FOR THE RECORD

Global sanitation woes continue

Progress toward the Millennium Development Goals for safe drinking water have exceeded expectations but those for sanitation remain largely in the open toilet, according to a joint World Health Organization (WHO) and UNICEF report.

Roughly 89% of the world's population has access to improved water sources, about 1% higher than the target of 88% that was set 12 years ago for 2015, according to the report, *Progress on Drinking Water and Sanitation 2012* (www.wssinfo.org/fileadmin/user_upload/resources/JMP-report-2012-en.pdf).

But with 11% of the globe's population still without access to improved water sources, "the numbers are still staggering," UNICEF Executive Director Anthony Lake states in a press release (www.who.int/mediacentre/news/releases/2012/drinking_water_20120306/en/index.html). "But the progress announced today is proof that MDG targets can be met with the will, the effort and the funds."

By contrast, the Millennium Development Goal for sanitation falls well short of mark with just three years to go before the 2015 deadline. Just 63% of the population had access to improved sanitation facilities in 2010 and that percentage is estimated to only rise to 67% by 2015, well below the proposed goal of 75%. The target is not expected to be reached until 2026.

While open defecation has decreased in all developing regions, over one billion people, or about 15% of the global population, still resort to the practice. Open defecation in developing countries remains much higher in rural areas (949 million) than in urban areas (105 million). By far the largest population practicing open defecation belongs to India, where 626 million (nearly 60%) practice open defecation. The report also indicates that there is a vast discrepancy in access to adequate water supply and improved sanitation facilities between wealthy and poor people in most regions.

Lack of improved sanitation is most evident in southern Asia and sub-Saharan Africa, where just 41% and 30% of the population, respectively, have access to improved facilities. In southern Asia, 41% of the population practices open defecation (a decrease of 110 million people), while 18% use a shared or unimproved sanitation facility. In sub-Saharan Africa, 25% of people practice open defecation, while 45% use a shared or unimproved sanitation facility.

Although the report paints a dismal picture with regard to improved sanitation, its authors stated there have been impressive improvements among individual countries. Although access to sanitation facilities has improved for just 12.2% of all people within sub-Saharan African since 1995, it's risen by more than 20% in Angola, Rwanda, Cape Verde, Gambia, Botswana and Malawi. They also noted that the Democratic Republic of the Congo provided 10 million citizens with improved sanitation facilities.

The report was based on data collected from over 1100 surveys and censuses, and 300 reports from developing countries, covering the period 1980–2010. — Chris Hemond, Ottawa, Ont.

Graphic warnings more effective

Warnings on tobacco packages that highlight life-threatening diseases linked to smoking or the habit's potential harm to children pose a greater deterrent than those that focus on cosmetic harms or health benefits, a European Commission report indicates.

Current, ex- and nonsmokers across European Union member states reacted most strongly to warnings that made "any mention of cancer," according to the *Tobacco Packaging Health Warning Labels* aggregate report, which ranked some 24 tobacco pack warnings for impact based on 270 in-depth interviews (http://ec.europa.eu/health/tobacco/docs/eurobaro_tobaccowarninglabels_ql_5818_en.pdf).

The European Union subsequently adopted 14 new warnings to appear on tobacco packs based on the findings of the report (http://ec.europa.eu/health/tobacco/docs/tobacco_warnings_2012_en.pdf).

The most persuasive warnings as ranked by respondents include:

- Smoking can kill your unborn child
- Smoking causes 9 out of 10 lung cancers
- Smoking causes mouth and throat cancer
- Smoking destroys your lungs
- Quit now — stay alive for your children.

Warnings which contained new or previously unknown information about the risks of smoking — such as that smoking can cause leg amputations or blindness — also had a "high initial impact," the report states. However, "such new information can also serve to make the warnings contentious" as "some respondents will try and deny the existence of the claimed link or underplay smoking's significance as a causal factor."

Moreover, "there is a tendency to assume that the warnings are applicable only to heavy smokers or those who have been smoking for many years ... [and] many young people tended to see ill health as something that would only be relevant to them in the distant future."

Written warnings should be accompanied by "photographs or pictorial representations to increase the impact," and "include statistics or evidence to add impetus," the report recommends.

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It also suggests that if the connection with smoking is unclear or "new," a link to a website or other information source should be included in support of the proposition.

Respondents were more likely to dismiss warnings that emphasized what they perceived to be largely cosmetic harms of the habit, such as wrinkles, rotten teeth or reduced sports performance. They also rejected warnings about the toxic and addictive properties of tobacco products, the benefits of quitting and the harms of second-hand smoke.

"Most of the respondents already knew about the effect of passive smoking on other people," the report states. "Furthermore, whilst it may encourage people to move away from others to smoke, it is not sufficiently motivating to encourage people to give up smoking."

Exceptions were warnings that specifically targeted parents or referenced "potential harm or impact on children." Most respondents reacted "very strongly" to such statements, finding them "shocking, frightening and direct."

Written health warnings have been compulsory on tobacco products sold in the European Union since 2003. — Lauren Vogel, *CMAJ*

One-stop insurance shops

One-stop comparison shopping for health insurance must be made available for all Americans before Jan. 1, 2014 under final regulations unveiled by the United States Department of Health and Human Services.

The regulations — Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers — compel all states to establish online "affordable health insurance exchanges" in which they certify health insurance plans, provide clear comparisons of the costs, benefits and coverage levels of those certified plans, and then help consumers purchase a plan of their choice (www.ofr.gov/OFRUpload/OFRData/2012-06125_PI.pdf). The exchange must also feature a toll-free consumer hotline and information regarding eligibility for federal subsidy programs, including Medicaid and premium tax credits, which are available for all people with annual incomes four times the poverty level, or about US$90 000 for a family of four.

State governments must also establish a "small business health options program" sketching health insurance options for firms with fewer than 50 or fewer than 100 employees through 2015. While a state must choose either the under-50 or under-100 option through the first two years of their program, as of 2016, their exchanges must be open to all firms with under 100 employees and commencing in 2017, a state can opt to allow firms with more than 100 employees to participate.

But states will be given considerable flexibility in designing their exchanges by Jan. 1, 2013, for approval by the federal government.

For a start, they'll be entitled to limit the number of health insurance plans offered within an exchange. They also have the latitude to operate their exchanges as a nonprofit entity, as an independent public agency or a division of an existing state agency, though in every instance, they must abide by standardized governance principles, strict conflict-of-interest and financial disclosure provisions, and include consumer representation on their boards. States can also create regional exchanges in partnership with other states "regardless of whether the States are contiguous" or subsidiary exchanges within a state that operate within a "geographically distinct area."

Health and Human Services Secretary Kathleen Sebelius lauded the savings to consumers, which the US Congressional Budget Office has estimated to be on the order of 7%–10% per year for individuals and 2% for small businesses. "These new marketplaces will offer Americans one-stop shopping for health insurance, where insurers will compete for your business," she stated in a press release (www.hhs.gov/news/press/2012pres/03/20120312a.html). "More competition will drive down costs and Exchanges will give individuals and small businesses the same purchasing power big businesses have today."

"Exchanges will offer Americans competition, choice, and clout. Insurance companies will compete for business on a level playing field, driving down costs. Consumers will have a choice of health plans to fit their needs and Exchanges will give individual and small businesses the same purchasing power as big business," the US Center for Consumer Information & Insurance Oversight added in its analysis of the impact of the regulations (http://cciio.cms.gov/resources/files/Files2/03092012/cms-9989-fwp.pdf).

Federal grants will be awarded to states to help establish their exchanges until Dec. 21, 2014. They'll also be entitled to "generate funding, such as through user fees on participating issuers, for Exchange operations."

In the event that a state fails to establish an exchange, the Department of Health and Human Services will step in to establish one on its own. — Wayne Kondro, *CMAJ*

Relief for family caregivers

The stresses of providing health care to ailing family members and loved ones in their homes are all but ignored by the health care system despite its trend toward deinstitutionalization, which is shifting more of the burden of care onto the shoulders of individuals, the Canadian Healthcare Association says.

To alleviate those stresses, the association urges the adoption of a "pan-Canadian approach" to support those who provide care to family and friends; various tax changes to ease the financial burden of caregiving; improved training of respite workers; and more research aimed at determining the most effective means of providing respite.

Respite care in Canada is "disorganized and disconnected," the association states in a report, *Respite Care in Canada* (www.cha.ca/documents/Respite_Care_in_Canada_EN_web.pdf). "Most respite falls under home care services and because the needs are so diverse it often falls through the cracks. Residents of rural and remote communities are at a particular disadvantage in trying to obtain respite care."

Citing Statistics Canada data, the report estimates that the number of

people providing unpaid care to family and friends in Canada rose to 2.7 million in 2007. "Family/friend caregivers between the ages of 45 to 64 years had been providing care for an average of 5.4 years. Caregivers over 65 years old had given assistance for an average of 6.5 years."

It notes that there is a substantial difference in respite support provided by provinces and territories for home care and home support programs. "In some regions there are direct fees associated with adult day care, meal delivery and respite. Some respite care is funded through home care programs. There are no data available indicating how much is funded. Most respite is paid for by the families that need it. Donor-funded programs of charitable organizations and religious organizations provide some home support in terms of friendly visiting, transportation to appointments, and physical stimulation programs."

There are also variations in respite care provided through compassionate care benefits, which typically are offered only to those caring for people expected to die within 26 weeks and thus generally preclude support for those caring for family and friends who are suffering from Alzheimer Disease or a related form of dementia. "Under this leave provision all jurisdictions provide for a maximum of eight weeks paid leave, other than Saskatchewan and Quebec which both provide for 12 weeks annually. In Saskatchewan, an employee can also take this leave due to his/her own serious illness or injury. Quebec may extend an employee's absence to 104 weeks if a child of the employee under the age of 18 has a serious and potentially fatal illness. British Columbia, Saskatchewan, Ontario and Quebec provide extensions in special circumstances. Eligibility requirements vary across the jurisdictions. British Columbia and Manitoba require a medical certificate, while the other jurisdictions may request one. Most jurisdictions allow the compassionate leave to be shared between caregivers."

"The labyrinth of government departments involved in the delivery of respite care may seem daunting to caregivers. Searching for resources can be a frustrating experience for caregivers and this may be one of the factors that accounts for the low use of certain services. Caregivers often need an advocate to assist them in finding out what respite services are available," the report added.

In comparison, several other nations have developed more comprehensive programs, the report indicated. Australia, for example, has had a National Respite for Carers Program in place for 10 years in which regional centres "arrange respite, including in-home respite, and residential respite care, by organizing, purchasing or managing respite care assistance packages for carers," while the United Kingdom has a program which, among other things, provides "a taxable allowance of CA$108 per week, which may be paid for up to four weeks in any 26-week period." Six countries in Europe (Austria, France, Germany, Italy, the Netherlands and Sweden) have "cash for care plans" which essentially allow people to hire care providers. Most of those programs are needs tested.

The association recommends a number of measures to redress the flaws in Canada's approach to respite care, including:

- "The creation of a provision in the CPP/QPP [Canada Pension Plan/Québec Pension Plan] to allow for adjustment in pension calculation for Canadians who have taken time from the workforce to provide care or permit those caregivers who leave the labour force to continue to contribute to CPP/QPP; and that the amount reserved for the Compassionate Care Benefit be treated in the same manner as the Maternity Benefits program. Benefits should be based on the number of hours of care provided and earning capacity of the caregiver."
- The provision of transitional funding to the provinces to explore means of improving equitable access to respite services, "with specific attention to: resolving the lack of coordination and integration of available services; improving the effectiveness of centralized access systems; and the nature of the support of in-home respite."
- The establishment of standardized curricula for training respite care providers.
- Bolstered support for "local healthcare organizations to provide respite training and follow-up to informal caregivers."
- More research to quantify the total economic benefit of respite services and to determine the most effective means of providing respite.

"There is no one perfect type of respite that suits all circumstances," the study notes. "With the potential of a looming crisis in the need for respite, health service planners/providers need to comprehend the costs of supporting facility-based care versus those associated with in-home respite care. Furthermore, it must be understood that the lack of access to respite care has several kinds of costs — spiritual, familial, financial, emotional.

More research is required to better identify all relevant costs and appreciate their impact on individuals, families, the health care system and society. What are the benefits of in-home and out-of-home respite? What is the balance? When care recipients need additional therapeutic care is it more effective to admit them to an acute care setting or a continuing care environment? Answers to these and other questions will help prepare the appropriate respite services for the future." — Wayne Kondro, *CMAJ*

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