## FOR THE RECORD

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### National system needed for long-term care in Canada, study says

Canada should consider creating a mandatory social insurance scheme for long-term care, similar to the Canada Pension Plan, the Canadian Healthcare Association urges in a comprehensive review of facility-based long-term care services across the country.

A publicly administered insurance plan, funded either by taxes or premiums and featuring specified eligibility requirements to receive benefits, will resolve current inequities in the availability of appropriate long-term care services across the country, argued the research study, *New Directions for Facility-Based Long Term Care*. Under such a plan, "there would be an equitable distribution of premium costs and care would not be provided on the basis of ability to pay but rather on the basis of need."

Canadian Healthcare Association President Pamela Fralick says such a plan would place long-term care services on a more sustainable and responsible footing. By requiring contributions from Canadians directly, "it would also force us to face up to our own vulnerability."

Adoption of a social insurance model of long-term care insurance is among a raft of recommendations contained in the report, which is breathtaking in its scope and depth as it catalogues the strengths and weaknesses of long-term care in Canada (www.cha.ca/documents/CHA_LTC_9-22-09_eng.pdf).

With long-term care not falling under the rubric of the Canada Health Act, what has emerged across the country is a checkerboard system, both between and within provinces. "It's a poster child for what goes wrong when you don't have some kind of a national system," Fralick says.

Other measures urged in the report included mandatory accreditation of facilities, the development of pan-Canadian minimum staff models and the creation of a federal facility-based long-term care fund similar to the ones the federal government established for Health Infoway and for primary health care reform.

The report also recommends a raft of accountability measures, including the development of pan-Canadian long-term care indicators, such as "staffing ratios, staff qualifications, levels of care, waiting lists, admissions, discharges, and deaths in long-term care homes."

Fralick says the report is also unique in its call for the development of a "culture of caring" within long-term care facilities. "Dignity and respect should be two fundamental values on which a pan-Canadian facility-based long-term care system is built and maintained. The consumers and baby boomers of today will be the residents and families of tomorrow. They will not accept institutional settings, structured schedules, rigid dining hours and waiting for care. Privacy, respect, flexibility and the right to manage one's own risk should be the cornerstones of facility-based long-term care services," the report states. — Wayne Kondro, *CMAJ*

### British nurse warned over confirmation cross

A British nurse threatened with disciplinary action for refusing to remove a small confirmation cross has filed religious discrimination charges with an employment tribunal.

Shirley Chaplin, a ward nurse at the Royal Devon and Exeter Trust, says she's worn the one-inch pendant throughout her career, beginning with her training at the hospital in 1978. No patients complained and aside from an occasional "odd remark," the cross had not been an issue.

But on June 10, Chaplin received a letter citing "health and safety reasons" and instructing her to remove the cross or else wear it inside her uniform.

"The argument was that a patient might grab it and somehow harm me," she says. "But the chain is a fine one, and it would likely break if pulled." Chaplin notes there's no record of a necklace ever injuring a patient or staff member and that many hospital staff wore items of jewellery that were larger and more visible than her confirmation cross. Chaplin offered to sign a disclaimer, absolving the hospital of any liability if injured, or to wear the cross pinned to her uniform, noting that hospital staff wore name tags in a similar fashion. Both offers were rejected.

On Sept. 21, Chaplin, who was due to retire in eight months, was informed she must either accept a transfer to an administrative job or face suspension. The Christian Legal Centre has filed discrimination charges on her behalf, but advised Chaplin to accept the transfer rather than risk losing her job and pension. — Mary Helen Spooner, London, UK

### Canada earns "B" grade on health indicators

Canada's national rate of diabetes, the infant mortality rate and deaths due to musculoskeletal system diseases are three key national health problems, according to the Conference Board of Canada's 13th annual international comparison of health status indicators.

Overall, Canada earned a "B" ranking for health, placing it 10th out of 16 countries — behind Japan, Switzerland, Italy, Norway, Sweden, France, Finland, Germany and Australia, but ahead of the Netherlands, Austria, Ireland, the United Kingdom, Denmark and last-place United States.

But Canada earned a "C" ranking for rates of diabetes and infant mortality, as

well as deaths due to musculoskeletal system diseases.

Worldwide, diabetes causes as many deaths annually as HIV/AIDS. The incidence of diabetes is rising in Canada, signaling a probable hike in the number of deaths from heart disease in the future, states the report (www.conferenceboard.ca/HCP/Details/Health/life-expectancy.aspx).

Canada's relatively high rate of diabetes is influenced by two factors: Aboriginal people are three to five times more likely to develop type 2 diabetes than the general population, and more than 75% of new Canadians come from populations at higher risk for type 2 diabetes, the report states. "This is particularly troubling because the bulk of Canada's population growth now comes from immigration."

Canada's infant mortality rate represents a "shockingly poor performance" — it ranks 15th among the countries, the report states.

But the health components of the report, *How Canada Performs*, acknowledge that differences in how countries define and register live births likely contribute to Canada's apparently higher rate. As well, researchers suggest that Canada's success in delivering preterm and very low-birth weight babies contributes to higher mortality rates, since these babies are more likely to die.

Indeed, Dr. Michael Kramer of McGill University in Montréal, Quebec, a leading researcher in infant health, says Canada "does a better job of counting (registering) its births regardless of their outcome than most other developed countries."

"Our infant mortality rate is probably a bit higher than Japan's, Sweden's, and Finland's but probably lower than that of many other countries who report lower 'official' rates but under-register stillborn fetuses or very immature newborns who die shortly after birth," he states in an email.

Canada's sole "A" ranking is on self-reported health status, though it also placed sixth for life expectancy which is generally considered "a good indicator of overall health."

The average Canadian can now expect to live at least as long as the average Swede, largely because both Sweden and Norway have lost their "A" ranking for life expectancy, while Canada has maintained its "B" grade for almost 50 years. — Ann Silversides, *CMAJ*

## Ontario sues tobacco companies

Ontario has launched a $50-billion lawsuit against tobacco companies in an attempt to recoup the health care costs of treating people with smoking-related illnesses.

The statement of claim, filed on Sept. 29 in Ontario's Superior Court of Justice, states that tobacco companies "owed a duty of care to design and manufacture a reasonably safe product, and to take all reasonable measures to eliminate, minimize, or reduce the risks of smoking the cigarettes they manufactured and promoted. The Defendants have breached, and continue to breach, these duties."

The statement, which can be viewed on the website of Smoke Free Canada (http://smokefreecanada.ca/wp-content/uploads/2009/09/tobbacco-statement-092909.pdf), goes on to make other claims against tobacco companies, such as: they misled the public by adding ineffective filters to cigarettes and by promoting "mild" and "low tar" brands; they failed to warn the public of known risks, and they suppressed information about the risks of smoking and the risks of second-hand smoke.

The Ontario government claims that treating tobacco-related illnesses costs the province $1.6 billion each year, and that it has spent $50 billion to treat these illnesses since 1955.

Two other provinces — British Columbia and New Brunswick — have launched similar lawsuits. Most other provinces have passed legislation that would allow them to launch similar action against cigarette makers. In 1998, tobacco manufacturers in the United States lost a landmark health care lawsuit and were forced to pay state governments US$246 billion over 25 years.

The tobacco companies involved in the Ontario lawsuit — which include Imperial Tobacco Canada Ltd., JTI-Macdonald Corp. and Rothmans, Benson & Hedges Inc. — claim that the government is being hypocritical, as it collects billions from taxes on cigarettes. Spokespeople for several of the companies have said they plan to fight the lawsuit vigorously in court. — Roger Collier, *CMAJ*

## From care by default to care by design

Nova Scotia's largest district health authority has rolled out a new program designed to improve the health of residents in nursing homes and the efficiency of the physicians who treat them.

The Continuing Care Physician Network assigns one community family physician to a nursing home floor (or specified area). Doctors meet with staff on that floor, usually once a week, to develop treatment plans and discuss patient issues. They can see patients at this time or as required. What the doctors don't have to do is run around all over town to visit patients scattered throughout numerous nursing homes, says Dr. Barry Clarke, district medical director, continuing care, with Capital Health.

The flip side of that coin, he notes, is that nursing home staff don't have to spend time trying to track down a doctor. Indeed, under the new program, community family physicians must respond to a phone call from a nursing home within 20 minutes and be onsite within 30 minutes, if required.

The initiative, which Clarke calls a shift from "care by default" to "care by design," appears to have earned a round of applause from physicians, particularly because patient care is enhanced. The patient has the benefit of being treated by a single doctor, notes Dr. David Zitner, a family physician and professor of medical informatics at Dalhousie University in Halifax, Nova Scotia. "They'll even know the patient."

The program also works on a broader level. "Although the association hasn't been directly involved with the program, members have told us that any efforts to improve patient care while streamlining physician time is a welcomed addition to our health care

system," says Doctors Nova Scotia President Dr. Ross Leighton.

There are issues, however. Zitner points out that the current health care system does not support family physicians who want to continue seeing patients after they move into nursing homes. The program may compound the problem. "If you reduce the scope of practice," he says, "we will lose our skills."

The province is also quick to point out that what's good for the Halifax Regional Municipality may not necessarily be good for all areas of the province. "Not all districts experience the same challenges," notes Lynn Cheek, director of system planning and liaison with the Department of Health.

"At this stage," she adds, "[the program] is a one-off." — donalee Moulton, Halifax, NS

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