FOR THE RECORD

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Canada gains 19 world-class researchers

Following a rigorous peer review and selection board process, 19 of the world's top researchers — six of whom study health and related life sciences — will be settling into Canadian universities for the next seven years.

The appointed researchers — who come from the United States, Britain, Germany, France and Brazil — will each receive up to $10 million in federal funding as part of the Canada Excellence Research Chairs (CERC) program.

CERC was announced by the federal government in its 2008 budget and is designed to help Canada "build a critical mass of expertise in the priority research areas of environmental sciences and technologies; natural resources and energy; health and related life sciences and technologies; and information and communications technologies" (www.cerc.gc.ca/cpov-pcap-eng.shtml).

Stage one of the two-step selection process had Canadian universities compete for the opportunity to establish chairs at their institutions. After a review of some 130 research proposals, 40 proposals went on to be short-listed and the final selection was made by a selection board.

Researchers studying health and related life sciences include: Oliver Ernst, structural neurobiology (University of Toronto, Ontario); Matthew Farrer, neurogenetics and translational neuroscience (University of British Columbia); Michael Houghton, virology (University of Alberta); Adrian Owen, cognitive neuroscience and imaging (University of Western Ontario); Patrik Rorsman, diabetes (University of Alberta); and Frederick Roth, integrative biology (University of Toronto).

In a press release, Minister of Industry Tony Clement said, "The CERC program confirms Canada's standing as a global centre of excellence in research and higher learning. This program supports our government's commitment to ensuring Canada's future economic growth by investing in innovation and research capacity in priority areas." — Emily Panetta, Ottawa, Ont.

Cosmetic surgery regulation

Ontario's cosmetic surgery clinics — and all out-of-hospital facilities which use anesthesia and other sedation methods — are now subject to provincial inspections.

The College of Physicians and Surgeons of Ontario recently acquired the authority to conduct on-site inspections of clinics where anesthesia is used, including centres for cosmetic surgery, endoscopy and chronic pain management.

According to a news release issued by the college, inspections of these clinics will ensure that standards for procedures, infection control and quality assurance are in place. The move is part of the college's patient safety plan, which was established in April 2007 following the liposuction-related death of a Toronto woman.

The action plan includes: keeping records of the location, level of training and number of cosmetic surgeons; increasing public awareness about alternatives to surgery; and requiring that a new doctor notify officials before changing the scope of their practice.

Formal inspections are also considered to be a key component, in order to ensure that cosmetic surgery clinics and other out-of-hospital centres adhere to these regulatory measures.

In April, the college was granted the authority "to assess physicians who perform anesthetic-related procedures in prescribed premises, and to inspect the premises to ensure that patients are receiving quality care that is provided safely" (www.cpso.on.ca/whatsnew/news/default.aspx?id=4046).

The latest move, announced May 17, establishes formal standards for these out-of-hospital centres which "are widely available and form the basis for inspections and assessments."

"This regulation gives the College the authority to help ensure that patients who undergo procedures are receiving quality care in compliance with the proper standards," Dr. Jack Mandel, the college's president, said in a news release. — Emily Panetta, Ottawa, Ont.

WHO takes on alcohol abuse

Delegations from the World Health Organization's (WHO) 193 member states are all committed to taking action to reduce alcohol abuse, the WHO announced at the World Health Assembly on May 21.

According to the WHO's statistics, alcohol kills 2.5 million people annually, including 320 000 people between 15 and 29 years of age. Estimates from 2004 indicate that alcohol is the eighth leading risk factor for deaths globally, and harmful alcohol consumption contributes to almost 4% of all deaths in the world.

The WHO also notes that alcohol abuse is a major avoidable risk factor for cardiovascular diseases, cirrhosis of the liver and various cancers. Similarly, it is associated with infectious diseases — including HIV/AIDS and TB — as well as traffic accidents, violence and suicides.

To address the issue, the WHO's executive board worked in collaboration with member states to draft a global strategy aimed at reducing the harmful use of alcohol. "The strategy focuses on 10 target areas, which should be seen as supportive and complementary to each other." The 10 areas are: leadership,

awareness and commitment; health services' response; community action; drunk-driving policies and countermeasures; availability of alcohol; marketing of alcoholic beverages; pricing policies; reducing the negative consequences of drinking and alcohol intoxication; reducing the public health impact of illicit alcohol and informally produced alcohol; and monitoring and surveillance (apps.who.int/gb/ebwha/pdf_files/WHA63/A63_13-en.pdf).

"The resolution and the strategy set priority areas for global action, provide guidance to countries and give a strong mandate to WHO to strengthen action at all levels on reducing harmful use of alcohol," the WHO's Assistant Director-General, Dr. Ala Alwan, said in a news release (www.who.int/mediacentre/news/releases/2010/alcohol_20100521/en/index.html).

The WHO cautions that "concerted action by countries, effective global governance and appropriate engagement of all relevant stakeholders," is required to ensure a successful implementation of the strategy. — Emily Panetta, Ottawa, Ont.

Low-income Canadians more likely to suffer heart attacks

People living in Canada's poorest neighbourhoods are 37% more likely than affluent Canadians to suffer a heart attack, according to a report from the Canadian Institute for Health Information (CIHI) and Statistics Canada.

The report, *Health Indicators 2010*, looked at the number of heart attacks in different neighbourhoods and regions for 2008–2009 (http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=download_form_e&cw_sku=HI2010PDF&cw_ctt=1&cw_dform=N). It shows a higher rate of heart attacks among low-income Canadians. However, CIHI found few differences in the quality of treatment among Canadians of different socio–economic statuses. For instance, the percentage of those who die in hospital is almost the same regardless of how much the person earns and the percentage of unplanned readmission to hospital after a heart attack is only slightly higher among poorer Canadians (5.2% as opposed to 4.8% among the most affluent group).

The report also indicates that geographic location affects the incidence of heart attack. Residents of British Columbia have the fewest heart attacks, with a rate of 165 incidents per 100 000 people. People who live in Newfoundland and Labrador are more than twice as likely to suffer a heart attack, with a rate of 347 incidents per 100 000 people.

"Regions with higher heart attack rates also tend to have higher rates of hypertension, diabetes, smoking and other cardiac risk factors," warned Eugene Wen, manager of health indicators at CIHI in a press release (http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=media_20100527_e#report).

The report suggests that reducing social and regional inequalities would significantly lower the overall rate of heart attacks and save hospitals money. According to their statistics, if all of Canada had the same heart attack rate as the country's most-affluent neighbourhoods, there would have been more than 10 000 fewer hospitalizations in 2008–2009.

CIHI and Statistics Canada also analyzed rates of hysterectomies among women of different social classes. While middle-class women had the highest rate among Canadians, there was a more significant disparity between those living in rural and urban areas. In 2008–2009, the hysterectomy rate was 47% higher for women living in a rural setting.

"The differences in hysterectomy rates for menstrual disorders between urban and rural Canada may point to differences in clinical practice, rather than health differences," stated Dr. Vyta Senikas, associate executive vice-president of the Society of Obstetricians and Gynecologists of Canada, in a press release. "Menstrual disorders include irregular or abnormal levels of bleeding, pain, etc. While hysterectomies may be necessary, there are other less-invasive treatment options that may not be as widely available to women in rural areas." — Elyse Skura, Ottawa, Ont.

World Health Assembly adopts code for recruitment of health workers

The World Health Assembly has unanimously adopted a voluntary global code of practice for the recruitment of health workers from developing countries.

The code, approved at the assembly's 63rd gathering in Geneva, Switzerland, from May 17–21, "discourages states from actively recruiting health personnel from developing countries that face critical shortages of health workers, and encourages them to facilitate the 'circular migration of health personnel' to maximize skills and knowledge sharing. It also enshrines equal rights of both migrant and non-migrant health workers. Member States are to provide WHO [World Health Organization] with data on health worker migration in two years, and thereafter provide updates every three years," according to a summary of proceedings (www.who.int/mediacentre/news/releases/2010/wha_closes_20100521/en/index.html).

The long-promised code is the product of a Health Worker Migration Policy Initiative, launched by the World Health Assembly in 2004 and tasked with providing recommendations to WHO member states that clarify "the responsibilities of both 'source' and 'destination' countries for managing health workforce and migration policies" (*CMAJ* 2008: DOI:10.1503/cmaj.0718180).

The code states that "international recruitment of health personnel should be conducted in accordance with the principles of transparency, fairness and promotion of sustainability of health systems in developing countries" (www.who.int/workforcealliance/knowledge/themes/migration/wha_A63_A_Confpaper_11.pdf).

"The specific needs and special circumstances of countries, especially those developing countries and countries with economies in transition that are particularly vulnerable to health workforce shortages and/or have limited capacity to implement the recommendations of this Code, should be

considered," it adds. "Developed countries should, to the extent possible, provide technical and financial assistance to developing countries and countries with economies in transition aimed at strengthening health systems, including health personnel development."

But the code quickly notes that the right of health workers to migrate is inviolate. "Member States should take into account the right to the highest attainable standard of health of populations in source countries, individual rights of health personnel to leave any country in accordance with applicable laws, in order to mitigate the negative effects and maximize the positive effects of migration on the health systems of the source countries. However, nothing in this Code should be interpreted as limiting the freedom of health personnel, in accordance with applicable laws, to migrate to countries that wish to admit and employ them."

The 63rd assembly also adopted resolutions on a variety of other global health issues, including:

- The creation of an intergovernmental working group to examine, within a year, the WHO's "role in ensuring availability of good-quality, safe, efficacious and affordable medicines; relationship with the International Medical Products Anti-Counterfeiting Taskforce (IMPACT); and role in prevention and control of sub standard/spurious/falsely-labelled/falsified/counterfeit medical products."
- The strengthening of international mechanisms to inform countries about threats to food safety, including the International Food Safety Authorities Network, to "improve the assessment, management and communications of foodborne and zoonotic risks in a timely manner. WHO was encouraged to continue working directly with Food and Agriculture Organization of the United Nations (FAO), the World Organization for Animal Health (OIE) to strengthen public health, support economic development, and continue joint risk assessments through WHO/FAO expert bodies, and establish standards through the FAO/WHO Codex Alimentarius Commission."
- The revision of guidelines on human organ and tissue transplantation to include two new principles. "The first improves safety, quality and efficacy of both donation and transplantation procedures — as well as the human materials used. The second increases transparency, while ensuring the protection of the anonymity and privacy of donors and recipients." — Emily Panetta, Ottawa, Ont.

Cancer becoming more common in developing world, WHO says

The incidence of cancer in the developing world is rising, according to new data from the World Health Organization (WHO).

Roughly 56% of new cases of cancer in 2008 came from less-developed regions, the WHO says. The developing world also accounted for 63% of cancer deaths.

"Striking differences in the patterns of cancer from region to region are observed," Dr. Christopher Wild, director of WHO's International Agency for Research on Cancer said in a news release (www.iarc.fr/en/media-centre/pr/2010/pdfs/pr201_E.pdf). "Cervix and liver cancers are much more common in developing regions of the world, whereas prostate and colorectal cancers are more common in developed regions."

Lung, breast and colorectal cancers were the most common worldwide. Lung cancer was also the deadliest form of the disease, at 18.2% of all deaths attributed to cancer. WHO expects that trend will continue as long as tobacco use remains common in countries around the world.

The information was released as part of GLOBOCAN 2008, an interactive website containing maps, graphs and fact sheets (http://globocan.iarc.fr/). The site allows users to compare cancer rates among different genders and in different parts of the world.

Using the new statistics, and based on population growth and aging, WHO predicts that the number of new diagnoses of cancer per year will almost double by 2030 (from 12.7 million cases in 2008 to 21.4 million). Likewise, the number of cancer-related deaths is projected to jump from 7.6 million to 13.2 million.

Taking into account that developing nations are growing more rapidly and aging more dramatically, the International Agency for Research on Cancer expects the trend toward higher rates of cancer in the developing world to continue.

Wild said the statistics currently provide the most accurate view of the "global cancer burden" and will "form a vital foundation to future responses to the UN resolution on noncommunicable diseases." — Elyse Skura, Ottawa, Ont.

Reducing alcohol-related deaths

Making alcohol more expensive and less available is the best way to curb alcohol-related health problems, according to a public health guidance issued by the United Kingdom's National Institute for Health and Clinical Excellence.

While the group also suggested more frequent and targeted screenings for alcohol problems, their guidance states that "policy change is likely to be a more effective — and more cost-effective — way of reducing alcohol-related harm among the population than actions undertaken by local health professionals" (www.nice.org.uk/nicemedia/live/13001/48984/48984.pdf).

"Alcohol is much more affordable now than it ever has been — and the price people pay does not reflect the cost of the health and social harms that arise," Anne Ludbrook, a professor of health economics at the University of Aberdeen in Scotland who helped develop the guidance, said in a press release (www.nice.org.uk/newsroom/pressreleases/20100062alcoholaffordable.jsp). "When it is sold at a very low price, people often buy and then consume more than they otherwise would have done. It is a dangerous pattern which many people have unknowingly fallen into."

The guidance, *Alcohol-use disorders: preventing the development of*

hazardous and harmful drinking, suggests a "minimum price per unit" of alcohol and a prohibition of "below-cost" sales by retailers. It also recommends limiting the number of places that sell alcohol in a given area and "the days and hours when it can be sold."

The guidance also promotes strengthened regulation for alcohol advertisements, as ads are "associated with the onset of drinking among young people and increased consumption among those who already drink."

The institute estimates that more than 8000 Britons die of conditions such as alcohol poisoning and liver cirrhosis annually, while a recent report by the National Health Service Confederation and the Royal College of Physicians indicated that the cost of treating alcohol-related conditions doubled for the National Health Service between 2001 and 2007 (www.nhsconfed.org/Publications/Documents/Briefing_193_Alcohol_costs_the_NHS.pdf). — Elyse Skura, Ottawa, Ont.

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