

50 years; this conclusion is also supported by meta-regression of risk difference (figure C), which indicates that the incremental benefit of antipsychotics has shown no significant change for 50 years ( $p=0.39$ ).

One explanation is that this tendency towards worsened outcomes from 1960 to 2010 is a casual finding. Alternatively, it could reflect differences with time in other variables that could be further explored, particularly in these 24 randomised studies.

We declare that we have no conflicts of interest.

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- 1 Leucht S, Tardy M, Komossa K, et al. Antipsychotic drugs versus placebo for relapse prevention in schizophrenia: a systematic review and meta-analysis. *Lancet* 2012; **379**: 2063–71.
- 2 Vasques F, Messori A, Lucenteforte E, Biancari F. Immediate and late outcome of patients aged 80 years and older undergoing isolated aortic valve replacement: a systematic review and meta-analysis of 48 studies. *Am Heart J* 2012; **163**: 477–85.
- 3 Messori A, Fadda V, Maratea D, Trippoli S. Meta-analysis of observational studies to evaluate immediate outcomes after endarterectomy or stenting for carotid artery stenosis. *Ann Vasc Surg* (in press).
- 4 Messori A, Del Santo F, Fadda V, Maratea D, Trippoli S. Interpreting randomised trials evaluating newer agents or interferon in multiple sclerosis. *Eur J Clin Pharmacol* 2012; **68**: 1225–26.
- 5 Biondi-Zoccai GG, Abbate A, Agostoni P, et al. Long-term benefits of an early invasive management in acute coronary syndromes significantly depend on intracoronary stenting and aggressive antiplatelet treatment: a metaregression. *Am Heart J* 2005; **149**: 504–11.

### Authors' reply

Andrea Messori and colleagues' analysis is important because it shows that efficacy differences between antipsychotic drugs and placebo remained stable over time. We interpret this finding in a positive way, because in other areas early trials (of potentially lower quality) seem to have yielded larger differences than more recent ones.<sup>1</sup>

We feel that, overall, the definitions of relapse have broadened in more

recent studies, making the absolute risk of relapse for both drug and placebo groups larger. Expression of the difference as a risk ratio has the advantage that relative effect measures can account for some of the heterogeneity due to varying definitions of relapse.<sup>2</sup> That being said, we have now done a meta-regression based on relative risks, and this confirmed Messori and colleagues' analysis based on absolute risk differences, because it found no significant association between publication year and difference in relapse reduction (mixed effects, unrestricted, maximum-likelihood regression: slope 0.003, 95% CI –0.011 to 0.016,  $df=1$ ,  $p=0.70$ ).

We agree that the efficacy of most new second-generation antipsychotics is identical to that of most of the older first-generation antipsychotics, with a few exceptions (clozapine, amisulpride, olanzapine, and risperidone) which are somewhat more efficacious.<sup>3</sup> But we emphasise that the difference in relapse prevention between antipsychotic drugs and placebo for schizophrenia seems to be one of the largest effect sizes achieved by most of the commonly used drugs in medicine.<sup>1</sup>

Finally, we agree that large meta-analyses such as this one deserve further exploration. Further meta-regressions showed that the following were not significantly associated with relapse reduction at 7–12 months: sex (slope 0.003, 95% CI –0.011 to 0.016;  $p=0.70$ ); mean participant age (0.003, –0.024 to 0.019;  $p=0.82$ ); duration of illness in years (0.001, –0.022 to 0.024;  $p=0.93$ ); good versus bad or unclear compliance (test for subgroup differences heterogeneity  $Q=0.85$ ,  $df=1$ ,  $p=0.36$ ); and single-centre versus multiple-centre design ( $Q=0.10$ ,  $df=1$ ,  $p=0.75$ ).

SL has received honoraria as a consultant or member of advisory boards from Alkermes, Bristol-Myers Squibb, Eli Lilly, Janssen, Johnson & Johnson, Medavante, and Roche; lecture honoraria from AstraZeneca, Bristol-Myers Squibb, Eli Lilly, EssexPharma, Janssen, Johnson & Johnson, Lundbeck Institute, Pfizer, and Sanofi-Aventis; and

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- 1 Leucht S, Hierl S, Dold M, Kissling W, Davis JM. Putting the efficacy of psychiatric and general medicine medication in perspective: a review of meta-analyses. *Br J Psychiatry* 2012; **200**: 97–106.
- 2 Furukawa TA, Aketchi T, Wagenpfeil S, Leucht S. Relative indices of treatment effect may be constant across different definitions of response in schizophrenia trials. *Schizophr Res* 2011; **126**: 212–19.
- 3 Leucht S, Corves C, Arbreiter D, Engel RR, Li C, Davis JM. Second-generation versus first-generation antipsychotic drugs for schizophrenia: a meta-analysis. *Lancet* 2009; **373**: 31–41.

## The Irish health system and the economic crisis

The Irish economy has moved from roaring tiger to half-drowned kitten in the space of a few years, with knock-on effects for the health sector. From averaging more than 5% growth in the early 2000s, the economy shrank by over 10% between 2008 and 2010. Debt has ballooned from 25% of gross domestic product (GDP) in 2005 to more than 100% of GDP in 2010. Unemployment leapt from 4% to 14% in 4 years and the government has taken on the extensive debt of the banks. The bailout by the European Central Bank in late 2010 confirmed that there are no quick fixes for the current malaise of this multidimensional crisis.<sup>1</sup>

In consequence, the Irish health system has faced cuts to public funding of more than €2 billion, or a whopping 17% of the government health budget from 2010 to 2012. Health accounted for almost 30% of cuts to public expenditure between 2010 and 2012. These cuts have been achieved through general wage and fee reductions, voluntary

redundancies and non-replacement of retiring staff (with a reduction of 4000 staff between 2009 and 2011), and tough measures to manage demand and to squeeze efficiencies from the system.

Nevertheless, and perhaps surprisingly, the effects of this extensive liposuction of resources from the Irish health system are not all negative. Several measures of acute sector activity have improved, including day case ratios (up by 7% between 2009 and 2010<sup>2</sup>), day case surgery rates, and average length of stay (down, albeit marginally). This evidence suggests that the health system generally did well in adapting to the substantial reductions in expenditure and staffing, through maintaining and even improving access and some activity indicators. It is not all rosy, however, with ambulance response times both below target and worsening from 2009 to 2010.<sup>3</sup>

Part of the good performance might be explained by the availability of “fat” in the system, which could be removed without too much harm. Public-sector wage levels were high by European standards and the Celtic tiger boom years saw public resources pumped into health without corresponding increases in activity. As noted by Musgrove<sup>4</sup> in his reflections on South American health systems in crisis, “it is easier to fast if one is too fat to start with, and easier to become more efficient...if the system was initially wasteful”. The substantial increases in funding of the Irish health system in the boom years might well have allowed fat to accrue, which is now being removed.

Still, mistakes have been made. The removal of universal entitlement to free care for those older than 70 years in 2008 generated little revenue and much uncertainty and political discord. The imposition of a €0.50 charge per prescription item on the poor seems mean and could well affect appropriate compliance with

prescribed medicines. In all likelihood, the costs of collection will outstrip the revenue gained. The removal of some dentistry benefits for those on medical cards seems similarly inappropriate.

Yet perhaps more importantly, front-line services can no longer be guaranteed and there is concern in the system that the easy efficiencies and cuts have been made. With a further €750 million to be removed in the next two budgets, it is difficult to see further easy efficiencies. Consequently, more and more demoralised doctors and nurses are choosing to vote with their feet, or their air ticket, and migrate.

A further key concern is that the continued austerity might imperil the government’s plans to deliver universal health care.<sup>5</sup> Free primary care and universal access to health insurance are key pillars of government policy for the first time in the history of the Irish state. Continued liposuction might remove more than just fat.

The Irish Health Research Board funds the research project “Resilience of the Irish Health System: surviving and utilising the economic contraction”. ST is the principal investigator on this project and RL is a collaborator. The project provides salary funding for CK and SB.

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- 1 Ó Cinnéide S. Annual national report 2009: pensions, health and long-term care—Ireland. [http://www.socialprotection.eu/files\\_db/292/asisp\\_ANR09\\_Ireland.pdf](http://www.socialprotection.eu/files_db/292/asisp_ANR09_Ireland.pdf) (accessed Jan 17, 2012).
- 2 Health Service Executive. National service plan 2011. Dublin: HSE, 2011.
- 3 Health Service Executive. Corporate plan report: report against the HSE corporate plan 2008–11. Dublin: HSE, 2011.
- 4 Musgrove P. Economic crisis and health policy reform. In: Tapinos GP, Mason A, Bravo J. Demographic responses to economic adjustment in Latin America. New York: Oxford University Press, 1997.
- 5 Fine Gael, Labour Party. Government for national recovery 2011–2016. Dublin: Fine Gael/Labour Party, 2011.

## Latin American medical journals indexed by Thomson ISI

One of the most important challenges for Latin America today is to achieve a higher volume and quality of scientific publications. Scientific journals are the medium of communication and measurement of science.

The impact of a journal can be measured in several ways, the most common being the impact factor, which is low in Latin American journals.<sup>1</sup> This can be partly explained by the fact that most Latin American journals are published in their native language rather than in English, the latter being the factor governing most international journals with a higher impact factor.<sup>2</sup> Indices of scientific publications are another way to assess the quality and visibility of a journal, with the Thomson Institute for Scientific Information (ISI) being the most respected.

We did a search of the Latin American journals indexed by ISI,<sup>3</sup> and identified medical and public health journals. We did not include in the analysis countries that did not have medical journals in ISI. We also analysed the language of publication of the medical journals by looking at information provided on the official websites of these journals.

The countries with the highest number of ISI journals in Latin America are Brazil, Chile, Mexico, and Colombia

	Total journals	Medical journals	Native language only	English only	Bilingual	Trilingual
Brazil	139	33	1	12	10	10*
Chile	49	3	3	0	0	0
Mexico	43	6	3	1	2	0
Colombia	23	1	0	0	0	1
Argentina	21	6	3	0	3†	0
Venezuela	14	4	0	0	3	1
Ecuador	1	1	1	0	0	0
Total	290	54	11	13	18	12

Bilingual= native language plus English. Trilingual= Spanish, Portuguese, and English.  
\*Three journals also publish in French. †One journal publishes in Spanish plus Portuguese.

**Table: Distribution by country of Latin American journals indexed by the Thomson Institute for Scientific Information (ISI)**