

Evidence-based sustainability

I was surprised to read the editorial by Hébert and colleagues, which implied that Canada's health care system is financially sustainable when the evidence clearly shows that it is not.¹ From 2000–2009, the federal government's revenue increased 22%,^{2,3} and Ontario's revenue increased 49%.^{4,5} Meanwhile, Ontario's health care costs increased by an unsustainable 88%.^{4,5}

With rapidly expanding expensive investigative tools, treatments and medications in conjunction with a free, comprehensive, universal health care system, both patients and physicians are being persuaded to perceive of "limitless essential services." Unfortunately, we do not have "limitless funds." There is no Canadian politician or leading physician who is prepared to state clearly that health services must be limited to those that are justified and tort reform must be introduced. Any provincial health costs that exceed perhaps 35% of provincial program spending should be raised from premiums and a portion of health care expenses based on a patient's ability to pay. Very fair, very Canadian.

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Oral contraceptives and risk of gallbladder disease

Etminan and colleagues reported on an interesting study in which they found merely a little association between the use of oral contraceptives and gallbladder disease.¹ This resembled the results of our recently completed observational study (unpublished data: 2011) in which the cumulative adjusted rate ratio (RR) was 1.01 (95% confidence interval [CI] 0.97–1.12).

However, we found that oral contraceptives are an important contributor to gallbladder disease in patients with a body mass index (BMI) over 30 during drug administration (RR 1.46, 95% CI 1.20–1.79). Etminan and colleagues gave information about the history of obesity but not the weight or BMI of the participants. They also did not perform subgroup analysis on the relationship between a history of obesity and gallbladder disease. Given large differences in diet and somatotypes in Occidental and Asian women, we think their study should have included a subgroup analysis based on demographic characteristics specifically for BMI or weight. Although we concluded from our study that women with a BMI less than 30 should not be concerned about gallbladder problems when taking oral contraceptives, those with a BMI over 30 should be careful.

We want to know whether Etminan and colleagues' retrospective study could obtain the same results as ours.

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We agree with Wang and colleagues that the risk of gallbladder disease with the use of oral contraceptives may be modified by different levels of BMI.¹ Unfortunately, information on BMI was not available for our study.² We agree that future research should examine this issue carefully.

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Absolute risk reduction a must

After reading the article by Wells and colleagues on cardiac resynchronization therapy,¹ I was not sure that the article had come from *CMAJ*; it sounded like a salesperson had just dropped by and "detailed" me on the merits of putting a pacemaker/implantable cardioverter defibrillator into every patient with NYHA (New York Heart Association) class II disease.

To quote the authors, there was "no need for further clinical trials" because "the cumulative evidence is now conclusive" that there is "an unequivocal benefit ... in reducing all-cause mortality." Nowhere in the article is the absolute risk reduction mentioned. One would have to refer to Figures 2 and 3 to calculate it.

What happened to the peer review process at *CMAJ*? And where was the *CMAJ* editor? How can an article be published without the most relevant information in a trial — the absolute risk reduction?

I thought this was just an oversight, and I proceeded to the next excellent article in that issue by Eisenberg and associates.² Again, no absolute risk reduction! How can I counsel patients