Correspondance

[The author responds:]

David Spence misses the point of the series of 3 articles in suggesting that they are about cost.[1–3] These articles systematically review the best available evidence from randomized controlled trials using a hierarchy of evidence; cost is the least and last consideration. The clear conclusion from the available evidence, independent of cost, is that thiazides are the best first-choice drugs. In other words, if thiazides were the most expensive antihypertensive drug class, the conclusion would be the same.

Spence inaccurately implies that the evidence in these articles is biased. It is true that I am the Managing Director of the BC Therapeutics Initiative. However, he does not understand the relationship between the Therapeutics Initiative and BC Pharmacare. The Therapeutics Initiative assesses evidence of the efficacy and safety of new and existing drugs and provides a summary of that evidence to Pharmacare. The Therapeutics Initiative does not consider or include cost in that assessment. Evaluation of cost and cost-effectiveness evidence is the mandate of the Pharmacoeconomics Initiative. The Drug Benefit Committee of Pharmacare and the Director of Pharamacare make funding decisions on the basis of summaries of evidence (not funding advice) from the Therapeutics Initiative and Pharmacoeconomics Initiative plus other considerations.

Spence is asking us to put aside evidence from randomized controlled trials and in its place accept the conclusion from 2 retrospective observational studies.[4,5] Both of these studies were funded by the drug industry and the conclusions ratified their vested interest. In my opinion, this type of study reflects the profound influence drug companies can have on measures of drug compliance that rely on dispensed medication. The industry accomplishes this by providing drug samples (not detectable as dispensed medication) and intensive one-on-one promotion to physicians. Answering whether medication persistence differs with different drugs necessitates randomization of patients to the alternate drugs and blinding of both physicians and patients.

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Change the Canada Health Act? Why?

I am concerned about your recent editorial on the Canada Health Act (CHA).[1] It suggests that the CHA is unsustainable at current government funding levels and therefore needs to be revisited. This is equivalent to responding to an increase in the cost of prosecuting drunk drivers by raising the blood alcohol limit rather than by increasing funding for police and prosecutors. The answer lies not in abandoning the CHA's principles but in reconsidering the financing of the current system.

The editorial suggests that comprehensiveness is potentially the most unsustainable of the CHA's 5 principles, largely owing to advances in medical technology and the resulting elevation of public expectations. A natural consequence of successful research is to increase our ability to care for our patients. Not surprisingly, these advances may cost more than the technology currently available. Should we maintain the status quo in order to contain costs? Obviously, this is not what Canadians want. The cheapest solution is not necessarily the most efficient one.

Although I agree that a better method of financing — both for medicare and capital investment — must be found, I disagree that this necessarily requires re-examination of the CHA's principles. The CHA embraces, ideologically, what many Canadians feel to be essential, both for health care and as an expression of our nationality. If changes are going to be made on an ideologic basis, there should be evi-

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dence that the national ideology has changed. If changes are going to be made on the basis of efficiency, there should be proof that such changes are for the better. At the moment, evidence is lacking on both levels.

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Helping physicians with alcohol problems

A recent public health item in *CMAJ* pointed out that although the precise prevalence of problems with alcohol and other drugs among physicians is unknown, it is probably similar to that in the general population.[1] Single and colleagues' estimate of 9% was quoted.[2] This estimate applies to current drinkers who have experienced any of a list of specific problems at least once in the past year; these individuals do not necessarily need treatment. Single and colleagues broke down the overall estimate by demographic variables: 7.6% of those with university education and 5.8% of those employed in a profession reported any alcohol-related problem in the past year. These latter figures are probably better estimates of the rate of problems among physicians.

More recent data from the 1996–1997 National Population Health Survey showed that, overall, 2.5% of people who drank in the year before the survey drank at "levels associated with clinical dependence on alcohol."[3] The rates were 1.1% for those with a university education and 0.8% for those employed in professional or semi-professional positions. These figures approximate the percentages of physicians ever having received treatment for problems with alcohol and other drugs: 1.2% in Ontario,[4] 1.8% in Canada[5] and 1.3% in the United States.[6]

Most provincial medical associations have programs for physicians who need treatment for problems with alcohol and other drugs. However, the discrepancy between estimates of those who experience consequences of drinking and those who require and receive treatment points to a large group whose needs are not being addressed. Provincial physician health programs include educational outreach and lectures to medical students and physicians,[7] but there is little help for those who feel distress and are beginning to develop problems. Medical schools, hospitals, professional organizations and individual physicians should unite in a health promotion approach to physician health that goes beyond prevention programs, to reduce systemic stresses and involve physicians in building a healthier work environment.

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Policies must keep pace with the evolution of vaccines

Although I wholeheartedly support your editorial on vaccination, I feel that one important element was lacking: the need for ongoing research.[1] Concerns have been expressed about various vaccines at various times, and re-evaluations have led us to modify certain products and policies.

The pertussis vaccine is a different product today than it was some years ago. Policies regarding the administration of injected and oral poliomyelitis vaccines have been changed. We are now in the process of eliminating thimerosal as a preservative and replacing it with other agents. Questions have been raised regarding a possible relationship between the measles–mumps–rubella vaccine and the significant increase in the incidence of autism; such an association remains unproven, but more research is needed. We are administering more vaccines than ever before, and concern has been expressed about possible overburdening of the immune system in some infants; this needs to be evaluated.

As responsible and caring people of science, we must keep our minds open and, from time to time, recheck beliefs and policies we have taken for granted.

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