

appointed the scientific director of the new Institute of Health Services and Policy Research of the Canadian Institutes of Health Research.¹ Please, no more cuts.

Ian Hammond

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Reference

1. Sinclair A. Heads of new institutes to set tone for Canadian research. *CMAJ* 2001;164(2):254.

One hundred pennies for your thoughts

I find it difficult to believe that this [Ad-Q] survey was mandated by *CMAJ*. It has more to do with drug advertising than anything else. Frankly, I find the enclosure of a US\$1 bill insulting and not dignified.

Constant Nucci

Obstetrician–Gynecologist
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Can you please explain the enclosure of an American dollar bill for the completion of a survey issued by *CMAJ*?

Darlene Hammell

Physician
Victoria, BC

[The Editor of *CMAJ* responds:]

The costs associated with producing *CMAJ* (and most other general medical journals) are largely offset by advertising by pharmaceutical firms. Occasionally readers complain about the number of ads in *CMAJ*, and some suggest that we cut advertising completely. But this is not a reasonable option for an association journal that is received as a benefit of membership by more than 50 000 CMA physicians and wants to remain affordable to subscribers such as libraries, researchers and physicians in other countries.

Without advertising the only alternative would be to increase CMA membership dues and journal subscription prices.

Information on the types and numbers of physicians who see their advertisements in various journals helps companies to decide how to spend their advertising dollars. *CMAJ* participates in 2 surveys a year to get feedback from readers on both advertising and editorial content. The latter gives us some information on the types of articles that *CMAJ* readers like and dislike. We value this feedback, and thank those of you who have participated for your comments (positive or otherwise).

The surveys are conducted by Harvey Research of Fairport, NY; no Canadian company offers a comparable program. The firm's decision to offer *CMAJ* readers a US\$1 bill as a token of thanks for participating in the survey is unfortunate. Thank you for bringing this to our attention. We thought of asking the firm to use a Canadian loonie, but this would be clunky. (Or we could suggest a Canadian \$5 bill, which might shortly be equivalent to a US\$1 bill ... but I digress.) We've forwarded your comments to Harvey Research.

You've each returned to us the US dollar you received. We've included them in our contribution to a local charity.

Pity the NHS

In his review of the report of the commission on the British National Health Service (NHS),¹ Terrence Sullivan says that the United Kingdom spends a third less on health care than Canada but provides broader coverage. The coverage may indeed be broader, but it is spread a great deal thinner.

The NHS has been starved of money almost from its inception, and I am sure that Canadians would not accept the strictures imposed by spending a third less on their own health care system. Somehow, health care policy

planners in Canada have felt that savings of this magnitude have been achieved in Britain by the panacea of capitation and salary as the payment options for physicians. This is not the case.

First, these savings have been achieved by avoiding necessary hospital upgrades. For example, until the early 1990s, the main referral hospital for the county of Somerset was still using Quonset huts for its wards. They were erected by the Americans in 1944, prior to the D-Day invasion.

Second, staff salaries were saved by employing foreign graduates, which robbed developing countries of the physicians and nurses they had used so much of their limited resources to train.

The third saving in the NHS involves rationing by death. By keeping elderly patients waiting many years for their operations, the NHS avoids a large percentage of hip replacements and other operations.

The commission that Sullivan reviewed sounds like the changing of the officers on the bridge after the *Titanic* has hit the iceberg. The NHS has tried everything from fund-holding practices to a Charter of Rights for patients, but it will remain a second-class service for most users unless it receives dramatically more funding. Unfortunately, this is unlikely to happen in an elitist society where efficient, fee-for-service private care is always available for the affluent.

Paul Cary

Physician
Cambridge, Ont.

Reference

1. Sullivan T. New life or green poultice? *CMAJ* 2000;163(10):1317-8.

[The author responds:]

Paul Cary makes several important and worthwhile points. However, in discussing why the British spend one-third less on health care than Canadians, he suggests that "health care policy planners in Canada have felt that savings of this magnitude have