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CORRESPONDENCE

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Economics of coronary artery bypass grafting

SIR,—On the last occasion that you opened your columns to health economists "for debate"[1] I was one of the few correspondents to rise to the challenge with a deliberately, if mildly, offensive letter, which drew no reply from the authors of the paper but which did earn me two letters from professional health economists, who applauded my attack on the pretensions of some of their colleagues. You now have given space "for debate" to Professor Alan Williams (August 3, p 326), who I understand is a guru among health economists. Perhaps he can be provoked to reply.

I was intrigued by the last paragraph in his summary: "The data on which these judgments are based are crude and in need of refinement. The methodology is powerful, far reaching, and open to comment." I entirely agree that the data are crude; whether or not the methodology is powerful cannot be ascertained from the content of the paper. Perhaps Professor Williams could be persuaded to provide evidence for the "power" of the methodology and also define what he means by this term, which in epidemiology and statistics does have a mathematical definition.

It is surely naive, however, to separate the quality of the data from that of the analytic methods. In appraising an epidemiological study I have to satisfy myself that the statistical analysis is appropriate, properly performed, and worthy of the database. There is little point in applying powerful statistical techniques to rubbishy data. Our statistical colleagues encourage us, rightly, to use confidence estimates to make comparisons. Where are these to be found in the health economists' firmament, or in Professor Williams's paper? For instance, fig 2 is based on the opinions of three (albeit "well informed") cardiologists. Their prognoses, elicited under protest, are then magically transformed (table II) into single figure values of "quality adjusted life years" with no indication of statistical confidence. Professor Williams does, of course, dwell on the need for better data for his sums (whose responsibility is it to provide them?), but this does not prevent him from asserting in his discussion that "these treatments should take priority over additional facilities for patients needing kidney transplants . . . for which the costs per quality adjusted life year gained are higher."

I would be prepared to accept that health economists are more likely, given adequate information, to be able to cost a medical or surgical procedure than the average doctor. I would also accept that this costing could be related to outcome in terms of mortality—a "hard end point" in epidemiologists' jargon. When it comes to evaluation in terms of "quality of life," however, the end points become so subjective and "soft" that the health economists' opinion, or that of doctors for that matter, becomes no more or less valid than that of the "person in the street." Professor Williams's reply to this would no doubt be to reiterate that those engaged in clinical trials should incorporate measurements of "quality of life" as well as looking at hard end points such as death and serious morbidity. This demand, however, raises several issues. Firstly, the methods of assessment need to be developed and validated under different circumstances before designers of clinical trials can be expected to incorporate them into studies. Validation will include costing the procedures themselves, and their degree of efficiency will need to be included in the calculation of sample size. This may affect the cost of mounting a clinical trial (upwards, of course), which means that it may never get started, at least in the United Kingdom, where funds for large scale trials are extremely difficult to obtain. Data, in terms of costs, from experience in North America or other parts of Europe may not be relevant to the United Kingdom. Furthermore, overall economic costing of therapeutic procedures involves factors outside the circumstances of a trial—for example, the local rate of unemployment and costs may go up or down with time without necessarily affecting outcome.

A final point concerns Professor Williams's remark that "economic appraisal is to ensure that as much benefit as possible is obtained from the resources devoted to health care." This is an admirable objective, but it presupposes in the context of his paper that we are devoting as much as we can afford to health care. Here we enter the area of politics, which cannot be separated from economics, health or otherwise. One criticism I would make of (some) health economists is that they start with the premise that the present health budget is finite, and choices have to be made within those preset limits (hence the need for health economists). The present health budget, on the contrary, is set by the present administration, and there is no sufficient reason why we should have to choose between coronary artery bypass grafting and renal transplantation. If we cannot have guns and the medical equivalent of butter perhaps we could have fewer guns.

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1 Mooney GH, Tudman A. The NHS: efficiency need not be a dirty word. *Br Med J* 1984;288:1817-8.

Over the counter sale of topical corticosteroids

SIR,—Professor Sam Shuster's paper (6 July, p 38) contains a surprisingly reactionary view on over