For the record

"Tax us. Canada's worth it."

Hoping to tap an altruistic streak within the medical profession, a group of physicians is calling on their colleagues in Canada to petition governments to implement a progressive wealth tax on high-income earners to help pay for health care and other public services that make Canada a civil society.

The physicians, Doctors for Fair Taxation, say the federal government could generate $3.5 billion per year, and the Ontario government $1.7 billion annually, to reduce debt loads and pay for public services by introducing a progressive wealth tax that would have physicians cough up 2%–24% on taxable income above $100 000, in four tax brackets starting at $100 000 (with the maximum 24% levied on those whose taxable income tops $1.85 million).

"Almost all the economic gains of the past decade have gone to Canada's top 1% but our taxes haven't gone up accordingly," Dr. Gary Bloch, a family physician and assistant professor of family and community medicine at the University of Toronto in Ontario, stated in a press release (http://doctorsforfairtaxation.ca/wp-content/uploads/2012/03/120322-Media-). "Now that our governments are dealing with deficits, the main ideas on the table are to cut programs that all Canadians rely on. Instead of cutting public services, we say to the Ontario and federal governments, that's not healthy. There's another option: Tax us. Canada's worth it."

The group argues that a wealth tax would help to redress the growing disparity between top income earners and the remainder of Canadians, while noting that innumerable studies "demonstrate that persons with lower income and education have poorer health and higher overall death rates" (http://doctorsforfairtaxation.ca/wp-content/uploads/2012/03/120322-Final-).

Their tax proposal would see "both the federal and Ontario governments institute new income tax brackets of 1% for the top 10% (approx. $100,000 taxable income), 2% for the top 1% (approx. $170,000 taxable income), 3% for the top 0.1% (approx. $640,000 taxable income), and 6% for the top 0.01% (approx. $1,850,000 taxable income). These rates apply to both levels of government and are cumulative so the top marginal tax rates would go up by 2% for income between $100,000 and $170,000 by 6% for income between $170,000 and $640,000, by 12% for income between $640,000 and $1,850,000 and by 24% for income above $1,850,000. The top Ontario marginal tax rate would be 70%, adding 24% to the current top marginal rate of 46%."

A wealth tax would help governments balance their budgets and spare Canadians from program cuts, the group argued.

"Our group considers higher taxes a small price to pay for a more enlightened Canada," Dr. Michael Rachlis, associate professor with the University of Toronto Dalla Lana School of Public Health, argued in the press release.

The petition states that "the Canadian public sector isn't healthy," (http://doctorsforfairtaxation.ca/petition/). "We have deteriorating physical infrastructure like bridges that need re-engineering. And, our social infrastructure is also crumbling. Canada suffers from increasing economic inequality, rising socioeconomic segregation of neighbourhoods, and resultant social instability. Canada spends the least of all OECD (Organisation for Economic Cooperation and Development) countries on early childhood programs and we are the only wealthy country which lacks a National Housing Program."

"Most of the wounds to the public sector are self-inflicted — government revenues dropped by 5.8% of GDP from 2000 to 2010 due to tax cuts by the federal and secondarily the provincial governments. This is the equivalent of approximately $100 Billion in foregone revenue. The total of the deficits of the federal and provincial governments for this year is likely to be around $50 Billion.

The foregone revenue has overwhelmingly gone in the form of tax cuts to the richest 10% of Canadians and especially to the richest 1% of Canadians. The other 90% of Canadians have not reaped the tax cuts and face stagnating or lower standards of living. This massive redistribution of income has been facilitated by cuts in personal and corporate income taxation rates. Canada had very rapid growth in the 1960s when the top marginal tax rate was 80% for those who made more than $400,000, over $2,500,000 in today's dollars. Today the richest Ontarians pay only 46% on their income above $132,000.

We are pleased that so far most of the health care system has been spared the cuts made to other sectors. But we see the impact of these cuts in our patients who lack the community services, housing, and income to be full participants in Canadian society.

If the times are really so tough that we must choose between such horrors as axing homeless shelters or school feeding programs then we (the undersigned) believe that we must ask those who are doing better to give more back.

We recommend that the federal and Ontario governments institute new income tax brackets of 1% for the top 10% (approx. $100,000 taxable income), 2% for the top 1% (approx. $170,000 taxable income), 3% for the top 0.1% (approx. $640,000 taxable income), and 6% for the top 0.01% (approx. $1,850,000 taxable income).

The province and the federal governments should immediately request their finance committees investigate other options for fair revenue generation and bring forth proposals in time for their 2013 budgets.

We recommend that the federal and

Ontario governments take whatever other action is necessary to protect the most vulnerable Canadians as our country slowly recovers from the 2008/2009 recession.

When a family faces a loss of income it doesn't resolve the crisis by denying food to one its members. A functional loving family makes the existing food go further. Our country should similarly find ways to best use our existing resources so no Canadian will be deprived of their health and security." — Wayne Kondro, *CMAJ*

Ontario hunkers down in budget

Call it the no surprises austerity budget, as a wage freeze for physicians, a shift in funding toward home care and community services, tying seniors' drug benefits to income and cancellation of four new hospitals highlighted the health components of Ontario's fiscal 2012/12 blueprint.

The goal is to constrain "the overall growth in health spending in Ontario to an average of 2.1 per cent annually, over the next three years," Ontario Finance Minister Dwight Duncan stated in the budget, *Strong Action for Ontario* (www.fin.gov.on.ca/en/budget/ontariobudgets/2012/papers_all.pdf).

Duncan's budget essentially implemented the core elements and recommendations of the *Ontario Action Plan for Health Care* (www.health.gov.on.ca/en/ms/ecfa/healthy_change/docs/rep_healthychange.pdf) and the Commission of the Reform of Ontario's Public Services, which urged a systemic shift in the provision of health services toward patient-centred, continuum-coordinated, preventive, community-based care, as well as an immediate wage freeze for physicians (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4130).

Duncan said the government will demand the wage freeze for physicians as part of its forthcoming negotiations with the Ontario Medical Association. "Doctors are integral to the health care system and are at the forefront of providing quality care to patients. Since 2003, the government has worked with doctors to increase access to care and reduce wait times. Total payments to physicians increased by $5.1 billion between 2003–04 and 2011–12. Nearly one in 10 program expense dollars goes to physician compensation. The 2012 Budget reflects the government's plan to maintain total physician compensation at current levels through the next Physician Services Agreement with the Ontario Medical Association."

The budget also argued that physicians should be willing to agree to a wage freeze as they've been generously treated over the past decade. "Physicians play a critical role in providing health care and in Ontario they are well compensated," the budget stated, noting that payments to doctors now constitute $11 billion, or 23% of health care costs. "Average payments to physicians through OHIP [Ontario Health Insurance Plan] have increased by over 50 per cent since 2003. Physicians have also benefited from tax changes that provide them with a competitive corporate tax rate and support their families through income-splitting."

Hospital funding will also be constrained as efforts are expanded to treat patients in alternative care settings, the budget added. "Measures include: increasing access to doctors and nurse practitioners by expanding same-day and next-day appointments and after-hours care. This will help patients access primary care providers rather than going directly to hospital emergency rooms; integrating planning for family health care into the Local Health Integration Networks (LHINs) to leverage their expertise in helping patients navigate the health care system and access the right care, in order to reduce hospital readmission rates; and holding growth in hospitals' overall base operating funding to zero per cent in 2012–13, while continuing to increase investments in the community care sector by an average of four per cent annually." Total hospital funding will rise only by 2% in fiscal 2012/13 and only as a consequence of the ongoing rollout of measures aimed at reducing in wait times in designated priority areas "including for chronic kidney disease and transplants."

Duncan also extended the current wage freeze for executives at hospitals and universities for another two years.

As part of the effort to shift care from hospitals to other facilities in the health care chain, the budget indicated that it would enhance the capacity of such other facilities by:

- "increasing investments in home care and community services by an average of four per cent annually for the next three years or $526 million per year by 2014–15, to better support those seniors and other Ontarians who could benefit from care provided in the community;
- development of a new Seniors Strategy that will expand house calls, increase access to home care, and provide improved care coordination;
- care coordinators to provide seniors, particularly those with complex conditions, with guidance by working closely with all health care providers. Seniors will be directed to the care they need, in the appropriate setting. This will improve the coordination of care for seniors living at home and help avoid unnecessary hospital admissions;
- investments in chronic care services provided in the community to ease pressure on long-term care homes' waiting lists and help reduce the number of ALC [alternate level of care] patients in hospitals;
- moving forward with the proposed Healthy Homes Renovation Tax Credit to help seniors adapt their homes to meet their needs as they age and allowing them to live at home and independently for as long as possible, provided this Budget is passed by the legislature; and
- building on the significant investments made in long-term care since 2003 to create capacity in the sector, increasing overall long-term care home funding by 2.8 per cent in 2012–13. Included in this growth is a one per cent increase in direct care costs for long-term care home residents. The government will help the sector manage this growth by providing home operators with greater flexibility to pay for services from within their current funding structure."

The budget also confirmed earlier announcements that the government will shift authority for determining which medical procedures are to be covered under the Ontario Health Insur-

ance Plan to Health Quality Ontario, and that funding for hospitals will be based on a patient-centred model.

The revisions to the Ontario Drug Benefit program for seniors will see high-income seniors pay an income-tested deductible, commencing in August 2014. It will "increase gradually with net income. For high-income single seniors with an income over $100,000, the deductible amount will be $100 plus three per cent of income over $100,000. For high-income senior couples with a combined income of over $160,000, the new deductible for the couple will be $200 plus three per cent of their combined income over $160,000. Seniors with higher incomes will also continue to pay a co-payment of $6.11 per prescription after the deductible amount. The income thresholds will not be indexed for inflation."

"In addition, incomes will be checked each year, to ensure that seniors are receiving the correct level of benefits. These changes will not increase drug costs for seniors with incomes below the $100,000 or $160,000 thresholds who already get drug benefits. Seniors who currently pay the $2.00 co-payment will continue to pay $2.00 per prescription."

Duncan estimated that just 5% of Ontario's seniors will pay more for drugs as a result of the revisions.

The cutback in hospital construction will result in the cancellation of four new facilities, as well as the "rescoping" of two others, specifically the West Lincoln Memorial Hospital Redevelopment; Sunnybrook Health Sciences Centre — Replace Hemodialysis Unit; South Bruce Grey Health Centre (Kincardine) — Emergency and Ambulatory Project; and Wingham and District Hospital — Phase 1 Ambulatory and Inpatient Project. — Wayne Kondro, *CMAJ*

Court orders FDA to move on livestock antibiotic ban

The noose continues to tighten on use of antibiotics to promote animal growth in the United States after a federal judge kickstarted a 35-year-old plan by the US Food and Drug Administration (FDA) to outlaw the subtherapeutic use of penicillin and tetracycline antibiotics in animal feed.

The FDA has a statutory obligation to commence withdrawal proceedings when safety is an issue, United States District Court Judge Theodore H. Katz of the Southern District of New York ruled in *Natural Resources Defense Council, Inc., et al.* v. *United States Food and Drug Administration, et al*., while ordering the agency to notify drug makers that it would soon commence proceedings for a ban on bulk use of penicillin and tetracycline (http://nysd.uscourts.gov/cases/show.php?db=special&id=162).

"Upon a finding that the use of a drug under certain conditions has not been shown to be safe, §360b(e) (1) [of the Food, Drug, and Cosmetic Act] prescribes a clear course of conduct: issue notice and an opportunity for a hearing, and, if the drug sponsor does not demonstrate that the drug use is safe at the hearing, withdraw approval of such use," Katz stated, explaining that the FDA did not have the authority to evade withdrawal proceedings for any reason, including "administrative convenience."

The FDA, therefore, is obliged to reinitiate withdrawal proceedings on the use of penicillin and tetracycline to promote animal growth, Katz ruled. "Specifically, the Commissioner of the FDA or the Director of the CVM [Center for Veterinary Medicine] must reissue a notice of the proposed withdrawals (which may be updated) and provide an opportunity for a hearing to the relevant drug sponsors; if drug sponsors timely request hearings and raise a genuine and substantial issue of fact, the FDA must hold a public evidentiary hearing. If, at the hearing, the drug sponsors fail to show that use of the drugs is safe, the Commissioner must issue a withdrawal order. The Court notes the limits of this decision. Although the Court is ordering the FDA to complete mandatory withdrawal proceedings the relevant penicillin and tetracycline NADAs/ANADAs [new animal drug applications and in the case of generics an abbreviated new animal drug application], the Court is not ordering a particular outcome as to the final issuance of a withdrawal order. If the drug sponsors demonstrate that the subtherapeutic use of penicillin and/or tetracyclines is safe, then the Commissioner cannot withdraw approval."

In the late 1970s, the FDA had signaled its intent to ban some agricultural uses of antibiotics because of concerns about the threat antibiotic resistance poses to human health but retreated from its plan when the US Congress passed resolutions opposing the ban. With an estimated 80% of all antibiotics purchased in US now being used on animals and a growing number of outbreaks of antibiotic-resistant bacteria, the coalition of environmental and health groups (which included the Natural Resources Defense Council, the Center for Science in the Public Interests, the Food Animal Concerns Trust, Public Citizen and the Union of Concerned Scientists) had filed the suit asking that the FDA be compelled to reinitiate withdrawal proceedings.

Earlier this year, FDA announced it would prohibit the use of cephalosporins in cattle, swine, chickens and turkeys unless "they follow the dose, frequency, duration, and route of administration that is on the label" (www.ofr.gov/OFRUpload/OFRData/2012-00035_PI.pdf). It also prohibited the use of cephalosporin drugs for disease prevention (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4070).

Katz's ruling does not preclude the use of penicillin and tetracycline for disease prevention. Agricultural groups say that's now the primary reason such drugs are being inserted into animal feed. — Wayne Kondro, *CMAJ*

It's not our problem, feds say of drug shortages

The message was clear and unequivocal, though it seemed somewhat surprising to be coming from a physician, to wit: if you want action on drug shortages in Canada, contact your province.

Reasserting Conservative Party orthodoxy that all matters of health are not the responsibility of central government, Conservative Party Member of Parliament and Parliamentary Secretary (International Trade) Dr. Kellie Leitch (Simcoe–Grey) had harsh words for

Canadian Medical Association (CMA) President Dr. John Haggie and others calling for federal action on drug shortages during their presentations to the House of Commons Committee on Health's "Study of the Role of Government and Industry in Determining Drug Supply in Canada."

Although it is a major purchaser of drugs as part of its responsibility for providing health care to Aboriginal peoples, inmates and veterans, "the federal government under the Constitution has no responsibility in dealing the drug shortage problem," Leitch said.

As a surgeon, "when I run into a problem with the drug in my operating room, I don't pick up the phone and call the Minister of Health," Leitch told Haggie. "I call my pharmacist. We also deal with our provincial formularies, and we deal with the circumstance of our hospital making sure that the supplies are available to us. That's who's actually doing the negotiating. I want to be very clear that I think we understand that this health care and the provision of those medications is a provincial responsibility, a provincial negotiation, a hospital negotiation."

Leitch also advanced the proposition that a measure of responsibility for notifying patients about specific drug shortages falls with physicians and the CMA. "What has the CMA done to make sure that physicians know what's going on?," she asked. "You seem to be throwing it all back on our lap here as parliamentarians. … Doesn't the profession have a little bit of a responsibility as well to make sure that individuals who are physicians actually know what's going on?"

Haggie countered that while the provinces are responsible for drug purchasing, "they're doing it in isolation, in silos," when a more coordinated, national approach is needed.

With doctors heavily reliant on drug companies for information about shortages "we are in the position that the patients are: one of complete ignorance," Haggie added.

Gail Attara, president and CEO of the Gastrointestinal Society, speaking on behalf of the Best Medicines Coalition, an alliance of 27 advocacy groups and individuals, contended the federal government cannot legitimately absolve itself of all responsibility. "The provincial and territorial bodies have a role in reimbursement. It's actually Health Canada that has the role in notice of compliance for medications. There's certainly an area to piggyback safety and supply on to that."

In his presentation to the committee, Haggie called on the government to exercise leadership with respect to the "national crisis" caused by drug shortages and "live up to the trust that has been placed in you" (www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Submissions/2012/Health-DrugShortages_en.pdf). "As health care providers, we must have a monitoring and early notification system for pharmacies and physicians; and there must also be a proactive, systematic mechanism to prevent interruptions in the provision of medically necessary medications to our patients."

The federal government should "consider every lever available, including the economic inducements it provides to the pharmaceutical industry, to ensure that Canadians are assured of an uninterrupted supply of medically necessary drugs," he added.

To that end, Myrella Roy, executive director of the Canadian Society of Hospital Pharmacists, urged the creation of a national drug supply management system." It should feature "minimum time frames for notification of impending drug shortages and drug discontinuation by manufacturers," Roy said.

Others urged even more proactive solutions. A publicly owned generic drug company should be created to manufacture drugs and make them available at a reasonable price, argued Dr. Joel Lexchin, professor of the School of Health Policy at the University of Toronto in Ontario. Lexchin also urged that Health Canada convene an expert panel to identify precisely which generic drugs are in critical shortage and then "proactively identify possible alternative sources of these products and determine whether the companies making these products are prepared to supply Canada in the event of an emergency, and contingency contracts could then be negotiated with interested suppliers. In the future, any company marketing one of these critical drugs in Canada should be required to give Health Canada a minimum of six months notice before they stop supplying the product, and Health Canada should maintain a list of these drugs and post this list publicly."

A condition of being allowed to sell any of those drugs in Canada "should be a commitment by the company to guarantee the availability of the drug for a minimum of three years," Lexchin added.

Canadian Anesthesiologists' Society President Richard Chisholm urged that Health Canada develop "a methodology to identify situations where supply constraints meet the definition of a drug shortage that requires prescribers to choose an alternate therapy," as well as place "a clear onus on companies to immediately inform governments and the health services system of any events that may jeopardize drug supplies."

Attara called for a national "in-depth study on what really went wrong and solutions," while Dr. Brian O'Rourke, president and CEO of the Canadian Agency for Drugs and Technologies in Health (CADTH), advocated that his agency be given responsibility for serving as a "clearing house of shortage information and relevant [drug] substitution advice and perhaps to provide a link to currently available databases and information sources. Information from CADTH could be used to supplement local efforts and to support clinical decision-making at the patient-clinician interface." — Wayne Kondro, *CMAJ*

Five procedures to question, times nine

Acknowledging that many tests and procedures are performed without justification and may, in fact, harm patients, nine medical special boards in the United States have identified 45 services that should be performed less often, and which patients should query if offered.

As part of a "Choosing Wisely" campaign aimed at identifying procedures that evidence suggests are overused in the US, each specialty society identified five procedures that it believes could "lead to significant

health benefits, reduce risks and harm and reduce costs" (http://choosingwisely.org/?page_id=13).

"Today these societies have shown tremendous leadership in starting a long overdue and important conversation between physicians and patients about what care is really needed," Dr. Christine K. Cassel, president and CEO of the American Board of Internal Medicine Foundation stated in a press release. "Physicians, working together with patients, can help ensure the right care is delivered at the right time for the right patient. We hope the lists released today kick off important conversations between patients and their physicians to help them choose wisely about their health care."

In the case of the *American Academy of Family Physicians*, for example, the "five things physicians and patients should question" were:

- "Don't do imaging for low back pain within the first six weeks, unless red flags are present" such as severe neurological deficits or the patient has indications of an underlying condition such as osteomyelitis.
- "Don't routinely prescribe antibiotics for acute mild-to-moderate sinusitis unless symptoms last for seven or more days, or symptoms worsen after initial clinical improvement." The US spends $5.8 billion per year on antibiotics for sinusitis.
- "Don't use dual-energy x-ray absorptiometry (DEXA) screening for osteoporosis in women younger than 65 or men younger than 70 with no risk factors."
- "Don't order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms. There is little evidence that detection of coronary artery stenosis in asymptomatic patients at low risk for coronary heart disease improves health outcomes. False-positive tests are likely to lead to harm through unnecessary invasive procedures, over-treatment and misdiagnosis. Potential harms of this routine annual screening exceed the potential benefit."
- "Don't perform Pap smears on women younger than 21 or who have had a hysterectomy for non-cancer disease" as, in the former instance, most abnormalities regress, and in the latter, there's little evidence for improved outcomes.

The top choices for each of the eight remaining were:

- *American Academy of Allergy, Asthma & Immunology*
  "Don't perform unproven diagnostic tests, such as immunoglobulin G (IgG) testing or an indiscriminate battery of immunoglobulin E (IgE) tests, in the evaluation of allergy."
- *American College of Cardiology*
  "Don't perform stress cardiac imaging or advanced non-invasive imaging in the initial evaluation of patients without cardiac symptoms unless high-risk markers are present."
- *American College of Physicians*
  "Don't obtain screening exercise electrocardiogram testing in individuals who are asymptomatic and at low risk for coronary heart disease."
- *American College of Radiology*
  "Don't do imaging for uncomplicated headache."
- *American Gastroenterological Association*
  "For pharmacological treatment of patients with gastroesophageal reflux disease (GERD), long-term acid suppression therapy (proton pump inhibitors or histamine2 receptor antagonists) should be titrated to the lowest effective dose needed to achieve therapeutic goals."
- *American Society of Clinical Oncology*
  "Don't use cancer-directed therapy for solid tumor patients with the following characteristics: low performance status (3 or 4), no benefit from prior evidence-based interventions, not eligible for a clinical trial, and no strong evidence supporting the clinical value of further anticancer treatment."
- *American Society of Nephrology*
  "Don't perform routine cancer screening for dialysis patients with limited life expectancies without signs or symptoms."
- *American Society of Nuclear Cardiology*
  "Don't perform stress cardiac imaging or coronary angiography in patients without cardiac symptoms unless high-risk markers are present."

Notably, three of the eight societies' top choices were essentially identical, confirming the widespread belief that cardiac imaging for asymptomatic patients is among the most overused procedures in America. Many experts have asserted that as many as 30% of all procedures performed in the US are unnecessary and often aimed solely at avoiding liability rather than improving people's health. — Wayne Kondro, *CMAJ*

Weighing the options

Tax breaks for pharmaceutical firms and orphan drug legislation are not as effective as direct grants to companies and patent pools in promoting research on diseases that affect more people in developing and poor countries, according to a World Health Organization (WHO) expert panel.

Arguing that intellectual property rights have clearly failed to promote research into such diseases, the WHO's Consultative Expert Working Group on Research and Development: Financing and Coordination also urged in its final report, *Research and Development to Meet Health Needs in Developing Countries: Strengthening Global Financing and Coordination*, that an international convention be crafted to ensure that some manner of global body be struck to coordinate health research and development (R&D) that is of value to developing nations, and that the entire effort be financed through such measures as revenues generated from national airlines, financial transaction or tobacco taxes (www.who.int/phi/CEWG_Report_5_April_2012.pdf).

The panel was struck in 2010 to "examine current financing and coordination of research and development, as well as proposals for new and innovative sources of financing to stimulate research and development related to Type II [diseases such as HIV/AIDS and tuberculosis in which the majority of the burden falls on poor countries] and Type III diseases [such as sleeping sickness, river blindness, buruli ulcer, Chagas, leprosy, dengue, leishmaniasis, guinea worm and others in which burden falls almost exclusively in poor countries] and the specific research and

development needs of developing countries in relation to Type I diseases [such as Hepatitis B, measles, cardiovascular diseases and tobacco-related illnesses in which the burden is large in both rich and poor countries]."

The expert panel's core recommendation is that "all countries should commit to spend at least 0.01% of GDP on government-funded R&D devoted to meeting the health needs of developing countries."

The panel's assessment of alternative means of financing R&D aimed at treating diseases that predominantly affect people in developing countries indicated that beneficial measures would include a "Global Framework on Research and Development, Open approaches to research and development and innovation, Pooled funds, Direct grants to companies, Milestone prizes and end prizes and Patent pools."

Regulatory harmonization and removal of data exclusivity would have less impact, while several approaches would have virtually no value, including "Tax breaks for companies, Orphan drug legislation, Green intellectual property, Priority review voucher, Transferable intellectual property rights, Health Impact Fund and Purchase or procurement agreements."

The panel also concluded that proposed measures such as indirect taxes, voluntary contributions from businesses and consumers, a tax on repatriated industry profits and new donor funds for health R&D would not be of universal value but might work in some countries. "It would be unrealistic, given the multifaceted nature of development needs, to think that one specific new source that would generate very significant amounts of money on a global scale would or should be devoted to the particular field of health R&D of relevance to developing countries. Rather we argue that from any new source of funding that might emerge a portion should be related to the improvement of health as an acknowledged development priority, and that another portion also should be devoted to currently underfunded R&D areas."

Targeted taxes, such as airline or financial transaction taxes, or sin taxes such as ones on fat, sugar and tobacco, might be the most effective revenue generators as long as they are aimed at the rich rather than the poor, the panel argued.

The expert panel also contended that there is a need for a "binding international convention" to set out the obligations and responsibilities of all countries, including funding commitments from all developed countries toward a major international initiative to address R&D needs related to diseases that burden developing countries. That effort should be overseen by some manner of WHO coordinating body, the panel added. — Wayne Kondro, *CMAJ*

Home care muddles along in Canada

While other developed nations are aggressively moving to systematically bolster their home care programs and some provinces have expanded their programming, the overall home care picture in Canada remains fractured, incoherent and woefully inadequate in the face of spiraling demand, according to the Health Council of Canada.

"Even as the importance of home care is acknowledged, there is no shared understanding of what home care should look like for Canadian seniors — no shared vision, common principles, or collective standards — and in the absence of this, there is significant variation in what is happening across the country, such as the types and hours of publicly funded home care services that people can receive," the council states in a report, *Seniors in need, caregivers in distress: What are the home care priorities for seniors in Canada?* (http://healthcouncilcanada.ca/tree/HCC_HomeCare_FA.pdf).

"There are differences in eligibility, the types and amounts of services that are provided, and whether clients need to pay for a portion of their services. This variability may lead to inequities in both access to and the quality of home care services."

The report provides a comprehensive overview of the state of home care in Canada but few specifics with respect to needed changes except for sweeping, general calls for home care to be reformed, such as one that calls for it to be "integrated" into national continuing care strategy.

To that end, the report calls for changes in the manner in which funding is allocated for home care in the health system. It notes Organisation for Economic Co-operation and Development data reveals that "among OECD countries, Canada has one of the larger gaps between spending on long-term care institutions [0.96% of gross domestic product] and home care [0.21% of gross domestic product]. This raises questions about the appropriate balance between the two, particularly since many caregivers of high-needs seniors — who may also be seniors themselves — are struggling with limited hours of home care support and are becoming overburdened."

As a part of that shift in funding, it will be necessary to ensure "that home care workers have better and more interprofessional training, as well as comparable wages and benefits, to improve quality of care, reduce turnover, and provide a sufficient workforce for the future."

The funding gap is a major contributor to regional variations in home care, the report argues. "Our analyses show that increasing levels of need are not necessarily matched by increasing levels of home care services. High-needs seniors receive, at most, a few more hours of care per week than those with moderate needs. In some regions, the hours of care do not increase at all. Due to limited funding, some provinces and territories cap the number of hours or spending on home care clients to the equivalent cost of a bed in a long-term care facility."

The variations include the extent to which users of home care services must absorb costs out of their own pockets. "In Ontario, Manitoba, Quebec, Prince Edward Island, the three territories, and in federal programs, there are no income tests or direct fees for home care services. In the remaining six provinces (British Columbia, Alberta, Saskatchewan, New Brunswick, Nova Scotia, and Newfoundland and Labrador), professional and often personal care services are covered by provincial plans, while direct fees based on income are generally attached to personal and community support."

In order for many people to continue to receive care at home, "either longer-term or while waiting for placement in a long-term care facility — more resources would need to be allocated to ensure that both clients and family caregivers receive the care and support they require. This is not always the case. Due to limited resources and funding, many provinces and territories cap the number of hours of home care that are provided, even as clients' needs increase." As a consequence, many family caregivers are being asked to shoulder more and more of the burden and are becoming more stressed.

"Challenges in home care include the lack of supports for family caregivers, difficulties in the recruitment and retention of home care workers, and determining how best to allocate funds to ensure the most appropriate care for seniors."

Other challenges identified include ensuring that physicians, and more specialists, are adequately trained to care for the elderly; to advocate on their behalf; and to help them navigate the home care system.

In response to the confusion and disparities in the planning of home care policies across the country, the Canadian Home Care Association is now crafting a national framework to outline the role of home care within the health care system (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4110). That framework is expected to include national standards for elements of a system, including standardized geriatric assessments and data collection. The lack of such national standards has made it difficult to compare home programs across Canadian jurisdictions (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-3731). — Wayne Kondro, *CMAJ*

National dementia strategies lacking

National dementia strategies are underdeveloped and underutilized in the face of the growing global incidence of the disease, the World Health Organization (WHO) says.

Only a handful of nations currently have national dementia strategies — Denmark, England, France, Japan, Korea, Norway, Scotland and Wales — which should include bolstered early diagnosis, public awareness campaigns to reduce stigmatization, increased funding for dementia research and more intensive treatment programs, WHO states in a report, *Dementia: A Public Health Priority* (http://whqlibdoc.who.int/publications/2012/9789241564458_eng.pdf). Northern Ireland, China, the Czech Republic, India, Malta and the United States are in the process of implementing strategies, while Australia and the Netherlands have discontinued funding for their strategies.

"Barriers to prioritization include the complexity of dementia care which involves health and social care, the family, and the private and voluntary sectors. This obscures recognition of who should take responsibility, complicates financing, and therefore hinders the process of advocacy and action. There are also powerful societal misconceptions concerning dementia — that it is not a very common problem, that it is a normal part of ageing, that there is nothing that can be done to help, that it is better not to know, and that it is the families' responsibility to provide care. These misconceptions, which are the norm rather than the exception, reinforce beliefs that dementia is not an issue for health care systems or governments. They are shared by many politicians, policy-makers, health administrators and health professionals. They are generally benignly held but they result in a lack of prioritization of dementia and therefore a lack of action."

The report projects that 35.6 million people worldwide are now living with dementia and estimates the total will double by 2030 and triple to 115.4 million by 2050. About 7.7 million new cases of dementia are reported annually — the equivalent of one new case every four seconds. The total cost of dementia care worldwide was US$604 billion in 2010.

National dementia strategies can improve the quality of life for people with dementia and their caregivers, WHO argues in urging nations to adopt national approaches or incorporate dementia strategies into existing health plans. "There are several key issues that are common to many national dementia policies and plans, and these may be necessary to ensure that needs are addressed in an effective and sustainable manner. These include: scoping the problem; involving all the relevant stakeholders, including civil society groups; identifying priority areas for action; implementing the policy and plan; committing resources; having intersectoral collaboration; developing a time frame; and monitoring and evaluation. The priority areas of action that need to be addressed within the policy and plan include raising awareness, timely diagnosis, commitment to good quality continuing care and services, caregiver/support, workforce training, prevention and research."

Even when nations have services available for people with dementia and their caregivers, they are not well utilized, the report states, surmising that gap may be due to lack of awareness, stigmatization of the disease or other barriers. "Awareness-raising and improved understanding can reduce the stigma associated with dementia and reduce the fear of the disease. Better understanding in society generally and among those who provide the care should increase help-seeking and help-giving."

The report also indicates that dementia will post an ever-increasing burden in low- and middle-income nations. But it offers no specific recommendations to help the developed world cope with the burden, other than to generally note that "political commitment is needed to generate strategies, policies, programmes and services that work for people with dementia. Strategies and their implementation can be at the level of health services, or at sub-national level, but coordinating and direction is also required nationally and internationally in view of the global nature of the coming epidemic and its profound fiscal and societal impacts." — Andrea Hill, Ottawa, Ont.

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