

## ON THE NET

## Assessing health technology assessment

Health technology assessment (HTA) involves the evaluation of everything from pharmaceuticals and procedures to health systems. The evidence-based assessment considers 4 factors: safety, efficacy, effectiveness and economics.

The Canadian Coordinating Office of Health Technology Assessment ([www.ccohta.ca](http://www.ccohta.ca)), which was founded in 1989, issues technology reports and overviews and discusses emerging issues, technology diffusion and method guidelines. The site contains executive summaries of reports, lists current and planned projects, and provides a link to EuroScan, a collaborative network of European HTA offices.

Another Canadian HTA site is the Therapeutics Initiative ([www.ti.ubc.ca](http://www.ti.ubc.ca)), which has operated from the University



of British Columbia since 1994. The site, which focuses on evidence-based drug therapy, offers a bimonthly *Therapeutics Letter*. Recent issues have looked at the effectiveness of influenza prophylaxis and the safety of COX-2 inhibitors.

In the United Kingdom, the NHS Health Technology Assessment Program site ([www.hta.nhsweb.nhs.uk](http://www.hta.nhsweb.nhs.uk)) offers a list of projects, a monthly email bulletin and online executive summaries. It also acts as a liaison between review groups and the National Institute for Clinical Excellence (NICE, [www.nice.org.uk](http://www.nice.org.uk)), which took over the technology-assessment roles of several groups in 1999. The turbulent early days of NICE have been well documented in the *BMJ* ([www.bmj.com/cgi/content/full/321/7273/1363](http://www.bmj.com/cgi/content/full/321/7273/1363)).

In the US, the Clinical Information Directory maintained by the Agency for Health Care Research and Quality ([www.ahrp.gov/clinic](http://www.ahrp.gov/clinic)) contains evidence reports, information on outcomes and effectiveness, technology assessments and reviews, and clinical practice guidelines.

The US and UK both maintain na-

tional research registers. In the US, the National Institutes of Health and the National Library of Medicine host a clinical trials site ([www.clinicaltrials.gov](http://www.clinicaltrials.gov)) that allows doctors and patients to conduct text searches or browse. In the UK, the National Research Register is at [www.update-software.com/National/](http://www.update-software.com/National/). — Alison Sinclair, CMAJ

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## Is Canada smoked out?

Canada has started the new century by marking its lowest overall smoking rate since monitoring began in 1965. Results from the Canadian Tobacco Use Monitoring Survey indicate that 24% of Canadians older than 15 smoked during 2000, down 1% from 1999.

For physicians, the best news is probably that the proportion of young smokers aged 15 to 19 dropped from 28% to 25% in 1 year. There was also a 3% drop, to 32%, in the 20-to-24 age group.

Statistically, physicians in Nova Scotia have the least to celebrate, since the province's 30% smoking rate is highest in the country. The lowest rate, 20%, is found in British Columbia. Doctors in Quebec probably have the most to shout about, since the province's smoking rate has dropped by 10 percentage points, to 28%, in the last 6 years. — CMAJ

## Caseloads may be responsible for regional differences in care: CIHI report

Chances of surviving a myocardial infarction (MI) or having a cesarean section may depend on where you live, the second annual health report from the Canadian Institute for Health Information (CIHI) and Statistics Canada says.

Jennifer Zelmer, coauthor of *Health Care in Canada 2001* ([www.cihi.ca](http://www.cihi.ca)), told *CMAJ* that the reasons for these regional variations need to be analysed carefully. "It's important to know how our care compares [in different] parts of the country and to work to improve patients' health."

The most extensively studied regional difference involved mortality rates for patients who had acute MIs (adjusted for regional differences in age, sex and comorbid conditions). In large health regions (population greater than

100 000), 13% of these patients (1998/99) died in hospital within 30 days of admission. However, the rate varied widely: it was 18% in St. John's, but only 8% in Calgary.

The report, which documents key measures of health and health care for 63 of Canada's largest health regions outside of Quebec, speculates that this difference may be due in part to patient characteristics and regional determinants of health, such as income and lifestyle, but is also partly attributable to caseloads. (A *CMAJ* study published at the same time [164(10):1431-5] reached a similar conclusion about caseloads.) The authors of the CIHI report speculate that higher caseloads allow hospitals to perfect procedures.

Does this mean hospitals with low

case loads should stop performing those procedures? "The data suggest we have too many centres undertaking complex procedures such as heart surgery," said Michael Dexter, chair of the CIHI board. "The result may be unnecessary complications and unnecessary death."

The report also took a careful look at growth in health care spending. Public and private spending on health care increased by 6.9% in 1999/2000, reaching about \$95 billion, or \$3000 per capita — an increase of about \$175 from the previous year. — Barbara Sibbald, CMAJ