figures from Statistics Canada the total amount spent on prescription drugs in 1996 was $7.67 billion.[4] Out of that total, private sector spending was just under $4 billion. Let us suppose that only 50% of the private spending ($2 billion) would be covered under a pharmacare plan and that the other 50% would be for drugs not included in a national formulary. Conservatively, let us assume that joint provincial buying power would lower drug prices by 10%. Therefore, instead of costing $2 billion, the drugs covered would cost $1.8 billion; a savings of $200 million. Let us also assume that administrative costs go from 10% to 5%. On $2 billion, administrative costs would drop from $200 million to $100 million, another $100 million in savings. The 1996 prescription drug bill under a national pharmacare plan would drop from $7.67 billion to $7.37 billion. Public spending would definitely rise, but the overall cost to society would drop.

We need to be realistic, as Hoey and Flegel conclude, but we should also be bold enough to suggest radical reforms. A true commitment to lowering the rate of poverty and to implementing a national pharmacare plan are 2 bold steps that the new minister could take.

Joel Lexchin, MD
Toronto, Ont.
Received via email

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Health care on the election agenda

The article "Health care among forgotten issues in forgettable federal election" (*Can Med Assoc J* 1997;157:57-8), by Charlotte Gray, presents an inaccurate assessment of the treatment of health care issues during the election.

Gray acknowledges that polls consistently showed that medicare was voters' number-two concern. The federal leaders clearly recognized the importance of health care issues. This was illustrated by the frequent high profile discussions about medicare in speeches, political advertisements, news conferences and perhaps most significantly in the English-language leaders' debate.

As part of its Future of Health Care Strategy, CMA launched the Election '97 Campaign Strategy, which was effective in putting the public spotlight on health care issues during the federal election. Indeed, CMA was flooded with news clippings from across Canada in which reporters and pundits commented on health care as an important election issue. In addition, as a result of a coordinated media and public relations campaign, CMA received intense media interest during the campaign about the federal election. CMA also fielded calls from MD–MP contacts and candidates about the future of health care and its impact on the electoral agenda.

The appointment of a strong minister, Allan Rock, as federal minister of health is a further indication that health care is recognized as a top priority by the federal government. Far from being "yesterday's flavour," CMA's early indications all point to health care remaining front and centre on the political agenda in the new Parliament.

The election has shown us that voters demand that their elected officials act as responsible stewards of our health care system. CMA will continue to work with Canadians to ensure that parliamentarians commit to adequate health care funding and an evidence-based approach to health care reform.

Judith C. Kazimirski, MD
Past President
Canadian Medical Association
Ottawa, Ont.

[The author responds:]

Dr. Kazimirski is absolutely correct when she points out that party leaders all spoke frequently about medicare during the election and gave the survival of our health care system a high priority in their news conferences, political advertisements and leaders' debates.

However, health care was not the determining factor in how most Canadians voted. I pointed out in the article that, from the day the writ was dropped, the major parties unanimously insisted there should be no more cuts to medicare. The preelection lobbying efforts of the CMA and other health care organizations were so successful that every party leader wanted to claim the credit for saving medicare. Voters therefore felt sufficiently optimistic about the preservation of our health care system that they turned to other issues on which to make their voting decision — issues on which parties disagreed. Chief among these issues was national unity, because the Liberals, the Reformers, the Progressive Conservatives, the Bloc Québécois and the NDP all have radically different approaches.

As any political observer knows, an election campaign is a nerve-wracking race that often seems more like a test of stamina than a serious debate about national interests. The media (which is always more interested in disagreement than unanimity) play a major role in defining the issues. The

fact that health care never became a hot election issue last June says nothing about its priority for the new government.

Charlotte Gray
Ottawa, Ont.

Spirometric testing and the breathalyser

Our recent criminal court experience supports the caution to physicians contained in "Don't use medical excuses to escape breathalyser, MDs warn" (*Can Med Assoc J* 1997;156:157).

A 61-year-old man was arrested for operating a motor vehicle while impaired by alcohol. At the police station he did not provide a suitable breath sample for the breathalyser, citing "shortness of breath" from smoking and work in a dusty area that day. The breathalyser technician noted that the accused did not blow hard enough to raise the piston, and no exhalation or venting was detected after several attempts.

A physician wrote that the accused had "a degree of chronic destructive [sic] lung disease," and with no objective spirometric data concluded that it would be difficult for the accused to provide a breath sample for the breathalyser.

At trial, a videotape of the accused taken at the police station showed he had no apparent breathing problems while walking or talking. The physician testified that the accused had some degree of chronic obstructive pulmonary disease (COPD), but upon cross-examination admitted it was not severe enough to warrant spirometric testing.

In a study of 10 patients with known COPD, all were able to provide an adequate sample for the breathalyser. These patients (aged 56 to 78 years) had a forced expiratory volume in 1 second (FEV_1) between 0.46 and 1.86 L and a ratio of FEV_1 to forced vital capacity of from 0.19 to 0.53.[1]

Our experience is that objective spirometric testing, showing significantly diminished values, is required for reliable testimony in these types of cases. In this case, the accused was convicted of failing to provide a breath sample.

James G. Wigmore, BSc
Michael Corbet, PhD
Steven Lintlop, MSc
Toxicology Section
Centre of Forensic Sciences
Ontario Ministry of the Solicitor General and Correctional Services
Toronto, Ont.

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Drug- and caffeine-induced headaches

The article "Guidelines for the diagnosis and management of migraine in clinical practice" (*Can Med Assoc J* 1997;156:1273-87), by Dr. William E.M. Pryse-Phillips and associates, is an excellent overview. On the basis of my personal and practice experience, I would like to see more emphasis on the importance of drug-induced and caffeine-induced headaches. Anyone with frequent headaches (more than 2 per week) should be carefully questioned about intake of caffeine and use of over-the-counter and prescription drugs.

Acetaminophen and NSAIDs are the drugs least likely to cause headaches. Anything else needed to relieve headache pain (including sumatriptan) is prone to causing rebound headaches when withdrawn.

The initial management should involve identification and avoidance of triggers, careful and sensitive provision of information, the simplest single analgesic, rest, ice and massage. An appropriately informed patient can then be his or her own headache expert, detective and healer.

Philip E. Shea, MD
Hamilton, Ont.

[The principal author responds:]

I certainly agree with Dr. Shea that there are several areas to do with migraine that require emphasis for their optimal management in Canada.

Our article was written according to the strict requirements for guidelines based on randomized controlled trials. Very few of the nonpharmacologic therapies have been subject to such analyses; as a result, they could not be included. As we mentioned in the article, we have decided to perform a separate review of all such therapies, including acupuncture, biofeedback and hypnosis.

The whole problem of drug-induced headache is a very important one. We referred to it briefly in our article but, to my knowledge, no firm guidelines for diagnosis have yet been constructed and agreed upon, although this work is in progress.

William Pryse-Phillips, MD
Memorial University of Newfoundland
Health Sciences Centre
St. John's, Nfld.

Feverfew products

The article "Herbal products begin to attract the attention of brand-name drug companies" (*Can Med Assoc J* 1996;155:216-9), by Kate Cottrell, contains some errors.

The Health Protection Branch (HPB) of Health Canada regulates botanical products under its Food and Drug directorates. If a product is classified as a drug, usually after a manufacturer makes a therapeutic