OF COURSE. CHEERS! THE FUNDAMENTAL FALLACY OF UNIVERSAL DRUG COVERAGE

A program to provide prescription drugs to all Canadians is wasteful and wrongheaded. We should simply be targeting those who need help

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As a parliamentary committee in Ottawa drafts its report on the possibility of a national drug plan, a new study estimates that roughly one out of every 12 Canadians who required a prescription in 2016 had difficulty paying for it. The authors also estimate that one million Canadians reduced spending on food and heat due to drug costs.

If these estimates are accurate, there's certainly a case for identifying and supporting these patients.

However, somewhat bizarrely, the solution often hinted at by the study's authors, several media outlets, and (quite likely) members of the parliamentary committee is a national government-run pharmacare program. Such a program would use scarce health-care dollars to subsidize everyone, including the majority of Canadians who likely don't need it.

This is akin to noticing one person in need of nourishment standing next to 11 healthy, well-fed people and deciding to give each of them an equal slice of pie.

Not only is it potentially inefficient, it may not solve the issue at the heart of the problem. Consider that provincial governments across Canada already employ various programs to assist vulnerable populations with medication costs. That these patients still struggle means, if anything, governments may not be best suited to do the job. To believe that an even larger and more imprecise federally-run program would do a better job is simply a misguided (and expensive) fantasy.

Perhaps the knee-jerk reaction to advocate for a national federally-funded pharmacare program relates to the true, but unqualified, notion that most other countries with universal health care also generally provide coverage for pharmaceuticals.

For example, Switzerland, the Netherlands, Germany, France, the United Kingdom, Australia and New Zealand all provide some level of coverage for pharmaceuticals under their universal plans. However, only some of these countries (such as the U.K. and Australia) rely on government-run programs to provide coverage for drugs. Others, such as Switzerland and the Netherlands, provide universal access for all health-care services (including pharmaceuticals) through private insurers.

What's often ignored in Canada's ongoing health-care debate is that all of them - even the U.K. - allow the private sector to play a significant role as partner or alternative for the insurance and delivery of medical goods and services.

Another important factor is that private insurance plans in Canada are more generous with the number and type of drugs they reimburse. Therefore, if Canadian patients are paying large sums of money out of pocket because government formularies don't list their preferred medication, a nationwide expansion of similar programs won't necessarily help.

Finally, on the delicate topic of patient cost-sharing, remember that most countries with universal health care routinely expect patients to share in the costs of treatment, surgical or pharmaceutical.

Of course, we should all be concerned for fellow Canadians who struggle to pay for necessary medication, including the estimated one million Canadians who may have reduced spending on food and heat to pay for their prescriptions.

However, we should not subsidize Canadians who can either comfortably afford their own prescriptions or hold generous private insurance plans.

We should instead focus on identifying Canadians who are falling through the cracks, and target resources and policy to help them first.

CATCHING A RIDE ON THE 'CREATIVE DESTRUCTIVE' ECONOMY

What do creation, destruction, sharing and profit have in common?

When it comes to the sharing economy, the answer is everything.

In slightly over a decade, Uber and Lyft have gone from San Francisco startups to worldwide juggernauts. Their march to becoming international multibillion-dollar companies has sometimes met fierce resistance from taxi companies and community groups led by hospitality unions.

Governments that feel caught between competing commercial interests (not to mention groups of consumers) should let the marketplace sort out winners and losers.

"Creative destruction" was defined by economist Joseph Schumpeter in 1942. In Capitalism, Socialism and Democracy, he noted that new markets and organizational development revolutionize "the economic structure from within, incessantly destroying the old one, incessantly creating a new one. The process of Creative Destruction is the essential fact about capitalism. It is what capitalism consists in and what every capitalist concern has got to live in."

Will taxi drivers feel the pinch in the 633 communities that Uber operates in?

Yes. A company worth $50 billion must have a substantial market share of the taxi business.

Will neighbourhoods and hospitality unions be affected when Airbnb claims four million listings in 65,000 cities?

Yes. How could they not?

But in a world where the one constant is change, all of us must change too or be left behind. Had we not done so in the past, we would still be heating our homes with wood fires and travelling on horses and donkeys. For those who can accept it, the oil industry saved a lot of trees; yet that also put woodcutter jobs on the chopping block. Charioteers climbed off their seat and into vehicles. Maybe some became cab drivers.

Fast-forward to today and cabbies are wary of Uber drivers with their GPS guidance, surge pricing algorithms and flexible work hours.

The good news, even for them, is that such an impact is more minimal than it seemed initially. A 2017 study conducted by Carl Benedikt Frey of the Oxford Martin School showed that in the United States, the presence of Uber led to a 10 per cent drop in income for salaried taxi drivers and a 10 per cent increase in the earnings of self-employed cabbies, whose number grew by 50 per cent. This means that Uber increased the market for ride-sharing instead of taking jobs or income from taxi drivers.

Thanks to its famous ride-sharing companies, San Francisco has 1,500 taxis and 45,000 ride-sharing drivers, most of whom work less than 10 hours a week. New York City has eight times the population of San Francisco but has just 55,000 Uber drivers and 13,000 taxis. The ratio of taxis per capita is very similar in the two cities, but the ride-sharing services had a head-start in San Francisco and the movement probably hasn't reached its true demand in New York.

Inadequate parking and increased congestion in many large cities create challenges for policy-makers. But saving the taxi industry for that industry's sake is not and should not be a priority of a government.

Let no one forget that Uber and Airbnb could yet go the way of Myspace and Netscape. Being a dominant player early in a new medium doesn't guarantee a permanent place. New technology, such as driverless cars, will bring more innovation to the marketplace and greater challenges to ride-sharing companies.

If that means the downfall of Uber, should policy-makers struggle to save it? Not a chance.

VITAMIN C

This article is in response to a reader's request and I am happy to oblige.

I will be discussing that infamous vitamin C! So what is a vitamin? Vitamins are substances which are obtained through the diet and needed in very small quantities for normal good health/biochemical function. Originally isolated in 1928 vitamin C plays a very important role in a number of biochemical actions in the human body and we still do not understand all those functions. Good connective tissue, healthy bones and tissue repair involve vitamin C. Collagen and cortisol from the adrenal gland require vitamin C, anti -viral and anti -bacterial in nature, vitamin C more importantly can alter brain chemicals and is involved in the synthesis of noradrenaline which affects things like blood pressure. The best sources of vitamin C are green vegetables, most fruits, parsley, liver, potatoes. It is destroyed by exposure to the atmosphere and prolonged cooking.

There is no medical evidence to show how much anyone individual needs per day. Various governments have postulated figures for daily RDA but these have scientific evidence behind them and are a one size fits all approach. We have some knowledge on the minimums usually required by healthy people and we know excess consumption gets peed out of the body or if administered intravenously may promote cancer. If you need extra, it depends on your diet and your medical condition. If you have plenty of green veggies and 1 orange a day (or most fruit) then you do not need to supplement. If you are on anti- biotics or have a cold then extra vitamin C is helpful as this vitamin is depleted in those conditions. It is rare these days to find a person who has low or inadequate levels of vitamin C. Scurvy a disease, from which sailors in the past typically suffered from is a lack of vitamin C and those with high alcohol intakes may experience low vitamin C levels. Vitamin C is not a stored vitamin in the human body, as it is water soluble – so in other words, if you are taking from whatever source more than 45-60 mg per day you will pee it out!, if your body has sufficient existing levels. There is one exception to this rule and I will talk about it later in this article. The maximum pool of vitamin C in the body on a daily basis is 100-150mg per day from all sources. Anything above 150mg is peed out of the body.

Dr Linus Pauling achieved world- wide fame by promoting the use of vitamin C to prevent the common cold. No evidence was ultimately produced to support this hypothesis – however some evidence showed that it is of benefit to reduce the severity of a cold. Dr. Pauling and Dr. Cameron, his colleague, wanted to show that high does vitamin C would 'cure' cancer in fact it has only been shown, that in patients, with low levels of vitamin C, that cancer can develop in conjunction with other issues such as eating a high level of processed foods. Vitamin C inhibits the nitrosamines which are found in bacon and pre disposes the colon to develop cancer. Long term administration of vitamin C, actually inhibits the absorption of a number of key minerals and some amino acids. In those pre disposed to kidney issues it can contribute to kidney stones. High doses of vitamin C cause diahorrea. More damagingly, high dose vitamin C can promote testosterone (Repro Biol Endocrinol 2011 July 27). which in hormonal cancers is precisely the opposite of what is desired. High doses of vitamin C are also known to cause thrombosis as it has a coagulant effect on blood plasma. Anyone with iron overload and or renal failure should not consume supplemental vitamin C and watch which fruits and veggies they eat which have high vitamin C. In my view no one should take vitamin by IV and particularly if you have thalassemia, on dialysis, sideroblastic anaemia often found in the lymphomas and leukaemias then it is contra indicated.

In the public literature on cancer, certain practitioners extol the use high dose injections of vitamin C as part of their cancer treatment protocols. Dosing by IV, as opposed to eating or drinking vitamin C, is a protocol fraught with potential danger as it alters the pharmacokinetics and absorption of vitamin C by the body. So if you dose via IV for example 10grms it will yield 1-5mM in the blood plasma. 18grams daily will yield 25-32mm. At 25m/M vitamin C is considered cytostatic.(this means inhibiting cell growth and division). Any level of 32m/M and above, vitamin C reverses any benefits as it promotes testosterone and coagulation as well as other issues. Any dosing needs to be monitored for plasma levels to be safe. Unfortunately this is almost never done. Anything which is injection into a vein in the body by passes the bodies defence mechanisms and what is known as the first pass past the liver when the optimum benefits of food are extracted. This alters the levels of substances in the body and goes to achieve potentially harmful effects.

It has been shown that Scutellaria biacalensis which I use in all cancer patients inhibits cancer tumours more than vitamin C!

There is no evidence to show that high dose vitamin C given either in conjunction with chemotherapy or without, is beneficial in treating cancer with a view to causing apoptosis or cancer cell death. I quote from The Oncologist a peer reviewed journal (Oncologist. 2015 Feb;20(2):210-223) in a review article on this issue:

"There is no high-quality evidence to suggest that ascorbate supplementation (Vitamin C) in cancer patients either enhances the antitumor effects of chemotherapy or reduces its toxicity "

The Americans have also arrived at the same conclusion and published their results. Although a considerable number of vials of vitamin C have been sold most of it is either a synthetic version or derived from vegetables. There are several reports of Laboratory studies in vitro which show the potential of vitamin C in killing cancer cells but this has not been translated into similar results from animal or human studies to date. Vitamin C that is administered intravenously is synthesised from glucose using fermented corn and for those with sensitivities to corn, tapioca is used (sago palm) as a substitute source - eat Camu camu instead!

November is the beginning of the citrus season so enjoy getting your daily vitamin C from an orange, lemon, lime, or grapefruit! But remember they often have less vitamin C than veggies!

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