

cost-saving. There is, in fact, good evidence that while smoking cessation may reduce health care spending over the medium term, in the longer term (15 to 30 years) health care spending is actually increased.²

The explanation for this is perfectly simple: nonsmokers live longer and therefore incur expensive health care costs in old age. These additional costs exceed the lower expenditures of earlier years. Quite apart from increased health care spending there would be two additional negative effects on government finances if all smokers quit: Governments would lose the hefty revenues generated by tobacco taxes, and there would be increased spending on pension payments.

This argument appeared in an analysis carried out by the British government in 1971. The report was never officially published but was leaked in 1980.^{3,4}

What applies to smoking also applies in other scenarios: the prevention of fatal diseases actually leads to an increase in health care spending.⁵

Indeed, our best evidence is that most medical interventions designed to prevent disease or improve health cause an increase in health care spending.⁶

Of course, the prevention of fatal diseases is undeniably of great value with regard to population health and should therefore be strongly supported. Moreover, prevention can often be much more cost-effective than many medical treatments.⁷ However, this is altogether different from decreasing health care spending.

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Polio immunity in Ontario

With reference to the article by King,¹ the population in Ontario cannot be considered to be fully immune to poliomyelitis when one considers the immune status of people 60 years of age and older. In all probability these individuals were never vaccinated against poliomyelitis during their infancy, childhood or adolescence. The vaccines were not available before 1960.

Such people could become infected with paralytic poliomyelitis if they were exposed to wild, live or vaccine-derived strains in the event of any importation and dissemination of the



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virus in Ontario or during a trip abroad. Indeed, two healthy British men, aged 62 and 65 years, were infected with paralytic polio while holidaying in Morocco.²

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A step in the right direction

I applaud the new vitamin D in adult health and disease guideline statement. Certainly this is a step in the right direction. Average 25(OH)D levels in all studies in Canada,² including Health Canada's household studies, are consistently below the recommended 75–80 nmol/L. Supplementation with 1000IU of vitamin D₃ in the general

population would result in a mean 25(OH)D level slightly above 85 nmol/L still leaving 20%–30% of Canadians below the suggested 75 nmol/L. That's not good enough. These studies show that children and teens have significant insufficiency. Addressing osteoporosis early will influence peak bone mass and result in stronger bones for the future.

Supplementation with 2000 IU of vitamin D₃ in an institutionalized group (tested after a minimum of five months of supplementation) did not result in toxicity and did not achieve normal levels for everyone (94% > 80 nmol/L).³

The use of 2000 IU in the first year of life reduced the risk of developing type 1 diabetes over the next 30 years.⁴

There is emerging evidence of the benefit of vitamin D in the immune system for oral health, tuberculosis, influenza, hepatitis C, eczema, wound-healing, etc. Vitamin D levels required may be significantly higher than 75 nmol/L.⁵

Should we not be looking at using 2000 IU for all Canadians since the

authors suggest this is safe and does not require monitoring? In implementing this strategy, the economic benefit to the Canadian population has been estimated in the billions of dollars.⁶

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* Strnad P, et al. Efficacy of Hypertonic Seawater Saline in the Treatment of Persistent Rhinitis/Rhinosinusitis. American Rhinologic Society, Combined Otolaryngology Spring Meeting 2007.