Briefly

Chronic disparities: Gender and income level have an impact on the level of primary care that people suffering from chronic diseases receive from their physicians, according to the Canadian Institute for Health Information (CIHI) study. Just 46% of women received all four recommended tests for chronic diseases monitoring, as compared with 56% of men, according to the study, *Disparities in Primary Health Care Experiences Among Canadians With Ambulatory Care Sensitive Conditions* (http://secure.cihi.ca/cihiweb/products/PHC_Experiences_AiB2012_E.pdf). Doctors explained the adverse effects of medications to 65% of men and to 56% of women, added the study, which was based on data culled from the *2008 Canadian Survey of Experiences with Primary Health Care*. "Compared with those in the highest income group, individuals with ambulatory care sensitive conditions in the lowest income group were less likely to report that their primary health care physician involved them in clinical decisions or helped them make a treatment plan to manage their conditions" (47%, as compared with 66%). — Wayne Kondro, *CMAJ*

Primary care reform: The province of Ontario's move toward the provision of primary care through some manner of family health team or network featuring physicians paid through capitation or salaries is more financially rewarding for physicians but doesn't necessarily improve health outcomes, in comparison with community health centres with salaried doctors, according to a study conducted by the Institute for Clinical Evaluative Sciences. "The capitation and team models that have received the most new resources are looking after relatively advantaged groups and are associated with higher than expected ED [emergency department] visits. The payment and incentive structures underlying these models therefore require re-examination," states the study, *Comparison of Primary Care Models in Ontario by Demographics, Case Mix and Emergency Department Use, 2008/09 to 2009/10* (www.ices.on.ca/file/ICES_Primary%20Care%20Models%20English.pdf). "Compared with the Ontario population, CHCs [community health centres] served populations that were from lower income neighbourhoods, had higher proportions of newcomers and those on social assistance, had more severe mental illness and chronic health conditions, and had higher morbidity and comorbidity. In both urban and rural areas, CHCs had ED visit rates that were considerably lower than expected. — Wayne Kondro, *CMAJ*

Turning to hospitals: Over 830 000 visits to hospital emergency departments in the United States in 2006 were for preventable dental conditions, an increase of 16% in just three years, according the Pew Research Center. Given estimates that about 330 000 dental-related visits cost roughly $110 million, the visits "add to the financial burdens confronting states," states the study, *A Costly Dental Destination* (www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/Reports/State_policy/Pew_Report_A_Costly_Dental_Destination.pdf). "A major driver of dental-related hospital visits is a failure by states to ensure that disadvantaged people have access to routine preventive care from dentists and other providers," the study added. "A dentist shortage exacerbates this access problem. Roughly 47 million Americans live in areas that are federally designated as having a shortage of dentists." — Wayne Kondro, *CMAJ*

Misery index: Americans living in Old South states are less likely to describe themselves as being in a higher state of "well-being" (using a range of physical, mental and social indices) than those living in less populated western states, according to Gallup-Healthways' annual survey. West Virginia was deemed the state in which residents were the most miserable, states the report, *State of Well-Being 2011* (www.well-beingindex.com/files/2011CompositeReport.pdf). Gallup-Healthways surveys 1000 Americans on 350 days each year to garner their opinions on six subindices, including life evaluation (the "evaluation of one's present life situation with ones anticipated life situation five years from now"); emotional health; physical health such as disease burden and body mass index; healthy behavior ("life style habits with established relationships to health outcomes"); work environment; and basic access to food, shelter and health care. The state in which the highest well-being was reported was Hawaii, followed by North Dakota, Minnesota, Alaska, Utah, Colorado, Kansas, Nebraska, New Hampshire and Montana. The most miserable was West Virginia, followed by Kentucky, Mississippi, Delaware, Ohio, Alabama, Arkansas, Missouri, Florida and Tennessee. — Wayne Kondro, *CMAJ*

Relief on a budget: The United Kingdom's National Health Service (NHS) would save £280 per patient daily and millions of pounds annually by providing end-of-life care in people's homes rather than in hospitals, according to a British charity. NHS would save £34 million in four days alone by reducing the hospital stay of 30 000 patients (or about 12% of those who die in hospitals in England each year), Marie Curie Cancer Care states in a report, *Understanding the cost of end of life care in different settings* (www.mariecurie.org.uk/Documents/HEALTHCARE-PROFESSIONALS/commissioning-services/understanding-cost-end-life-care-different-settings.pdf). "Ensuring that more people who are terminally ill are able to be cared for and die at home can release funds," Imelda Redmond, director of policy and pub-

lic affairs at the Marie Curie Cancer Centre stated in a press release (www.mariecurie.org.uk/en-gb/press-media/news-comment/press-release-3/). "Even small reductions in the number of days people at the end of life spend in hospital can lead to substantial savings. The National Audit Office found that a reduction of just 10% in emergency admissions and of three days in hospital stay could save the NHS £104 million. But we think we can help the NHS to achieve even more." — Wayne Kondro, *CMAJ*

Home care as torture: There are enough examples of mistreatment of the elderly during the provision of home care that the United Kingdom's government should step in with measures to ensure that basic human rights are protected, according to the UK's Equality and Human Rights Commission. "There has been evidence of breaches to the prohibition against inhuman or degrading treatment and to the right to respect for private and family life," the commission states in a report, *Close to home: An inquiry into older people and human rights in home care* (www.equalityhumanrights.com/uploaded_files/homecareFI/home_care_report.pdf). Among measures recommended are regular inspections of care providers, surveys of patients and implementation of "the provisions in the Equality Act 2010 outlawing age discrimination in services and public functions by no later than by April 2012, recognizing the adverse impact of age differentiated treatment in social care and the link between negative ageist attitudes and human rights abuses of older people." Home care services must respect people's basic human rights, Sally Greengross, commissioner of the commission, stated in a press release (www.equalityhumanrights.com/news/2011/november/home-care-often-fails-to-meet-older-peoples-basic-rights-says-inquiry/). "This is not about burdensome red tape, it is about protecting people from the kind of dehumanising treatment we have uncovered. The emphasis is on saving pennies rather than providing a service which will meet the very real needs of our grandparents, our parents, and eventually all of us." — Wayne Kondro, *CMAJ*

Winners and losers: The government of Ontario has unveiled the formula to be used in the shift to patient-based funding for the majority of its hospitals. Demographic needs and the complexity of services provided lie at the basis of the formula, which will result in a small budget increase for about 60% of the 91 hospitals that are affected by the change, and cuts for the remaining 36. "This is not about cuts. This is not about saving money. This is about shifting resources. This is a zero-sum game (on funding)," Minister of Health and Long-Term Care Deb Matthews told reporters at a press conference at which she unveiled the "health-based allocation model." Commencing Apr. 1, it will result in 46% of a hospital's budget — rising to 70% by 2014 — in the case of 91 hospitals, allocated on the basis of demographic needs, patients treated and services provided (www.health.gov.on.ca/en/ms/ecfa/pro/initiatives/funding.aspx). Under ceilings and floors set by the province, the maximum percentage that a hospital's budget can rise in 2012 is 2%, while the most that a hospital's budget can drop is 3%. The province's remaining 55 smaller, rural hospitals will continue to be funded through lump sum operating grants. — Wayne Kondro, *CMAJ*

End of modern medicine: Antimicrobial resistance is becoming so prevalent as a result of antibiotic overuse and, in the case of food production, "gross misuse," that the world may soon face "the end of modern medicine, as we know it," says the head of the World Health Organization (WHO). "Things as common as strep throat or a child's scratched knee could once again kill," Dr. Margaret Chan, director-general of the WHO, warned in a keynote address to the "Combating antimicrobial resistance: time for action" conference held in Copenhagen, Denmark (www.who.int/dg/speeches/2012/amr_20120314/en/index.html). "Some sophisticated interventions, like hip replacements, organ transplants, cancer chemotherapy, and care of preterm infants, would become far more difficult or even too dangerous to undertake." In hopes of stemming that tide, Chan called for the adoption of measures outlined in a new WHO publication, *The evolving threat of antimicrobial resistance: Options for action*, that recommends more limited prescription of antibiotics and improved follow-up surveillance of patients (http://whqlibdoc.who.int/publications/2012/9789241503181_eng.pdf). Chan also urged that antibiotics in food production be restricted to therapeutic purposes. — Wayne Kondro, *CMAJ*

Chronic costs: The economic burden of three chronic lung diseases — lung cancer, asthma and chronic obstructive pulmonary disease — will double to $24.1 billion by 2030, although that could be reduced through measures designed to reduce smoking rates and exposure to pollutants, the Conference Board of Canada says. The three diseases cost $12 billion in 2010, including $3.4 billion in direct health-care costs (drugs, hospitals, physicians) and $8.6 billion in indirect costs (such as premature death and long-term disability), the board states in a report, *Cost Risk Analysis for Chronic Lung Disease in Canada* (www.conferenceboard.ca/e-library/abstract.aspx?did=4585). "These three diseases exact an enormous human and economic toll," Louis Theriault, director of health economics stated in a press release (www.conferenceboard.ca/press/newsrelease/12-03-15/Lung_Disease_Imposes_Major_Costs_on_Canada_s_Economy.aspx). "Reducing smoking rates, lessening exposure to second-hand smoke, and improving indoor and outdoor air quality would lower the economic burden of these diseases." — Wayne Kondro, *CMAJ*

Homeopathic hubbub: It is "unethical for health practitioners to treat patients using homeopathy, for the reason that homeopathy (as a medicine or procedure) has been shown not to be efficacious," according to Australia's National Health and Medical Research Council. "There is sufficient scientific evidence to conclude that homeopathy is no more efficacious than placebo. Homeopathy, while not harmful in its own right, may pose a risk to patients

if safe and efficacious conventional treatments are rejected or delayed in favour of homeopathic treatment," according to a draft of the council's statement on homeopathy that was leaked to the Melbourne-based newspaper, *The Age* (http://images.theage.com.au/file/2012/03/14/3125800/Homeopathy%2520statement.pdf?rand=1331694590279). Homeopaths are infuriated by the council's recommendation that homeopathic treatments be precluded from coverage in health insurance plans. The Australian Association of Professional Homeopaths has been seeking the creation of a formal registration scheme for homeopaths, similar to that of physicians and nurses. — Wayne Kondro, *CMAJ*

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