is apparent in the selected class 1 studies. Valid selections would have included the randomized controlled trials by Levine and colleagues[4] and Koopman and colleagues[5] in the management of deep venous thrombosis and by Wolter and colleagues[6] in the management of cystic fibrosis at home.

Without firm definitions and consistent clinical applications with which to define the interventions, cost comparisons are as problematic as assessments of the clinical outcomes of such trials. In an assessment of the cost of HIH care for the delivery of intravenous therapy to patients with cellulitis,[7] HIH admissions were approximately 40% less costly for patients admitted to the HIH directly from the emergency department and approximately 30% less costly for patients who required a stay within the hospital itself. The greatest savings were found in hospital overhead costs and nursing salaries, while HIH was more costly in the provision of pharmaceuticals and procedures. The results concurred with my clinical experience in the delivery of acute care to over 1200 patients at home.[8,9]

Systematic reviews of complex health service interventions such as HIH should be used with great care and usually resist efforts at reductionism. The results of the article by Soderstrom and colleagues[1] must be scrutinized in that light. The challenge is to establish high-quality HIH programs and then test their efficiency in a randomized controlled trial for a variety of clinical conditions and therapeutic interventions. To do otherwise is, to borrow from the biomedical vocabulary, to skip phases 1 and 2 and go straight to phase 3 trials.

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[The authors respond:]

In our review of the research evidence regarding the health and cost effects of substituting home care services for some inpatient acute care,[1] we drew 2 conclusions. First, although the evidence indicates that such home care has no notable effects on patients' or caregivers' health, it does not establish that this home care reduces health care costs. Second, the available, internally valid evidence is very limited, so well-designed evaluations of this home care are urgently needed. Michael Montalto's comments are consistent with our conclusions.

He argues that "genuine acute home care programs" were not evaluated in the 4 most valid studies we reviewed. We disagree. Those studies involved health conditions for which home care is thought appropriate clinically, and, in the programs evaluated, health professionals provided services in patients' homes that were substituted for inpatient care.

Montalto also argues that we should have considered 3 other studies. Two of them[2,3] evaluated programs in which patients with venous thrombosis self-injected heparin at home, not programs involving health professionals providing services in patients' homes. Moreover, had we included these 2 studies, there would still be no evidence that home care was cost-effective for most health conditions for which it was being used. The third study[4] concluded that home care was cost-effective. However, the cost-effect estimate is questionable. Inappropriate cost calculations were made by using hospital revenue data (i.e., diagnostic-related group reimbursement rates). The researchers did not estimate the change, caused by the use of home care, in the value of the hospital resources used to manage the patients' health problems.

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A straw-man argument?

A recent article by Martin Schechter and Michael O'Shaughnessy, "Krever 2008,"[1] is a hypothetical transcript set in the future in which the authors present the testimony of an "ex-

pert witness" who purportedly represents the collective wisdom of today's political policy-makers. The witness' arguments are neatly demolished by the fictitious commissioner, and the witness and his position are made to look foolish and weak.

In doing this the authors have set up a "straw-man" argument, so called because it is easier to knock down a man of straw than a real opponent. Another explanation is that, in the 19th century, witnesses-for-hire would hang about law courts, willing to say whatever was requested. These untrustworthy characters were identified by a straw in their shoe.[2]

Schechter and O'Shaughnessy create the impression that their opponents' point of view has been properly represented and justly defeated, but in fact no debate has taken place. An opponent of needle-exchange programs could easily write a similar script that would have a very different and equally unsubstantiated verdict. The authors may or may not be correct in their conclusions, but we won't know until a full and proper deliberation has occurred and each side has advanced its own arguments instead of relying on partisan interpretation of each other's views.

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[The authors respond:]

We did not write a technical article but rather a dramatic piece whose purpose was to raise the following point: If questions of civil and criminal negligence can be raised with regard to bureaucrats and politicians who knowingly did not provide the means to protect the blood supply, then cannot the same questions be raised about those who knowingly did not provide the means for injection drug users to protect themselves from lethal harm? We do not know the answer, but the question is legitimate.

As to whether the opinions of our decision-makers were properly represented, if only this were not so. Since 1986 both of us have sat on a number of national and provincial ministerial advisory panels, where we have discussed this subject with a host of federal and provincial bureaucrats and ministers of health. Sadly, the statements of our "witness" are virtual quotations from those discussions. If our witness was made to look foolish and weak, then we are better playwrights than we thought, for this is precisely how we believe decision-makers have acted.

Robert Patterson quite rightly asks for a full and proper deliberation. We invite him to read the report of the National Task Force on HIV, AIDS and Injection Drug Use,[1] which brought together national and international experts and evidence in 1997. He might also read the Le Dain Royal Commission report,[2] which was written more than 25 years ago. Unfortunately, these reports have been neglected, not discussed.

Patterson correctly notes that opponents of harm reduction could write a similar script to ours but with a different verdict. We would look forward to reading the testimony of their "witness" about his or her accomplishments over the last 30 years, including the overwhelming success of the war on drugs, the wonderful state of affairs in our inner cities and the tens of thousands of cases of hepatitis C and HIV infection that could have been prevented.

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Smoking out the economics of tobacco use

I read with interest the editor's preface on global tobacco use in a recent issue of *CMAJ*.[1] Whenever I see figures like these I can't help wondering what would happen if all smokers miraculously quit overnight. Presumably they would live longer, healthier lives. But what would be the cost of their health care as they fade into senility? Greater, less than or the same as the $14.5 billion you quoted as the maximum amount to look after smoking-related illnesses?

Finally, where did you get the statistics you quoted? Are there comparable figures for ordinary age-related morbidity?

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