For the record

Democrats move to close generic labelling loophole

Seeking to close a loophole that prohibited Americans from suing generic drug companies because their product labels do not alert patients to health risks, Democrats in the United States Senate and House have unveiled companion legislation that would "permit" generic firms to update warning labels and thereby, open them to liability.

The "Patient Safety and Generic Labeling Improvement Act," sponsored by six Senators, led by Patrick Leahy (Vermont) and two Representatives, Chris Van Hollen (Maryland) and Bruce Braley (Iowa) would "permit manufacturers of generic drugs to provide additional warnings with respect to such drugs in the same manner that the Food and Drug Administration (FDA) allows brand names to do so" (www.hpm.com/pdf/blog/Leahy%20Mensing%20Bill.pdf).

The aim is to reverse the effects of a 2011 US Supreme Court ruling that the generic company Pliva could not be held liable under state law for "failure to warn" Minnesota resident Gladys Mensing about the neurological disorder that ensued from long-term use of metoclopramide to treat a digestive tract problem, as federal law compelled the firm to use the same label as its brand-name counterpart. While the brand-name drug maker could held be liable, the generic could not, the court ruled in *Pliva* v. *Mensing* (www.supremecourt.gov/opinions/10pdf/09-993.pdf).

As a consequence of that ruling, the bill's promoters said that more than 40 cases against generic drug makers have been tossed by lower courts over the past year.

"The Mensing decision creates a troubling inconsistency in the law governing prescription drugs," Leahy stated in a press release (www.leahy.senate.gov/press/press_releases/release/?id=3f8893da-6518-4fea-9731-b2a6d452e102). "If a consumer takes the brand-name version of drug, she can sue the manufacturer for inadequate warnings. If the pharmacy happens to give her the generic version, she will not be able to seek compensation for her injuries. The Patient Safety and Generic Labeling Improvement Act will promote consumer safety by ensuring that generic drug companies can improve the warning information for their products in the same way that brand manufacturers can under existing law."

"It's common sense that any drug manufacturer — whether generic or brand name — ought to have the responsibility of warning its users of the risks of side effects for the drugs that they sell," added Senator Christopher Coons (Delaware).

"Generic drug manufacturers must clearly warn patients of known possible life threatening drug side effects — and be held accountable when they fail. Victims in Connecticut have been harmed and left without recourse. I will continue to fight to ensure this loophole no longer jeopardizes patient safety," stated Senator Richard Blumenthal (Connecticut).

The bill faces considerable political obstacles to passage. The House of Representatives is controlled by Republicans, while the powerful generic drug lobby is adamantly opposed to its provisions. The "misguided" legislation would undermine public confidence in generic drugs "and unduly burden physicians who would have to be aware of multiple labels for the same product," Ralph G. Neas, president and chief executive of the Generic Pharmaceutical Association said in a statement to the *New York Times* (www.nytimes.com/2012/04/19/health/bills-seek-to-change-rule-on-generic-drug-label.html).

Consumer groups have lined up behind the legislation by the dozens, including the nonprofit advocacy group, Public Citizen, which wrote in a letter to Leahy in his role as chair of the US Senate Committee on the Judiciary, that "under current law, a generic drug manufacturer is not authorized to revise product labeling when it becomes aware of inadequacies in the labeling. Specifically, FDA regulations provide that, unlike brand-name manufacturers, generic drug manufacturers are not permitted to initiate labeling revisions to strengthen warnings, contraindications, or precautions. As a result, the millions of patients who use generic drugs may not have access to up-to-date information on safety and proper use. And generic drug manufacturers lack incentive to monitor and ensure the safety of their products, even when the generic versions represent a majority of the market for a particular drug. Your legislation would correct this problem" (www.citizen.org/documents/public-citizen-letter-to-leahy.pdf). — Wayne Kondro, *CMAJ*

Global plan to eradicate measles and rubella

In the face of evidence that global measles control has faltered, international agencies have unveiled a strategic plan aimed at reanimating efforts to eradicate measles and rubella over the course of the next eight years.

While an international campaign to bolster measles vaccination rates resulted in a decline in measles deaths from 535 300 in 2000 to 139 300 in 2010, there were measles outbreaks (particularly in India, Africa, Asia, the Eastern Mediterranean and Europe) over the latter part of the decade as vaccination programs were scaled back, the World Health Organization (WHO), the American Red Cross, the United States Centers for Disease Control and Prevention, the United Nations Foundation and UNICEF said while unveiling a new Measles & Rubella Initiative.

The 74% decline in measles deaths was a function of vaccination campaigns that reached 9.6 million children,

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or about 85% of the targeted population, between the years 2000–2010. Although that fell short of WHO's 90% target, it's unclear how accurate the numbers are as the data are culled from a combination of hard information from 65 countries and modeling projections from 128 other nations.

While estimating that 19 million infants were not immunized in sub-Saharan Africa and South-East Asia in 2010, the agencies argued there's a need to dramatically step up vaccination campaigns within impoverished nations. "Recent measles outbreaks have affected children in the world unevenly, with the poorest and youngest children the most at risk of death or disability," Anthony Lake, executive director of UNICEF, stated in a press release (www.who.int/mediacentre/news/releases/2012/measles_20120424/en/index.html). "This new Strategic Plan stresses that measles and rubella vaccinations must be delivered to children deep in the poorest and hardest to reach communities."

"A three-quarters drop in measles deaths worldwide shows just how effective well-run vaccination programmes can be," added Dr. Margaret Chan, director-general of WHO. "Now we need to take the next logical step and vaccinate children against rubella, too."

The plan proposes to substantially bolster vaccinations for rubella by promoting the use of combination measles–rubella vaccines. Some 62 nations are currently not using a rubella vaccine in their immunizations schedules, WHO indicated.

But developing countries can now apply to The GAVI Alliance (formerly the "Global Alliance for Vaccines and Immunisation") for financial support in delivering a combined measles–rubella vaccine. "We're delighted to strengthen our partnership with the renamed Measles & Rubella Initiative, which has done great work to reduce measles infections and reduce mortality," Dr. Seth Berkley, CEO of the alliance, stated in the release. "With GAVI's US$605 million investment for both the combined MR [measles-rubella] and measles second dose vaccines in developing countries, this is an historic moment for the reduction and hopefully eventual elimination of both diseases."

But to achieve that goal, an additional US$112 million will be needed from governments, the private sector and individuals, added Kathy Calvin, CEO of the United Nations Foundation. "We need significant commitments from governments and the private sector if we are going to stop measles and rubella, as well as the support of individuals worldwide because a small donation from the public can go a long way and help save many lives."

The initiative aims to achieve objectives articulated in the *Global measles and rubella strategic plan 2012-20*, under which founding partners proposed to reduce global measles mortality by at least 95% by the end of 2015 and achieve measles and rubella elimination in five WHO regions by the end of 2020 (http://webcache.googleusercontent.com/search?q=cache:nvkLzCm-olAJ:www.measlesinitiative.org/mi-files/Tools/Presentations/Global%2520Measles%2520and%2520Rubella%2520Management%2520Meeting/Day1/4.%2520Dabbagh_Global%2520MR%2520strat%2520plan.pptx+measles+and+rubella+strategic+plan&hl=en&gl=ca).

The plan's milestones for the end of 2015 were:

- Reduce annual measles incidence to less than five cases per million.
- Achieve more than 90% coverage with the first dose of measles-containing vaccine, or "as appropriate," measles and rubella–containing vaccine, in all countries, and more than 80% vaccination coverage "in every district or equivalent administrative unit."
- Achieve more than 95% coverage with measles, MR, or measles mumps rubella vaccines "during SIAs [supplemental immunization activities] in every district."
- "Establish a rubella control/CRS [congenital rubella syndrome] prevention goal in >1 additional WHO region."
- "Establish a target date for the global eradication of measles."

The milestones for the end of 2020 are to achieve 95% coverage for first and second doses of measles-containing vaccine, or measles and rubella–containing vaccine, while establishing a target date for eradication of rubella and congenital rubella syndrome.

The plan proposes five strategies to achieve those objectives, to wit: "high vaccination coverage with two doses of M [measles] and R [rubella] containing vaccines; effective surveillance, monitoring and evaluation; outbreak preparedness and response & case management; communication to build public confidence and demand for immunization; [and] research and development." — Wayne Kondro, *CMAJ*

Limits on health care for refugees

The federal government will limit health coverage for refugee claimants and protected persons to hospital, physician, nursing, laboratory, diagnostic and ambulance services that are "of an urgent or essential nature."

The refugee claimants, and other groups falling under the ambit of the Interim Federal Health Program, such as resettled refugees, refugees whose claims have been accepted, rejected refugee claimants whose cases are under judicial review, victims of human trafficking or people detained at Canadian borders, will also be provided with medications and vaccines "only if needed to prevent or treat a disease that is a risk to public health or a condition of public safety concern" (www.cic.gc.ca/english/refugees/outside/summary-ifhp.asp).

The reforms, unveiled by Citizenship, Immigration and Multiculturalism Minister Jason Kinney, would strip all such groups of supplementary medical benefits such as pharmacy, dental and vision care, ambulance services and devices to assist with mobility.

The changes are designed to reduce expenditures under the program, which cost $84.6-million in fiscal 2010/11, by $100 million over five years, Kenney stated in a press release (www.cic.gc.ca/english/department/media/releases/2012/2012-04-25.asp).

"Our Government's objective is to bring about transformational changes to our immigration system so that it meets Canada's economic needs. Canadians

are a very generous people and Canada has a generous immigration system. However, we do not want to ask Canadians to pay for benefits for protected persons and refugee claimants that are more generous than what they are entitled to themselves," Kenney stated.

"With this reform, we are also taking away an incentive from people who may be considering filing an unfounded refugee claim in Canada," Kenney added.

Still to be determined is who will make determinations whether a refugee or protected person's health needs are urgent or essential.

Regulations unveiled in conjunction with the reforms define "urgent" services as "those provided in response to a medical emergency — an injury or illness that poses an immediate threat to a person's life, limb or a function. The services and products shall not be more than what is required to respond to the medical emergency" (www.cic.gc.ca/english/department/laws-policy/ifhp.asp).

"Essential" services are defined as ones provided to a refugee claimant or protected person:

- "who is presenting for assessment and follow-up of a specific illness, symptom, complaint or injury;
- for prenatal, labour and delivery, and postpartum care (including routine prenatal care and maternal care for up to 28 days after the delivery); or
- for the prevention, diagnosis, or treatment of a disease posing a risk to public health or of a condition of public safety concern."

Services which are deemed as neither urgent nor essential include those:

- "provided solely for the purpose of screening or prevention of a disease or injury except for screening or prevention of diseases posing a risk to public health or of conditions of public safety concern;
- for elective purposes or primarily provided to improve quality of life with respect to a condition that causes minimal dysfunction and that is unlikely to deteriorate to a medical emergency within 12 months or the current period of eligibility, if shorter;
- for cosmetic purposes or convenience of the beneficiary;
- for fertility and sterilization purposes;
- for the purpose of rehabilitation, including the cost of rehabilitation hospitals and facilities;
- primarily related to research or experimentation;
- not paid for by provincial or territorial health benefit programs;
- required by or paid by third parties such as insurance companies, business establishments (e.g. automobile insurance), or government agencies, but excluding immigration medical examinations; and
- for long term care and home care."

The changes will take effect June 30th. — Wayne Kondro, *CMAJ*

Promoting the psychological health of employees

Stress management training, mental health education and ensuring access to treatment are among a series of measures advocated by the Mental Health Commission of Canada in a newly developed guide to improve psychological health in the workplace.

The guide, *Psychological Health & Safety: An Action Guide for Employers*, recommends a six-step approach to improving mental health in the workplace (www.mentalhealthcommission.ca/SiteCollectionDocuments/Workforce/Workforce_Employers_Guide_ENG.pdf).

The six steps are referred to as the "P6 Framework," for policy, planning, promotion, prevention, process and persistence. Within each element lie recommended actions, including:

- **Policy**: Establish a commitment to improving psychological health and safety in the workplace by having organizational leaders endorse the idea and introducing pertinent policies;
- **Planning**: Assess the organization and employees for likelihood of mental health problems through such means as employee surveys and the gathering of data related to absences;
- **Promotion**: Introduce programs that aim to reduce stigma and equip employees with skills such as resilience;
- **Prevention**: Provide stress management training programs, design jobs and select employees with an eye toward reducing psychological risk caused by such factors as workload, train managers to respond to psychological health issues and ensure that treatment measures are accessible.
- **Process**: Conduct regular evaluations of programs;
- **Persistence**: Appoint "champions" and "create a culture of psychological safety."

The council maintains that the guide is "relevant to frontline managers, union leaders, occupational health care providers, and legal and regulatory professionals" and can be used regardless of the size, location or sector of an organization.

A growing recognition among employers of the impact of mental illness on the well-being of employees and on an organization's pocketbook, coupled with a want of solutions, was the impetus behind the creation of the guide. "Employers are increasingly identifying the need to promote psychologically healthy and safe workplaces but are asking, 'what can be done?'," Dan Bilsker, coauthor and psychologist with the Centre for Applied Research in Mental Health and Addiction at Simon Fraser University in Burnaby, British Columbia, stated in a press release (www.mentalhealthcommission.ca/SiteCollectionDocuments/Workforce/Workforce_Employers_Guide_Press_Release_ENG.pdf). "The Action Guide is based on the latest scientific evidence and professional practices. It provides employers with logical implementation steps and recommendations that are practical, accessible and actionable."

Recommended measures emerged from a survey of research on mental health in the workplace, a national consensus forum on workplace psychological health, and consultations with "informed Canadian business leaders, union representatives, disability managers, and occupational health care providers." — Michael Monette, *CMAJ*

Canadian drug spending continues to rise

The expiry of patent protection for several blockbuster drugs slowed the growth rate of Canadian pharmaceutical spending in 2011 and will continue to do so over the next two years, according to the Canada Institute for Health Information (CIHI).

But the overall bill nevertheless continued to rise, by 4% to $32 billion in 2011, while per capita spending on drugs rose 2.8% to an all-time high of $929, CIHI states in a report, *Drug Expenditure in Canada, 1985 to 2011* (https://secure.cihi.ca/free_products/DEIC_1985_2011_EN.pdf).

The report does not provide a split on Canadian drug spending by patented or generic drugs and CIHI says it does not have such information. But the report does note that "the generic share of the Canadian prescription drug market is expected to increase in the coming years, as drugs with patents that expired or will expire between 2010 and 2014 accounted for more than one-third (38.2%) of all wholesale spending on prescription drugs in Canada in 2009."

Drug spending as a share of total health expenditure in 2011 was unchanged at 16%, trailing only hospitals ($58.4 billion or 29.1% of the overall pie). Physicians took the third largest chunk ($28.1 billion or 14%).

Prescribed drugs gobbled 84.8% (up 0.5%) of total drug expenditures at $27.2 billion in 2011, while nonprescribed drugs rose at a similar pace to $4.9 billion, or 15.2% of total drug expenditures.

Governments picked up $12 billion of the overall drug bill, with most of that, $10.3 billion, coming out of provincial pockets. Private insurance covered $10.2 billion of the bill, while individuals coughed up $4.8 billion out of their own pockets for prescribed drugs and $4.8 billion for non-prescribed drugs.

Per capita spending on pharmaceuticals varied substantially by province in 2011, from a low of $701 in British Columbia to a high of $1139 in Nova Scotia. The share of prescription drug spending relative to overall drug spending similarly varies by jurisdiction. It ranged from 82% in British Columbia and 83% in Alberta to 88.2% in Quebec and 89.1% in Newfoundland and Labrador. In terms of government payments for prescription drug costs, Saskatchewan led the pack at 49%, followed by Alberta (48.3%), while Prince Edward Island (34.2%) and New Brunswick (29.7%) trailed the pack.

Canada's international stature as the second highest per capita drug spender was unchanged in 2009, according to a comparison of eight Organisation for Economic Co-operation and Development countries, the report added. After spending 17% of its overall health dollar on drugs in 2009, Canada trailed only Japan (19.4%). As for per capita outlays, those of Canada ($890 in 2009) trailed only the United States ($1145). "The public sector funded 38.8% of total drug expenditure in Canada. This was the second-lowest share, ahead of the United States (31.1%). The share of public drug expenditure in total drug expenditure was highest in the United Kingdom, at 84.7%."

Along with the trend towards greater use of generic drugs, factors identified by CIHI as influencing drug spending patterns in Canada include "price-related factors" such as the price of ingredients and inflation; "quantity-related factors" such as dosage changes and length of treatment; "population-related factors" such as aging; "health system-related factors" such as accessibility to third-party insurance; "new drugs"; or "other factors" such as changes in clinical practice guidelines and pharmaceutical promotions and advertising. Still other factors include "changes in pharmaceutical care practices, which can improve patients' compliance with treatment regimens, or the adoption of primary prevention strategies, such as improved diet, exercise or other forms of healthy living, which can improve the health status of the population." — Wayne Kondro, *CMAJ*

Cancer incidence rises while mortality declines

Although the mortality rate for most cancers continues to decline in Canada, the number of people diagnosed with a type of cancer will continue to rise as the population increases and ages, the Canadian Cancer Society says.

A projected 186 400 Canadians will be diagnosed with cancer in 2012 (a total that excludes roughly 81 300 projected new cases of nonmelanoma skin cancer), while 75 700 Canadians will die of cancer, the society projects in *Canadian Cancer Statistics 2012* (www.cancer.ca/Canada-wide/About%20cancer/~/media/CCS/Canada%20wide/Files%20List/English%20files%20heading/PDF%20-%20Policy%20-%20Canadian%20Cancer%20Statistics%20-%20English/Canadian%20Cancer%20Statistics%202012%20-%20English.ashx).

The report also indicates that there will continue to be substantial regional variations in cancer incidence and mortality rates in Canada, with residents of Atlantic Canada and Quebec continuing to have higher rates. There are also variations by gender. Cancer is slightly more common among men than women under age 19 and over age 60. But it is more common among women than men aged 20–50 because of the higher incidence of sex-specific cancers such as breast and cervical cancers.

Prostate cancer is projected to be the most diagnosed form of cancer in 2012 (at 26 500 new cases or 121 per 100 000 men), followed by lung (25 600 cases or 54 per 100 000 Canadians), colorectal (23 300), breast (22 900), and non-Hodgkin Lymphoma and bladder (7800 each).

Lung cancer will be the biggest killer, causing the deaths of 20 100 Canadians (or 42 per 100 000), followed by colorectal (9200), breast (5200), pancreatic (4300) and prostate (4000) cancer.

Mortality rates for cancers, however, have declined through time. Between 2001–2007 for males and between 1998–2007 for females, "the rates declined, on average, by at least 2% per year for the following cancers: prostate cancer (since 2001), lung cancer (since 1998), larynx (since 2001) and colorectal cancer (since 2003) in males, breast and cervical cancers (since 1998) in females, stomach cancer (since 1998) and non-Hodgkin lymphoma (since 2000) in both sexes. Between 1998 and 2007, the liver cancer mortality rate

increased more than 2% per year in males."

While there are no regional variations for some cancers, such as breast cancer, in general, both cancer incidence and mortality rates are higher in Atlantic Canada and Quebec, and lowest in British Columbia, particularly for lung cancer. Therein, there are also variations by gender. "The estimated incidence rates for all cancers combined in males are highest in the Atlantic Provinces, Quebec and Ontario. For females, highest rates occur in Quebec, Nova Scotia, Ontario and New Brunswick. Lowest rates for males and females are in British Columbia." Those regional variations also extend to specific cancers. The highest colorectal cancer incidence rates, for example, can be found in Newfoundland and Labrador.

Those variations extend to mortality rates. "For males, the estimated mortality rates for all cancers combined continue to be higher in Atlantic Canada, Quebec and Manitoba, with lower rates in Western Canada. The pattern is similar for females, although overall differences across the country are smaller than for males."

The report, though, cautions against drawing regional conclusions, saying that the variations in incidence and mortality rates may be due to such factors as: "the prevalence of cancer risk factors (e.g., higher historic smoking rates in Quebec and Atlantic Canada as the likely cause of higher rates of lung cancer); the early detection of cancer due to different rates of participation in formal screening programs (e.g., mammographic screening for breast cancer) or other screening procedures (e.g., PSA testing for prostate cancer); the availability of diagnostic services; access to and quality of health services, most notably treatment; (and) cancer registry practices."

The cancer toll will also continue to fall most heavily on the elderly. "Canadians aged 50–79 years will represent almost 70% of all new cancer cases and 62% of cancer deaths in 2012. The highest proportion of new cancer cases (28%) will occur in the 60–69 age group, while the highest proportion of deaths from cancer (34%) is expected in the 80 and older age group."

"Canadians aged 80 years and older will experience the highest proportion of cancer deaths at 34% (25,400 deaths). They will account for 19% of all new cancer diagnoses (35,400 cases) in 2012." — Wayne Kondro, *CMAJ*

Ontario seeks united front on physician payments

Hoping to limit an exodus of physicians from Ontario and create a unified provincial front to constrain the growth rate of physician salaries, Premier Dalton McGuinty is pleading with his counterparts to follow his lead and cut payments to doctors for medical services such as diagnostic radiology tests and cataract surgery.

"We must make evidence-based decisions on what services we fund and stop paying for treatments that do not benefit patients. It is also in the best interests of all Canadians that our publicly funded health care systems keep pace with the latest advancements in technology," McGuinty wrote in a May 11 letter to his fellow premiers.

"I know that all provinces and territories have been working to seize the new opportunities made possible by technological breakthroughs in areas such as pharmaceuticals, diagnostic imaging and surgical techniques. Like you, I believe that we need to consider how recent medical technology can help reduce the costs of health care for Canadians. It only makes good sense that, when medical breakthroughs allow a physician to greatly increase the number of procedures or surgeries done in a day, the payment made by Canadians to that physician be reconsidered and re-balanced, so that taxpayers share in the productivity improvements that this technology enables," McGuinty added.

McGuinty argued that Ontario's recent unilateral changes in the provincial fee schedule — which included a 50% reduction in payments for self-referrals, an 11% reduction in fees paid for diagnostic radiology tests and a $42.25 cut, to $397.75, in the fee paid for cataract surgery (http://news.ontario.ca/mohltc/en/2012/05/ontario-freezing-doctor-pay-to-invest-in-more-community-care-for-families-and-seniors.html) — were a "step forward" in pursuing evidence-based health reform.

"I recognize that each province and territory has its own plans to reform medicare — and each of us has our own starting point for payment arrangements with doctors. But I urge you to consider how we might work together through strong, forward-looking reforms — such as those we are implementing in Ontario — to improve medicare for future generations."

McGuinty indicated he expected the issue of reducing physician fees to be included on the agenda of the July meeting of the Council of the Federation. Last February, the premiers created a "Health Care Innovation Working Group" to examine scope of practice, health human resources and clinical practice issues across Canada (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4109). The working group was charged with crafting a nationwide strategy to improve health care that is so compelling it will shake down the federal government for more money (www.councilofthefederation.ca/pdfs/Communique_Task%20Force_Jan_17.pdf).

Meanwhile, the Ontario Medical Association (OMA) continued to sound alarms about the potential for an exodus of physicians, particularly to the United States, as a result of the fee schedule changes.

"The message from the McGuinty government to our medical graduates and doctors who might think of returning to Ontario is clear — we don't value your input in our health care system. There's no doubt that doctors will start to consider more seriously their options in other jurisdictions," Dr. Doug Weir, president of the OMA, stated in a press release (www.oma.org/Mediaroom/PressReleases/Pages/PhysicianShortageintheUS.aspx). "It wasn't that long ago Ontario was bleeding doctors. While we have made some progress to reverse that trend the government's scheme to unilaterally cut physician fees is going to seriously impair our ability to keep the doctors we have from being lured away by other jurisdictions like the U.S."

The OMA noted that the US will need 90 000 physicians in the next decade, including 45 000 family physicians, as it implements US President Barack Obama's health reforms. — Wayne Kondro, *CMAJ*

Multiple strategies needed to reduce obesity

With America's "epidemic of excess weight" causing nearly 21% of annual medical spending in the United States to be gobbled up in the treatment of obesity-related illness, the US Institute of Medicine is urging the adoption of a national "meta-strategy for obesity prevention."

Proposing a five-pronged systemic approach to reducing the weight of the populace, the institute advocates a raft of measures to "profoundly reshape the environments where people live, work, play, and learn," including a requirement that students be compelled to participate in 60 minutes of physical activity daily and the introduction of standardized national nutritional labelling requirements.

"If leaders across all levels of society are engaged and implement this comprehensive approach within the next decade, physical activity will become an integral and routine part of most people's lives, and adults and children will have opportunities for enjoyable physical movement anywhere they spend time," an expert panel of the institute states in its report, *Accelerating Progress in Obesity Prevention: Solving the Weight of the Nation* (www.iom.edu/Reports/2012/Accelerating-Progress-in-Obesity-Prevention.aspx).

"Healthy foods will become the most visible, attractive, and easy-to obtain options anywhere food is sold or served. The balance of information in the media that surround us will shift away from sedentary pursuits and unhealthy foods and toward active lifestyles and healthy foods. Patients will leave their health care providers' offices with more knowledge about obesity prevention that can be put into action. Employers will play a pivotal role in increasing physical activity and healthy food options for employees. And schools will become nutrition and wellness centers. The force of each action, compounded by the collective ability to accelerate and strengthen each other's impact, can profoundly improve the nation's health," the report added.

The meta-strategy is structured around five interlocking goals:

- "Make physical activity an integral and routine part of life."

To that end, recommendations include ones to promote the provision of more biking and walking trails in communities and compel licensed child care providers to adopt physical activity requirements.

- "Create food and beverage environments that ensure that healthy food and beverage options are the routine, easy choice."

Recommendations include ones aimed at reducing the consumption of sugar-sweetened beverages and other unhealthy foods. "Chain and quick-service restaurants should substantially reduce the number of calories served to children and substantially expand the number of affordable and competitively priced healthier options available for parents to choose from in their facilities." As well, schools should be required to provide healthy foods and beverages at reasonable cost and governments should "introduce, modify, and utilize health-promoting food and beverage retailing and distribution policies. States and localities should utilize financial incentives such as flexible financing or tax credits, streamlined permitting processes, and zoning strategies, as well as cross-sectoral collaborations (e.g., among industry, philanthropic organizations, government, and the community) to enhance the quality of local food environments, particularly in low-income communities." That should include providing incentives to supermarkets that agree to locate in "underserved" low-income neighbourhoods and utilize "health-promoting retail strategies (e.g., through placement, promotion, and pricing)."

- "Transform messages about physical activity and nutrition."

The federal government should launch a "sustained, targeted physical activity and nutrition social marketing program" and introduce common standards for marketing foods and beverages to children and adolescents. "The food, beverage, restaurant, and media industries should take broad, common, and urgent voluntary action to make substantial improvements in their marketing aimed directly at children and adolescents aged 2–17." All levels of government should "consider setting mandatory nutritional standards for marketing to this age group to ensure that such standards are implemented." The federal government should also "implement a standard system of nutrition labeling for the front of packages and retail store shelves that is harmonious with the Nutrition Facts panel, and restaurants should provide calorie labeling on all menus and menu boards."

- "Expand the role of health care providers, insurers, and employers in obesity prevention."

"All health care providers should adopt standards of practice (evidence-based or consensus guidelines) for prevention, screening, diagnosis, and treatment of overweight and obesity to help children, adolescents, and adults achieve and maintain a healthy weight, avoid obesity-related complications, and reduce the psychosocial consequences of obesity. Health care providers also should advocate, on behalf of their patients, for improved physical activity and diet opportunities in their patients' communities." As well, health insurance should cover obesity prevention screening, diagnosis and treatment, while employers should "create, or expand, healthy environments by establishing, implementing, and monitoring policy initiatives that support wellness."

- "Make schools a national focal point for obesity prevention."

Recommendations should include ones to compel all students from kindergarten through grade 12 to engage in 60 minutes of physical activity daily and schools to provide nutritional education, as well as healthy food options in their cafeterias.

The institute panel stated that it assessed 800 previously published strategies aimed at obesity prevention and concluded that only a systemic,

societal strategy could achieve reductions in obesity levels. "As the trends show, people have a very tough time achieving healthy weights when inactive lifestyles are the norm and inexpensive, high-calorie foods and drinks are readily available 24 hours a day," Dan Glickman, chairman of the panel and executive director of congressional programs of the Aspen Institute in Washington, DC, stated in a press release (www8.nationalacademies.org/onpinews/newsitem.aspx?RecordID=13275). "Individuals and groups can't solve this complex problem alone, and that's why we recommend changes that can work together at the societal level and reinforce one another's impact to speed our progress." — Wayne Kondro, *CMAJ*

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