FOR THE RECORD

Reforms urged to address illegal drug use in Australian prisons

The Australian prison system needs a "more balanced approach" to resolving the problem of illegal drug use, according to the Australian National Council on Drugs.

The existing system is almost entirely focused on reducing drug supply through the use of drug detection dogs and urinalysis and is far less inclined to utilize demand reduction strategies such as methadone treatment and drug-free units, or harm reduction strategies such as needle exchanges, the council states in a report, *Supply, demand and harm reduction strategies in Australian prisons: an update* (www.ancd.org.au/images/PDF/Researchpapers/rp23_australian_prisons.pdf).

The report, commissioned from the National Drug and Alcohol Research Centre, examined programs offered to the 29 300 inmates at more than 80 prisons and remand centres within the A$2.8-billion per year Australian prison system. It cites a survey of New South Wales inmates which indicates 80% of males and 81% of females had a drug problem at some stage in their lives. Imprisonment provided the only lifetime treatment opportunity for 18% of males and 15% of females reporting problematic drug and/or alcohol use in that survey.

"All jurisdictions relied heavily on supply reduction strategies, which in some cases were being expanded," the report states. These strategies include urinalysis (thousands test positive, most commonly for cannabis), cell searches and the use of drug detection dogs. On that score, it notes that "some evidence has suggested that urinalysis might provide a perverse incentive for prisoners to switch from smoking cannabis to injecting heroin," as it only detectable for two days after use.

Moreover, such supply reduction strategies may not be effective, the report states. "In general these measures have not been evaluated, which limits any assessment of them."

Demand and harm reduction strategies are less likely to be implemented within Australian prisons, despite positive evaluations by those who participated in them. Some prisons limit the number of inmates allowed to take part in reduction or treatment programs, such as opiate substitution treatment with methadone or buprenorphine.

The report describes prison authorities as "reluctant" to evaluate programs, documenting the refusal of some jurisdictions to complete a survey for the report or to provide information even after being assured that the researchers had met ethical requirements. "Gaining access to the data was a challenge, with many jurisdictions citing a range of reasons for failure to grant access or to provide only limited access to data."

"Vast sums of funding are spent on prison programs that are implemented without any evidence base," the report states.

The council urged regular, transparent and independent reviews of every prison to determine the level of services available to address drug and alcohol problems and to reduce reoffending, with evidence of outcomes and effectiveness.

"It is almost hard to envisage any other large taxpayer funded system, which so directly affects the lives of so many people and families, would be so difficult to access and assess information on how well its substantial funding is spent," the council stated in a press release (www.ancd.org.au/Media-Releases/supply-demand-and-harm-reduction-in-australian-prisons-28-august-2012.html).

The council also highlighted the fact that no prison in Australia has yet introduced a needle and syringe exchange program, despite effective community-based programs.

The report also noted that there's a need for targeted measures aimed at reducing drug and alcohol use by Indigenous prisoners, who comprise 25% of the male prison population and 28% of the female prison population in Australia. "In 2009, Indigenous prison entrants were more likely to report drinking at levels that put them at risk of harm than non-Indigenous prison entrants. They were also more likely to report having ever injected drugs than non-Indigenous prison entrants and to have hepatitis C. In 2008, the diagnosis rate for newly acquired hepatitis B infection among Indigenous inmates was between one and five times higher than that of the non-Indigenous population in New South Wales, the Northern Territory, South Australia, Victoria, Queensland and Western Australia. Only Western Australia had an ongoing program linking released prisoners with a deaths register where research found that, in the immediate post-release period, Indigenous male prisoners were 4.8 times more likely to die, and Indigenous female prisoners were 12.6 times more likely to die, than the general population. This compared with lower rates among all men (3.7) and women (7.8) in the cohort." — Laura Eggertson, *CMAJ*

More funding for mental health care of military personnel

The Canadian Forces will spend an additional $11.4 million to hire and retain mental health professionals and primary care physicians at Canadian Forces clinics across the country. The new money, which adds almost one-third to the existing $38.6-million budget that the Defence Department has allocated to mental health care, will be used primarily to recruit new staff.

"The health needs, including the mental health needs, of military personnel are my number one priority in this role and I am committed to doing everything I can to provide the care needed for those defending our country," Defence Minister Peter MacKay stated in a news release (www.forces.gc.ca/site/news-nouvelles/news-nouvelles-eng.asp?id=4373).

The monies involved a reallocation from an existing $408-million program that finances personnel transfers, which had declared surpluses in each of the past three years, says Jay Paxton, MacKay's director of communications. The additional funds will enable the Canadian Forces to hire at least four psychiatrists, 13 psychologists, 10 mental health nurses, 13 social workers and 11 addictions counsellors. Another $2.7 million will enable Canadian Forces' health clinics to retain nine doctors whose contract positions had been scheduled for termination. The department will also use $1 million to hire more primary care doctors at clinics with excessive wait times.

"Through his discussions with those in uniform who are ill or injured, Minister MacKay knew the Canadian Forces had a good program and that more could be done. This money ensures more care will be provided to those who need it," Paxton told *CMAJ*.

Currently, the Canadian Forces operate 26 mental health clinics at bases across the country, including five regional clinics in Halifax, Nova Scotia; Ottawa, Ontario; Valcartier, Quebec; Edmonton, Alberta; and Esquimalt, British Columbia. Another seven Operational Trauma and Stress Support Centres, located in Edmonton; Esquimalt; Gagetown, New Brunswick; Halifax; Ottawa; Petawawa, Ontario and Valcartier, provide assessment, treatment, outreach and research for such issues as post-traumatic stress disorder.

The government's goal is to have 447 mental health professionals working within the department and the Canadian Forces. Currently, 378 military and civilian mental health providers and support staff deliver programs. The exact number of new people hired will depend upon their salaries. — Laura Eggertson, *CMAJ*

US health system encourages "wasteful and ineffective care"

The American health care system is in desperate need of a complete overhaul as it wastes a staggering US$750 billion [all figures in US$] annually as a result of unnecessary procedures and paperwork, while "falling short on basic dimensions of quality, outcomes, costs, and equity," the United States Institute of Medicine says.

"Available knowledge is too rarely applied to improve the care experience, and information generated by the care experience is too rarely gathered to improve the knowledge available. The traditional systems for transmitting new knowledge — the ways clinicians are educated, deployed, rewarded, and updated — can no longer keep pace with scientific advances. If unaddressed, the current shortfalls in the performance of the nation's health care system will deepen on both quality and cost dimensions, challenging the well-being of Americans now and potentially far into the future," the Institute states in a report, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America* (www.iom.edu/Reports/2012/Best-Care-at-Lower-Cost-The-Path-to-Continuously-Learning-Health-Care-in-America.aspx).

Crafted by a blue-ribbon, 18-member panel of doctors, business people and public officials, the report argues that if health care adopted the best practices of other industries, "the nation could see patient care in which records were immediately updated and available for use by patients; care delivered was care proven reliable at the core and tailored at the margins; patient and family needs and preferences were a central part of the decision process; all team members were fully informed in real time about each other's activities; prices and total costs were fully transparent to all participants; payment incentives were structured to reward outcomes and value, not volume; errors were promptly identified and corrected; and results were routinely captured and used for continuous improvement."

The report estimates that US$210 billion is wasted through overuse of medical services "beyond evidence-established levels" while $130 billion is wasted through medical errors, "care fragmentation," unnecessary use of high-cost providers or operational inefficiencies. A further $190 billion is wasted through excessive administration, while $105 billion is wasted through price gouging and $55 billion through "missed prevention opportunities" and $75 billion as a result of fraud.

To redress the problem, the report urges the system be transformed so that it makes greater use of electronic health records and connectivity, while using more efficient procedures in delivering evidence-based care, particularly through "collaborations between teams of clinicians and patients."

To that end, the panel makes 10 recommendations:

- "Improve the capacity to capture clinical, care delivery process, and financial data for better care, system im-provement, and the generation of new knowledge.
  Data generated in the course of care delivery should be digitally collected, compiled, and protected as a reliable and accessible resource for care management, process improvement, public health, and the generation of new knowledge.
- Streamline and revise research regulations to improve care, promote the capture of clinical data, and generate knowledge. Regulatory agencies should clarify and improve regulations governing the collection and use of clinical data to ensure patient privacy but also the seamless use of clinical data for better care coordination and management, improved care, and knowledge enhancement.
- Accelerate integration of the best clinical knowledge into care decisions. Decision support tools and knowledge management systems should be routine features of health care delivery to ensure that decisions made by clinicians and patients are informed by current best evidence.
- Involve patients and families in decisions regarding health and health care, tailored to fit their preferences. Patients and families should be given

the opportunity to be fully engaged participants at all levels, including individual care decisions, health system learning and improvement activities, and community based interventions to promote health.

- Promote community-clinical partnerships and services aimed at managing and improving health at the community level. Care delivery and community-based organizations and agencies should partner with each other to develop cooperative strategies for the design, implementation, and accountability of services aimed at improving individual and population health.
- Improve coordination and communication within and across organizations. Payers should structure payment and contracting to reward effective communication and coordination between and among members of a patient's care team.
- Continuously improve health care operations to reduce waste, streamline care delivery, and focus on activities that improve patient health. Care delivery organizations should apply systems engineering tools and process improvement methods to improve operations and care delivery processes.
- Structure payment to reward continuous learning and improvement in the provision of best care at lower cost. Payers should structure payment models, contracting policies, and benefit designs to reward care that is effective and efficient and continuously learns and improves.
- Increase transparency on health care system performance. Health care delivery organizations, clinicians, and payers should increase the availability of information on the quality, prices and cost, and outcomes of care to help inform care decisions and guide improvement efforts.
- Expand commitment to the goals of a continuously learning health care system. Continuous learning and improvement should be a core and constant priority for all participants in health care—patients, families, clinicians, care leaders, and those involved in supporting their work."

— Wayne Kondro, *CMAJ*

Medical school tuition fees continue to climb

Tuition at Canada's medical schools rose an average of 5.1% for undergraduate medical students to $11 891 in the 2012/13 academic year, Statistics Canada reports. The average fee for medical students trailed only those for dentistry at $16 910, which increased 5.4%, Statistics Canada states in a report, *University tuition fees, 2012/13* (www.statcan.gc.ca/daily-quotidien/120912/dq120912a-eng.pdf). The average fee for medicine was $11 313 in 2011/12.

Tuition fees for pharmacy continued to rise at a higher rate than those for other health professions, climbing 5.9% to $10 297, while those for veterinary medicine rose 5.7% to $6224 and those for nursing rose 5.9% to $4909. By contrast, graduate fees in those disciplines did not rise as quickly. Those for pharmacy rose 4.5% to $5360, while those for nursing rose 4.7% to $5360, those for dentistry rose 4.4% to $4559, and those for veterinary medicine rose 4.7% to $3321.

Across all disciplines, undergraduate students in Canada paid an average 5% more in tuition fees, or $5581, when they returned to university this fall. Tuition fees were highest in Ontario ($7180) and Saskatchewan ($6017) and lowest in Quebec ($2774) and Newfoundland and Labrador ($2649), where they have been frozen since 2003/04.

Fees for graduate students in Canada rose an average 4.5% to $5695. Tuition fees were highest in Ontario ($8041) and Nova Scotia ($7613) and lowest in Quebec ($2969) and Newfoundland and Labrador ($2456).

Although tuition fees by medical school in Canada are not yet available for 2012/13, it is expected that there will continue to be a substantial variation in the fees charged by the 17 institutions. In 2011/12, the highest first-year tuition fees, for Canadian residents, were charged by McMaster University in Hamilton, Ontario ($22 497), followed by Queen's University in Kingston, Ontario ($19 567), and the University of Ottawa in Ontario ($19 686), according to the Association of Faculties of Medicine of Canada (www.afmc.ca/pdf/2011-12%20Tuition.pdf). The lowest fees were those charged by medical schools in Quebec for residents of the province. The University of Montreal charged $3252, the University of Sherbrooke $3324, Laval University $3396 and McGill University $5058. All four schools charged higher rates — between $8787 and $13 669 — for students from other provinces. The lowest medical school tuition fee outside of Quebec was the $6250 charged by Memorial University of Newfoundland.

By contrast, tuition fees in medical students in the United States continue to substantially outstrip those of Canada.

In the American Association of Medical Colleges' most recent survey of US medical school tuition fees, for 2011/12, the average tuition fee for a US resident attending one of 80 surveyed public medical schools was US$24 257 (with a median of US$27 014), while those attending one of 54 private medical schools paid an average US$42 407 (with a median of $44 171). Fees for nonresidents were an average US$45 536 (median US$47 550) in public medical schools, and an average US$43 943 (median $45 498) in private medical schools.

The combination of tuition, student and health insurance fees for American residents attending a public medical school was highest at the University of Virginia (US$43 815), followed by the Oakland Beaumont in Michigan (US$42 760) and the University of Oregon ($42 341). For those attending a private medical school, fees were highest at Tufts University in Massachusetts (US$57 962), followed by Tulane University in Louisiana ($US54 511) and the University of Albany in New York (US$53 364).

The lowest combination of tuition, student and health insurance fees at public schools was paid by medical students at University of Puerto Rico (US$11 751), East Carolina-Brody in North Carolina (US$13 529) and University Texas at Houston (US$15 713). The lowest combined fees at private medical schools were at Baylor University in Waco, Texas (US$19, 213) and the University of San Juan Bautista in Puerto Rico (US$24 958) and the University of Caribe in Puerto Rico (US$28 004). — Wayne Kondro, *CMAJ*

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