Correspondence

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 causal 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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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.1

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.2 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 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.3 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.4

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 is primary investigator of a trial for which Eli Lilly has provided medication. Supported by a grant from the Bündersministerium für Bildung und Forschung, number 01KG0816 88166528. MT and JD declare that they have no conflicts of interest.

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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.


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% in 2005 to more than 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.1

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), 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.

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 and the Celtic tiger boom years saw public resources pumped into health without corresponding increases in activity. As noted by Musgrove 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 between 2009 and 2010, day case ratios (up by 7% between 2009 and 2010), 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.

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. 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.

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, 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.

<table>
<thead>
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<th>Country</th>
<th>Total journals</th>
<th>Medical journals</th>
<th>Native language only</th>
<th>English only</th>
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<th>Trilingual</th>
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<td>11</td>
<td>13</td>
<td>18</td>
<td>12</td>
</tr>
</tbody>
</table>

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

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