played a role. Patients were taken to the nearest hospital with the shortest wait times and often transferred to the institution where their doctor had privileges. With those transfers, ambulances may have been unwittingly moving newly-incubated patients around. These factors are "how we became the kings of *C. diff!*" says Libman.

Health Minister Couillard declared *Clostridium difficile*-associated diarrhea a reportable disease in August 2004 — so far Quebec and Manitoba are the only provinces to do so. Libman says his colleagues worldwide have been impressed by how quickly Quebec put in place a sophisticated surveillance system. The data is entered on a secure Web site by all hospitals with more than 1000 patient admissions per year and instantly transmitted to public health authorities. Comparative data are compiled quarterly and published online, available for anyone to see.

L'institut national du santé publique du Québec analyzed how hospitals with high incidence rates changed their performance over the first 2 years of *C. difficile* surveillance.

"It seems the public reporting provides [hospitals] with a tool of comparison with other hospitals ... to motivate them to do better," says Dr. Rodica Gilca, a medical epidemiologist at the institute. "We saw hospitals with the highest incidence rates improved the most."

The institute's latest data (December 2006) show *C. difficile* infection rates declined 36% between August 2005 and August 2006, with the greatest drop in Montréal and the surrounding regions. The data also show the bacterium has spread to more far-flung regions of the province: Rimouski had rates as high as 10.8 per 10 000 patient days in 2006, and some hospitals north of Montréal also reported high rates (22.1 per 10 000 patient days in Lanaudière.)

But in Montréal, where the epidemic appears to have begun, most teaching hospitals are once again nearing pre-epidemic levels. Libman says infection control specialists may never again be able to let down their guard — but there does appear to be an end in sight.

"At one point, I thought, this is such a bad bug — it's so nasty — we will never be able to get back to where we were," says Libman. "I thought this is 'the new normal.' But in fact, with a lot of quite intensive effort by a lot of people, we have gotten closer to the baseline."

Still, that's little comfort to Danielle Raymond and her family who are in mourning for their father. "Is it because it is mostly old people that catch *C. difficile* that they don't do much about it?" Raymond asks. — Loreen Pindera, Montréal, Que.

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US grapples with covering the uninsured

With the 2008 presidential election in full flight, universal health care coverage has surged to the top of the political agenda in the United States, second only to the Iraq war.

Propelled by rising premiums and shrinking access to private insurance, the debate about how to cover 46 million uninsured Americans has picked up political traction as Democrats — who have always considered health care their "issue" — regain control of Congress and target the presidency.

To date, virtually all Democratic presidential candidates — including Senator Hillary Clinton, Senator Barack Obama and John Edwards — hope that universal health care is an issue they can ride all the way to the White House. But none are expected to advocate a single-payer government-controlled national health plan. Rather, all are opting for a combination of public and private solutions in measured, incremental steps.

Most Americans are insured through employer-based group plans in which they pay part of the premium. According to government figures, the average annual health insurance premiums in 2004 were $3705 for single coverage and $10 006 for family coverage.

Advocates for single-payer solutions, such as some trade union groups and the 14 000-member Physicians for a National Health Program, argue that private insurers are part of the problem not the solution. But even Senator Edward Kennedy, a long-time advocate for a national health program, concedes that some form of private–public plan using private insurers is the most "doable" in political terms and is pushing the mandatory program set up in his state last year as a model.

Under a proposed Massachusetts plan, everyone must buy health insurance, with the government subsidizing those who can't afford it. Employers not offering it to their employees are to be penalized through taxes.

In California, Governor Arnold Schwarzenegger has proposed similar mandatory universal health coverage: "If you can't afford it, the state will help you buy it. But you must be insured." His plan would also require hospitals and doctors to pay a percentage of earnings into a state fund subsidizing those who can't afford insurance, and insurers would be required to spend at least 85 cents out of each premium dollar on health care.

To date, more than a dozen states have introduced or are drafting similar public–private plans. Despite this movement, Dr. Oliver Fein, executive director of Physicians for a National Health Program, says "fiddling with the tax system and peddling skimpy private health plans will fail miserably. Like other plans that rely on private insurers ... the Massachusetts reform and the Schwarzenegger [plan] ... would leave millions without coverage and continue to squander $300 billion annually on private insurance marketing, bill collectors and other useless bureaucratic activities." — Milan Korcok, Ft. Lauderdale, Florida

Election promises to help the 46 million uninsured Americans.

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