FOR THE RECORD

Fewer Canadians lighting up

Canada's smoking rate has dropped to an all-time low, according to a Statistics Canada survey that indicates about 17% of Canadians over the age of 15 smoked in 2010.

Results from Health Canada's annual *Canadian Tobacco Use Monitoring Survey* also indicate that smoking rates have continuously declined since 1999, when 25% of Canadians were smokers (www.hc-sc.gc.ca/hc-ps/tobac-tabac/research-recherche/stat/ctums-esutc_2010-eng.php). The percentage of children under age 11 exposed to second-hand smoke at home also decreased from 26% to a historic low of 4% over the same period.

Provincial smoking rates still vary widely, from a low of 14% in British Columbia to a high of 21% in Saskatchewan, Nova Scotia and Manitoba.

"I'm particularly encouraged by the numbers when it comes to youth," federal Health Minister Leona Aglukkaq said in a press release (www.hc-sc.gc.ca/ahc-asc/media/nr-cp/_2011/2011_120-eng.php).

Smoking among teens aged 15 to 17 fell to 9% — the lowest recorded rate ever for the age group — down from a high of 23% in 1999 and a three-year plateau at 10% in 2007–2009. Some 18% of teens aged 18–19 were current smokers in 2010, a rate unchanged since 2009 but significantly lower than that in 2007 at 23%.

As smoking prevalence decreases, it becomes increasingly difficult to show year-to-year statistically significant differences, the survey states.

However, adolescents in some provinces have bucked the declining trend. Since 2009, smoking rates among teens aged 15–19 increased from 12% to 17% in Alberta, from 14% to 16% in Nova Scotia and from 18% to 20% in Saskatchewan. Alberta also saw a decrease in the number of teens who have never smoked from about 85% to less than 82%, while the average number of cigarettes Albertan teen smokers puffed daily jumped from 13.9 to 14.9, compared to the national average of 11.6. — Lauren Vogel, *CMAJ*

Infoway to seek clinical advice

Long criticized for being out of touch with clinical needs and realities, Canada Health Infoway has responded by appointing a "Clinical Council" to advise it on future electronic health records strategies and investments.

The eight-member council will be chaired by Dr. Michael Golbey, a family physician from Kelowna, British Columbia and chair of the Canadian Medical Association Board of Directors. Other members include: Dr. Bryce Taylor, surgeon-in-chief and director of surgical services at the University Health Network in Toronto, Ontario; Dr. Jean-Francois Rancourt, a family physician in the Montmagny region of Quebec; Iris Krawchenko, a pharmacist in Hamilton, Ontario; Mary O'Keefe-Robak, chief nursing officer with New Brunswick's Department of Health; Heather Sherrard, vice president of clinical services at the University of Ottawa Heart Institute in Ontario; and Sholom Glouberman, president of the Patients' Association of Canada.

"The new Clinical Council puts the voices of patients, nurses, pharmacists, doctors, and other health professionals at the heart of Infoway's work," Golbey said in a press release (www.infoway-inforoute.ca/about-infoway/news/news0-releases/784).

Glouberman has pressed for reformed federal and provincial e-health strategies that put greater emphasis on giving patients electronic access to personal health records. "I intend to ensure that patient's voices are heard," he says.

The new council is intended to complement reference groups for physicians, nurses and pharmacists, said Infoway. The council is also expected to work with provincial and territorial clinical peer support networks and advise on investments to support the needs of clinicians-in-training.

Clinicians have long complained that Infoway lacks clinical in-house expertise. The agency has previously relied on a physician advisory group that only met occasionally. A recent qualitative study of Canada's experience with the implementation of electronic health information technology based on a survey of 29 decisionmakers found that "inadequate attention to clinicians, the key users of electronic health records, was viewed as a critical ingredient missing from the e-health vision" (www.cmaj.ca/lookup/doi/10.1503/cmaj.100856). — Paul Christopher Webster, Toronto, Ont.

No-fault compensation for research-related injuries

The United States should create a system for compensating people who are harmed during participation in clinical trials or scientific research, an international panel convened by the US Presidential Commission for the Study of Bioethical Issues has recommended.

To that end, the government should establish a research-related injury fund modeled on the US National Vaccine Injury Compensation Trust Fund, argued the commission's International Research Panel in a report, *Research Across Borders* (http://bioethics.gov/cms/sites/default/files/IRP-Proceedings%20and%20Recommendations_0.pdf).

"Justification for such a fund rests on the notion that research is a socially collaborative project for the social good. If someone is injured in the course of research, in which they have

served the social good, they should not be left to their own devices to pay for those injuries. The presence of such a fund should not eliminate the right to litigate," the report states.

Existing systems for compensating those who suffer research-related injuries are inadequate, the panel argued. "In many countries, researchers must carry insurance to cover compensation to subjects harmed as a result of research. In the United States, some institutions carry liability insurance, but it is not a requirement for receipt of federal funds for research. Subjects who are harmed have legal recourse, as consent forms are not permitted to contain exculpatory language. But compensation is generally limited to negligence or malpractice claims."

The report also noted that there's a checkerboard approach in the US and around the world toward compensating those who suffer research-related injuries. "For example, many European countries legally require sponsors and/or investigators to carry indemnity insurance for research-related injuries. In India, bioethics committees ensure that research sponsors pay compensation to participants injured in research. Brazil's bioethics regulations similarly ensure that research sponsors pay such compensation. The University of Washington, a U.S. research institution, uses a self-insured no-fault system to compensate participants for research-related injuries."

Other recommendations of the panel included a call for more ethics training of researchers and institutional research board members. "Some members believe that qualifications of individual researchers and ethics review committee members should be confirmed by national standard setting organizations rather than research funders. All agree that training should address rules, standards, and practices as well as the ethical principles underlying them. Issues that arise in international studies are not always adequately addressed or cannot always be resolved by following written rules and standards. Appropriate training can provide researchers and ethics bodies with greater insight regarding the deeper moral values at stake, enhance their capacity for ethical analysis and reasoning, and help guide ethical actions. Familiarity with principles, combined with experience, is among the best means for creating a shared culture of responsibility."

"It is particularly important that host countries have competent ethics review committees in place to safeguard participants in research and that, when they do not, researchers and funders carefully consider additional steps to ensure that human subjects are protected. They must examine the quality and nature of local review — without unilaterally imposing their own systems — to ensure that the benefits of local review inure. Third-party ethics review groups, perhaps through the World Health Organization or another neutral group, could pre-review and/or monitor research as local capacity is improved," the report added.

As well, the panel urged that the US "consider requiring all greater than minimal risk research to be registered and the results reported" so as to promote more transparency and accountability within the research enterprise. — Wayne Kondro, *CMAJ*

Best buys for noncommunicable diseases

Roughly US$11.4 billion per year would have to be collectively spent by 42 low- and middle-income countries on priority actions to significantly reduce the toll taken by cardiovascular disease, diabetes, cancer and chronic lung disease, according to a World Health Organization study.

The study, *Scaling up action against noncommunicable diseases: How much will it cost?*, aimed to identify which specific interventions would offer the best bang for the buck in terms of saving lives and preventing the incidence of the four noncommunicable diseases (www.who.int/nmh/publications/cost_of_inaction.pdf).

The so-called "best buys" fell into two categories: population-based ones that address NCD (noncommunicable disease) risk factors and individual interventions in primary care.

The core population-based interventions were:

- "Tobacco use: Tax increases; smoke-free indoor workplaces and public places; health information and warnings about tobacco; bans on advertising and promotion
- Harmful alcohol use: Tax increases on alcoholic beverages; comprehensive restrictions and bans on alcohol marketing; restrictions on the availability of retailed alcohol
- Unhealthy diet and physical inactivity: Salt reduction through mass media campaigns and reduced salt content in processed foods; replacement of trans-fats with polyunsaturated fats; public awareness programme about diet and physical activity."

The core primary care interventions, which are collectively projected to cost US$9.4 billion per year, were:

- "Cancer: Prevention of liver cancer through hepatitis B immunization; prevention of cervical cancer through screening (visual inspection with acetic acid [VIA]) and treatment of pre-cancerous lesions
- CVD [cardiovascular disease] and diabetes: Multi-drug therapy (including glycaemic control for diabetes mellitus) to individuals who have had a heart attack or stroke, and to persons with a high risk (> 30%) of a CVD event in the next 10 years; providing aspirin to people having an acute heart attack."

To qualify as a "best buy," an intervention had to be one for which there was "compelling evidence for cost-effectiveness that is also feasible, low-cost and appropriate to implement within the constraints of the local health system."

The report argues that the per capita price tag for implementing the recommended interventions within the 42 nations would be "low. It represents an annual investment of under US$1 in low-income countries, US$1.50 in lower middle-income countries; and US$3 in upper middle-income countries."

The 42 nations, each of which has a population of at least 20 million, collectively account for 90% of the NCD burden in developing regions of the world and 77% of the global NCD burden, which is about 36 million people per year, the report states. The 13 low-

income countries which qualified were Afghanistan, Bangladesh, Côte d'Ivoire, Democratic People's Republic of Korea, Democratic Republic of the Congo, Ethiopia, Kenya, Myanmar, Nepal, Nigeria, Sudan, Uganda and the United Republic of Tanzania. The 13 lower middle-income countries were Egypt, Ghana, India, Indonesia, Iraq, Morocco, Pakistan, Philippines, Sri Lanka, Ukraine, Uzbekistan, Viet Nam and Yemen. The 16 upper middle-income countries were Algeria, Argentina, Brazil, Colombia, China, Islamic Republic of Iran, Kazakhstan, Malaysia, Mexico, Peru, Romania, Russian Federation, South Africa, Thailand, Turkey and the Bolivarian Republic of Venezuela.

WHO describes the best-buy interventions as a "financial planning tool" for countries to scale up their efforts to reduce the burden of the four diseases. "The new tool will help countries with limited resources work out what the 'best buys' are and what they will cost," Dr. Ala Alwan, Assistant Director-General for Noncommunicable Diseases and Mental Health at WHO, said in a press release (www.who.int/mediacentre/news/releases/2011/NCDs_solutions_20110918/en/index.html). "Implementing them would save literally millions of lives over the next 15 years."

In compiling the tool, WHO considered five key ingredients: the size of the population; the extent of the burden of disease; the proportion of the population that would be covered by the strategies; the resources required (human, medicines, technology); and the unit cost (for e.g. salaries and medicines). No intervention that costs more than US$0.50 per person per year was included. — Wayne Kondro, *CMAJ*

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