

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

**Ian Hammond**

Department of Radiology  
Ottawa Hospital – General Campus  
Ottawa, Ont.

**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  
Montreal, Que.

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),<sup>1</sup> 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

been achieved in Britain by the panacea of capitation and salary as the payment options for physicians." Serious analysis of the health care system in Canada has never suggested this, nor is it likely to. The work of the National Forum on Health and recent reports from Quebec and Saskatchewan all point to some form of primary care reform and diversification of physician compensation methods. This diversification has been advocated in every serious reform effort in Canada to allow greater flexibility and accessibility in the organization of health services, not simply to save money. I agree with Cary that the health care system of the United Kingdom will remain challenged for the foreseeable future. The market requires that the public system be continuously portrayed as second rate in the UK to make a private tier appealing. I am afraid that no amount of reform talk will change this reality.

#### Terrence Sullivan

President  
Institute for Work & Health  
Toronto, Ont.

## Prescription data

In their recent *CMAJ* article on the provision of prescription data, Dick Zoutman and coauthors missed some key points, misrepresented IMS HEALTH's current practice and reached conclusions that have the potential to harm health-related research in this country by compromising the availability of information.<sup>1</sup>

Although individual estimates of prescribing practice are compiled by IMS, *only* the individual physician can obtain a report on his or her prescribing practice. The data are released to the pharmaceutical industry *only* in aggregated form, wherein a physician is identified as part of a group.

Our practices have been approved in Quebec by the Privacy Commissioner and the Health Information Advisory Board, which has strong physician rep-

resentation. We have ongoing collaborative discussions with Le Collège des médecins. IMS is also the first company in Canada to gain certification according to the Canadian Standards Association's Model Code for the Protection of Personal Information, the standard upon which the new federal privacy legislation (Bill C-6) is based. IMS does not collect identifiable patient data and has undertaken 6 independent privacy audits that confirm this fact.

Zoutman and colleagues suggest that we have been less than transparent in informing physicians about our practices. In fact, IMS has gone to significant lengths to publicize its activities with physicians. Further, our Web site ([www.imshealthcanada.com](http://www.imshealthcanada.com)) clearly explains our practices and how physicians might communicate directly with us. As a result of our recent mailing to 17 000 practising physicians in Quebec, we received over 1000 requests for health information. Additionally, more than 100 physicians requested and received their prescribing profile free of charge from IMS, allowing them to take the initiative to review their own prescribing practices; only 8 physicians exercised their ability to opt out.

Zoutman and colleagues argue that it is principally the interests of the pharmaceutical companies that are being served by the data collected and provided by IMS. The interests of other stakeholders should also be presented: those of physicians who wish to receive information appropriate to their interests and practice, as part of their own continuing education and self-evaluation; those of researchers who monitor drug use and promote more effective and appropriate treatment methods; those of patients and consumers in an environment where evidence-based decision making is encouraged; those of health care professional bodies who identify, develop and evaluate continuing education programs; and those of governments who develop policy and manage health care resources.

We acknowledge Zoutman and colleagues' attempt to foster debate about prescription data mining practices. Un-

fortunately, their article does not reflect the current reality of the practices of IMS, nor the valuable role that IMS data plays in serving the information needs of many health sector stakeholders.

#### Roger A. Korman

President  
IMS HEALTH, Canada  
Pointe-Claire, Que.

#### Reference

1. Zoutman DE, Ford BD, Bassili AR. A call for the regulation of prescription data mining [commentary]. *CMAJ* 2000;163(9):1146-8.

I am puzzled by the debate in *eCMAJ* over the article by Dick Zoutman and colleagues.<sup>1</sup> Surely the moral of their paper is simply that there has to be a better way for researchers and governments to access prescribing data than from a proprietary supplier. In an era in which we have simultaneously come to appreciate that robust data are required to maintain a successful health system and that protection of individual confidentiality is paramount, it would seem that public policy on prescription information demands attention. If a national pharmacare program is ever to emerge and survive in Canada, it will require access to precisely this sort of data. Evidence-based policy requires evidence of undisputed probity. Zoutman and colleagues are to be commended for making this need so transparent.

#### Samuel E.D. Shortt

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Queen's Health Policy Research Unit  
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Kingston, Ont.

#### Reference

1. Zoutman DE, Ford BD, Bassili AR. A call for the regulation of prescription data mining [commentary]. *CMAJ* 2000;163(9):1146-8.

Directed medical education programs modify prescribing practices and can improve care.<sup>1</sup> It would be useful to learn how data management groups like IMS HEALTH could work together not only with pharmaceutical companies but also with medical societies, individual physicians and health services administrators to identify op-