hope of improving physical activity will produce the opposite effect, and progressive muscle weakness may finally end in a cholinergic crisis. The dose response curve for anticholinesterase compounds has a rapid fall-off once the peak is reached. This may be because to some extent these agents may occupy the acetylcholine receptors and if present in excess prevent the normal action of acetylcholine. Overdosage thus not only increases the quantity of acetylcholine at the neuromuscular junction but also reduces the number of free receptors available for its effect. Like other people, myasthenic patients are subject to the fatigue of mental and physical strain, and the temptation to increase the dosage to counter such physiological fatigue must be resisted. Intercurrent infection may also cause deterioration of myasthenia, but here the cautious and carefully supervised increase in drug dosage is justified. An increase may be required to cope with stress and occasionally premenstrually.

Neostigmine is given in a dose of 15 mg by mouth four-hourly or more often if necessary. It is effective within 30 minutes. The optimum frequency of administration must be decided and then the precise dose determined. When given parenterally a dose of 0.5 mg is equivalent to 15 mg by mouth. There are two varieties of peripheral cholinergic activity. Muscarine activity affects smooth muscle and glandular tissue while nicotinic activity affects autonomic ganglia and neuromuscular junctions. The cholinesterase inhibitors enhance both the muscarine and the nicotinic effects of acetylcholine. As muscarine activity affects

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