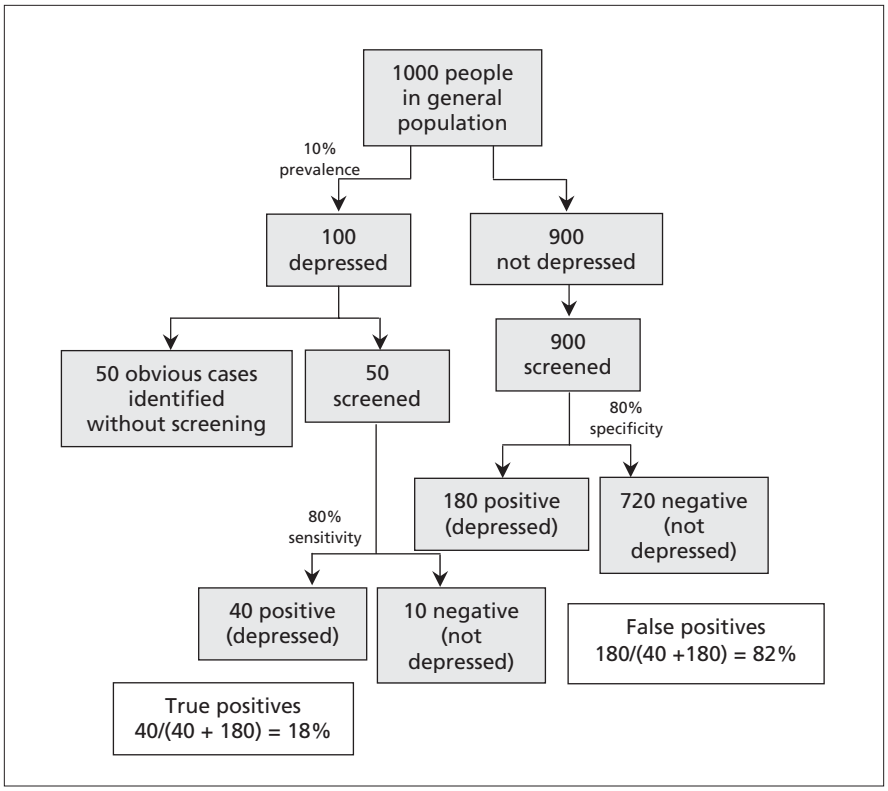

Figure 1: Percentage of true- and false-positive screens among patients who screen positive for depression.

negative trials.[2] Thus, we re-assert that the available evidence does not support screening for depression as routine health policy.

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References

1. Linden W, Vodermaier A. Re-rethinking the article by Thombs and colleagues [letter]. *CMAJ* 2012; 184:438.
2. Thombs BD, Arthurs E, El-Baalbaki G, et al. Risk of bias from inclusion of patients who already have a diagnosis or are undergoing treatment for depression in diagnostic accuracy studies of screening tools for depression: systematic review. *BMJ* 2011; 343:d4825.
3. Thombs BD, Coyne JC, Cuijpers P, et al. Rethinking recommendations for screening for depression in primary care. *CMAJ* 2012;184:413-8.
4. UK National Screening Committee. *Second report of the UK National Screening Committee*. London (UK): Department of Health; 2000.
5. Raffle A, Gray M. *Screening: evidence and practice.* New York (NY): Oxford University Press; 2007.
6. Carlson LE, Groff SL, Maciejewski O, et al. Screening for distress in lung and breast cancer outpatients: a randomized controlled trial. *J Clin Oncol* 2010;28:4884-91.

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Hospital parking fees

In 1999, while working at a local hospital, I conducted a small parking survey, which included 81 patients, out of concern that parking fees were having an impact on health care. I found 82.7% of patients were prevented from parking at hospital sites because of the cost of parking. Even more shocking were the methods of coping employed by patients due to their inability to pay parking fees. Many (86.4%) parked off hospital sites and walked; 42% chose not to attend for an appointment or program; 30.9% attended on a few occasions then stopped; and 35.8% attended only when they had money to pay for parking.

I brought the results to the attention of the hospital administration and to the Ministry of Health. That parking fees were seen as a source of future revenue became clear to me after meeting with various members of the administration of the Humber River Regional Hospital. The Ministry of Health pointed out that public hospitals are autonomous corporations that are run by boards of governors and that the parking issue is outside the jurisdiction of the Ministry of Health. This position flies in the face of the Public Hospitals Act,[1] which states,

> In making a decision in the public interest under this Act, the Lieutenant Governor in Council or the Minister, as the case may be, may consider any matter they regard as relevant including, without limiting the generality of the foregoing, … (b) the proper management of the health care system in general; … (d) the accessibility to health services in the community where the hospital is located.

This statute clearly indicates that the Ontario government has the power to step in and stop a practice that limits "accessibility to health services in the community where the hospital is located." The *CMAJ* editorial "Parking-centred health care"[2] indicates that nothing has changed since 1999.

Surely the provinces and hospitals can do better than this. People are not attending for treatment because they can't afford to pay for parking.

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References

1. *Public Hospitals Act*, RSO, 1990, c C-40, s 9.1 (1).
2. Kale R. Parking-centred health care [editorial]. *CMAJ* 2011;184:11.

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In Ontario, the provincial government funds 74% of the cost of operating hospitals. Hospitals generate the remaining 26% of operating funds themselves, and parking fees are one of the most common ways of making up the difference. If 1% of hospital revenue comes from parking, as the interim editor of *CMAJ* suggests,[1] then eliminating that revenue would create a funding hole as deep as $230 million in Ontario alone. With Ontario's provincial government running a deficit of more than $16 billion this year, while also signalling a

major tightening of health spending into the future, eliminating crucial revenues that hospitals use to fund clinical research and front-line patient care should be a non-starter, particularly for the nation's leading medical journal.

Canada is in a very difficult economic period and health care across the country faces serious challenges in terms of funding, affordability and accountability (particularly in primary care, which has high costs and almost no publicly reported accountability or performance metrics). Surely *CMAJ* has something to say about these and other more relevant issues, instead of banging away on the populist drum about parking fees.

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Reference

1. Kale R. Parking-centred health care [editorial]. *CMAJ* 2011;184:11.

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I support free hospital parking for patients. I would probably also support free transport to and from hospital visits, reimbursement for time lost from work due to hospital visits, and reimbursement for myriad of ancillary costs that hospital visits generate. That's the easy part. The hard part is knowing where to draw the line and who picks up the tab? Dr. Kale proposes that hospitals absorb the cost.[1] They certainly could, but at what price? If the Ottawa Hospital no longer generated the "small sum" of $10.8 million from its parking revenues, it would have to find $10.8 million worth of services to reduce or eliminate. Will the hospital then be more patient-centric? This was the reason such a proposal was defeated in England. No one was lining up with their chequebook to pick up the tab. If the objective of your editorial[1] is to provoke a larger debate about user fees, Godspeed. Your proposed remedy will not make our hospitals more patient-centric, but it will appeal to the media and the politician looking for a populist quick-fix.

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Reference

1. Kale R. Parking-centred health care [editorial]. *CMAJ* 2011;184:11.

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I was somewhat dismayed to read the *CMAJ* editorial regarding parking fees[1] given the need for sober and serious debate about the real funding issues in our current health care system. Just as a popular physician movement likes to point out that there is "no free lunch," I would like to point out that there is no free parking. Many might be puzzled by this statement because they experience daily the convenience of parking at big box retailers. However, retailers and landlords often work into their price point or leases "fees" for parking. Hospitals and medical clinics have no capacity to do this.

My cynicism for political motives leads me to believe that the politicians in the United Kingdom who outlawed parking fees for patients bought votes from patients, not parking spots for patients.

Although editorials such as these are provocative and entertaining, they distract from the real issues surrounding health care sustainability and access problems.

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Reference

1. Kale R. Parking-centred health care [editorial]. *CMAJ* 2011;184:11.

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Letters to the editor

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