counted for over 60% of the cost of drugs but comprised only 23% of prescriptions. Metformin accounted for 40% of prescriptions but comprised only 7% of the total medication bill. Since 1991, the proportion of total prescribing accounted for by metformin has doubled, while that for sulphonylureas has decreased by almost half. In 2004, spending on glitazones (£50.6 million) was higher than on metformin (£22.6 million) or sulphonylureas (£40.1 million).

Even in a very affluent country, such large increases in spending place considerable pressure on health service budgets. Developing countries would have considerably more difficulty in covering such high prescribing costs, even though hypoglycemic agents are essential in controlling the complications of diabetes. In recent years antiretroviral drugs have been made available to patients in developing countries at low cost, representing a great advance in the management of HIV infection. Perhaps the time has come for a similar scheme for drugs to manage diabetes and its complications in developing countries.

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Caring for young adults with diabetes

The recent *CMAJ* lead editorial on the challenges of caring for young adults with chronic diseases in the adult health care system is timely.[1] Young adults aged 20–29 years with type 1 diabetes are 4 times more likely to die than their peers without diabetes, a rate that is higher than at any other age.[2] These deaths are largely due to preventable causes: diabetic ketoacidosis and suicide.[3] Failure to adhere to the rigours of daily diabetes care can lead to chronic poor glycemic control and microvascular complications before 40 years of age.

Up to 50% of young patients with diabetes have reported difficulties with the transition to adult health care, and 25%–35% are lost to medical follow-up in the first few years after they move into the adult system.[4] Much discordance exists between the developmental tasks of young adults with diabetes (such as moving away from home and starting a career and a family) and the expectations of the systems involved in their care. These patients can feel overwhelmed by the demands of coping with the many changes that occur during the transition to adulthood, and often the result is inadequate self-care and negative attitudes toward their disease and treatment.

In August 2002, the Diabetes Education Resource for Children and Adolescents at the Winnipeg Children's Hospital established a program (Building Connections: The Maestro Project; www.maestroproject.com) that uses a systems navigation model to facilitate the transition from pediatric to adult diabetes care for young adults in Manitoba. The project coordinator maintains contact with the young adults in the program to address any issues that arise during their transition and provides referrals for community services. If we are to reduce morbidity and mortality in young adults with diabetes, new dedicated, flexible systems are required in adult health care to meet the needs of these patients.[5]

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Quality of care evaluation in France

Monitoring and enhancing physician performance is a major challenge. Several countries have developed programs for maintenance of certification, which may include written tests of medical knowledge, tests of clinical skills, and ratings by patients and peers, among other elements. The importance of self-regulation and of the independence of physicians has been stressed.[1]

In France, physicians are viewed to be personally responsible for providing good care. A program to promote professional development with a focus on performance in practice was introduced in 1998, and physicians in private practice were encouraged to join it on a voluntary basis. The program was a success (in our province, 1 of every 5 physicians in private practice joined the program) and since 2005 it has been mandatory for every physician. It is regulated by an independent body that is also responsible for the accreditation of hospitals.

We are seriously concerned about the increasing involvement of payers in the evaluation of quality of care. In September 2004, the main regional care trust (a regional council of the national public health insurance system) in France, l'Union régionale des caisses d'assurance maladie (URCAM) Ile-de-France, which operates in Paris and its suburbs, published an audit concerning the treatment of colon cancer that used clinical practice guide-

lines issued in March 1998.[2] Another regional care trust, URCAM Limousin, recently published an audit concerning the surgical treatment of thyroid masses that was performed in 2003 and that also used obsolete guidelines from December 1995.[3]

Care trusts have a major conflict of interest; outdated guidelines have already been used to deny coverage for new treatment strategies. Care trusts also usually focus on reactionary approaches that punish rather than reward. Evaluation is not magic: it must involve substantive, defensible and valid processes. The evaluation of quality of care requires professionalism and fewer fantasies on the part of the care trusts about total control.

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Correction

A News item concerning Health Canada's approval of the cervical cancer vaccine incorrectly stated the price of the vaccine.[1] Gardasil costs $134.95 for each of the 3 required doses. The total cost is thus $404.85 per client. *CMAJ* apologizes for any inconvenience this error may have caused.

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