



Coronary heart disease prevention: insights from modelling incremental cost effectiveness

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Primary care

 Editorial by Warburton

Coronary heart disease prevention: insights from modelling incremental cost effectiveness

Tom Marshall

Abstract

Objective To determine which treatments for preventing coronary heart disease should be offered to which patients by assessing their incremental cost effectiveness.

Design Modelling study

Data sources Cost estimates (for NHS) and estimates of effectiveness obtained for aspirin, antihypertensive drugs, statins and clopidogrel.

Data synthesis Treatment effects were assumed to be independent, and cost per coronary event prevented was calculated for treatments individually and in combination across patients at a range of coronary risks.

Results The most cost effective preventive treatments are aspirin, initial antihypertensive treatment (bendrofluazide and atenolol), and intensive antihypertensive treatment (bendrofluazide, atenolol and enalapril), whereas simvastatin and clopidogrel are the least cost effective (cost per coronary event prevented in a patient at 10% coronary risk over five years is £3500 for aspirin, £12 500 for initial antihypertensives, £18 300 for intensive antihypertensives, £60 000 for clopidogrel, and £61 400 for simvastatin). Aspirin in a patient at 5% five year coronary risk costs less than a fifth as much per event prevented (£7900) as simvastatin in a patient at 30% five year risk (£40 800).

Discussion A cost effective prevention strategy would offer aspirin and initial antihypertensive treatment to all patients at greater than 7.5% five year coronary risk before offering statins or clopidogrel to patients at greater than 15% five year coronary risk. Incremental cost effectiveness analysis of treatments produces robust, practical cost effectiveness rankings that can be used to inform treatment guidelines.

Introduction

Coronary heart disease is a major cause of morbidity and mortality, and its prevention has assumed increasing importance in UK health policy.¹ Several treatments reduce risk of coronary disease, the absolute benefits of treatment are proportional to pretreatment risk, and individual patients may be eligible for more than one treatment. Moreover, it is argued that treatments for lowering blood pressure and cholesterol are equally effective whether or not blood pressure or cholesterol levels exceed arbitrary thresholds.² This means that virtually all patients might benefit from risk lowering treatments.

A previous analysis explored rational identification strategies for coronary heart disease prevention in primary care, ranking patients by their likelihood of benefiting from treatment.³ Given that health service resources are finite, a

rational approach to treatment would offer patients treatments in order of their expected cost effectiveness. This requires knowledge of the incremental benefits of risk lowering treatments in relation to their incremental costs. Incremental cost effectiveness analysis provides a means of ranking treatments by calculating the incremental changes in both costs and benefits. Although widely advocated, it has seldom been used outside the evaluation of screening programmes. This paper presents an incremental cost effectiveness analysis of risk lowering treatments in patients at varying levels of risk. The treatments analysed are aspirin, initial antihypertensive treatment, intensive antihypertensive treatment, a statin, and clopidogrel.

Methods

Costs

Costs are considered from the perspective of the health service and are discounted at 6% per year.⁴ There are two main components to the costs of long term treatment—follow up costs and prescribing costs.

Follow up costs are based on two clinic appointments (of 15 minutes each) a year with a practice nurse. The total health service cost of a practice nurse clinic is £31 an hour.⁵ Patients taking thiazide diuretics require annual measurement of serum electrolytes and uric acid. Patients taking statins require annual measurement of serum lipid concentrations and liver function tests. I derived costs of blood tests from local standard costs of pathology services compiled by the London School of Hygiene and Tropical Medicine in 1996 (personal communication, Rheingold Gruen) and adjusted for annual price inflation of 6%.

Prescribing costs include drug and dispensing costs. I obtained drug costs from the *British National Formulary*⁶ and calculated dispensing costs at 87.4 pence per prescribed item on the assumption that four prescriptions are issued a year.⁷ Initial antihypertensive treatment is with bendrofluazide (bendroflumethiazide) 2.5 mg and atenolol 50 mg; further antihypertensive treatment adds enalapril 20 mg to these treatments. Cholesterol lowering is with simvastatin 40 mg. Clopidogrel is given at a dose of 75 mg daily.

Effectiveness

I calculated benefits of treatment as major coronary events (myocardial infarctions, new cases of angina, and cardiac deaths) prevented over five years, with the benefits discounted at 1.5% per annum in keeping with current guidelines from the National Institute for Clinical Excellence.⁴

In the base case analysis, I calculated cost effectiveness for a patient whose pretreatment five year coronary risk is 10%.⁸ This

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is the coronary risk of a non-diabetic, non-smoking man aged 62 with blood pressure of 160/98 mm Hg, total serum cholesterol concentration of 6.5 mmol/l, and high density lipoprotein cholesterol concentration of 1.3 mmol/l. Under current guidelines he is eligible for antihypertensive treatment, a statin, and aspirin.⁹

For each intervention, I derived relative risk of coronary heart disease from a recent meta-analysis. The relative risk of coronary events for patients taking aspirin is 0.72 (95% confidence interval 0.60 to 0.87).¹⁰ Aspirin also increases in incidence of major bleeding by 0.3% (0.2% to 0.4%) over five years of treatment.¹⁰ To take account of this, I offset the absolute reduction in coronary risk over five years by 0.3%, thus giving major bleeding events equal weight to coronary events. Compared with aspirin, the relative risk of a coronary event while taking clopidogrel is 0.88 (0.76 to 1.01).¹¹ Empirical studies suggest that an indirect estimate of the effects of clopidogrel compared with placebo should be accurate provided that the population groups in studies are similar.¹² Compared with placebo, the relative risk of a coronary event with clopidogrel is therefore 0.63 (0.45 to 0.82) ($0.63 = 0.72 \times 0.88$).

Compared with placebo, the relative risk of a coronary event with antihypertensive treatment is 0.83 (0.72 to 0.91).¹³ Compared with initial antihypertensive treatment, the relative risk of a coronary event with intensive antihypertensive treatment is 0.81 (0.67 to 0.98).¹⁴ The relative risk of intensive antihypertensive treatment in comparison with placebo is therefore 0.67 (estimated 95% confidence interval 0.49 to 0.85). The relative risk of a coronary event with a statin is 0.69 (0.64 to 0.74).¹⁵

In clinical trials the relative risk of coronary events with preventive treatments is similar in patients taking additional treatments and in those who are not.¹⁶ This supports the view that treatment effects are independent.¹⁷ This view is also biologically plausible, since treatments act through different mechanisms. If treatment effects are independent the relative risk with two or more treatments is the product of the relative risk on each treatment. For example, the relative risk of a coronary event with aspirin is 0.72, with a statin is 0.69, and with aspirin and a statin is 0.50 ($0.50 = 0.72 \times 0.69$).

Average cost effectiveness

I calculated the cost of each intervention over a five year time horizon, and calculated the reduction in absolute coronary risk by subtracting post-treatment risk from pretreatment risk. Post-treatment risk is the product of pretreatment risk and the relative risk with treatment. In the case of aspirin, 0.3% is subtracted from the reduction in absolute coronary risk to take account of major adverse effects. The cost effectiveness ratio (cost per event prevented) is the total cost divided by the reduction in absolute coronary risk. I estimated the average cost per

coronary event prevented for each treatment used alone. In a sensitivity analysis I calculated maximum and minimum costs per event prevented for each of the interventions using the upper and lower 95% confidence limits for effectiveness. The average cost effectiveness rankings inform the order in which treatments would be offered in an incremental cost effectiveness analysis. To test the robustness of cost effectiveness rankings, I explored the effects of changes in the costs of interventions and the frequency of adverse effects alongside changed assumptions about effectiveness.

Incremental cost effectiveness

An efficient prevention strategy would offer the most cost effective treatment first, then the next most cost effective treatment, and so on. This enables the largest possible proportion of the benefits of treatment to be achieved at the lowest possible cost. The incremental cost effectiveness ratio is the additional cost associated with adding each treatment divided by the additional benefit of the treatment.

Incremental cost per event prevented is calculated in much the same way as the average cost per event prevented. The incremental cost of treatment includes only additional costs of treatment. The incremental reduction in absolute coronary risk is calculated by subtracting post-treatment risk from pretreatment risk. Post-treatment risk is the product of pretreatment risk and the relative risk on the additional treatment. However, pretreatment risk is the post-treatment risk after any previous treatments. In the case of aspirin, 0.3% is subtracted from the reduction in absolute coronary risk to take account of adverse effects. The cost effectiveness ratio (cost per event prevented) is the total cost divided by the reduction in absolute coronary risk.

A sensitivity analysis tested the robustness of cost effectiveness ratios by changing assumptions about effectiveness and identifying the threshold costs at which cost effectiveness rankings would change. Since the cost per coronary event prevented decreases as patients' coronary risk increases, I also investigated the cost effectiveness of coronary disease prevention in patients at a range of five year coronary risks.

Results

Average cost effectiveness

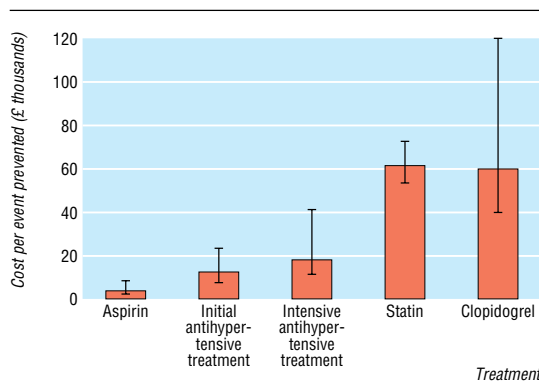
In a patient at 10% coronary risk over five years, aspirin is the most cost effective risk lowering treatment, at £3500 per coronary event prevented. Initial antihypertensive treatment costs £12 500, intensive antihypertensive treatment costs £18 300, clopidogrel costs £60 000, and simvastatin costs £61 400 per coronary event prevented (table 1).

In a sensitivity analysis I calculated the cost per event prevented for each intervention if its effectiveness was given by

Table 1 Average costs, effects, and cost effectiveness of preventive treatments in a patient at 10% risk of a coronary event over five years

Treatment	Relative risk with treatment (A)	Adverse event rate per 5 years (B)	Absolute risk reduction per 5 years		Discounted costs per 5 years*				Cost per event prevented (I=H/D)
			Simple (C=10%×(1-A)-B)	Discounted (D=C×(discount factor))	Prescribing (E)	Laboratory investigations (F)	Follow up (G)	Total (H=E+F+G)	
Aspirin 75 mg	0.72	0.3%	2.5%	2.4%	£19	£0	£65	£85	£3 500
Bendrofluzide 2.5 mg + atenolol 50 mg	0.83	0.0%	1.7%	1.7%	£124	£19	£65	£208	£12 600
Bendrofluzide 2.5 mg, atenolol 50 mg, + enalapril 20 mg*	0.67	0.0%	3.3%	3.2%	£497	£19	£65	£581	£18 300
Clopidogrel 75 mg	0.63	0.0%	3.7%	3.6%	£2071	£0	£65	£2136	£60 100
Simvastatin 40 mg	0.69	0.0%	3.1%	3.0%	£1744	£39	£65	£1848	£61 400

*Costs have been discounted at 6% and benefits at 1.5% in accordance with NICE guidelines.



Average cost effectiveness of preventive treatments in a patient at 10.5% risk of a coronary event over five years. (Error bars represent cost per coronary event prevented if effectiveness is at upper and lower 95% confidence limit)

the upper and lower 95% confidence limits of the estimates (see figure). The cost effectiveness of aspirin, initial antihypertensive treatment, and intensive antihypertensive treatment are sensitive to changes in assumptions about effectiveness. However, for simvastatin to be of similar cost effectiveness to intensive antihypertensive treatment, the relative risk with treatment must be at the lower 95% confidence interval and the cost of the drug 65% lower. This is unlikely, as drug prices typically fall by less than 50% when they come off patent. There is a wide degree of uncertainty about the cost effectiveness of clopidogrel, reflecting uncertainty about the relative risk on treatment.

Varying the discount rates for either costs or benefits from 0% to 10% has no effect on rankings. Using a general practitioner for follow up has no effect on cost effectiveness rankings. Cost effectiveness of initial and intensive antihypertensive treatment is sensitive to increases in the price of drugs. If sufficiently high cost drugs are used (such as for brand name calcium channel blockers) the cost per event prevented with initial antihypertensive drugs is as high as with a statin.

Incremental cost effectiveness of additional treatments

Costs of follow up clinic visits do not increase with extra treatments. The incremental costs of additional treatments therefore include only additional drug costs and additional laboratory investigations. The incremental effectiveness of additional drugs is also smaller than their effectiveness as initial treatments because incremental effects act on progressively smaller pretreatment risks.

If a patient at 10% five year coronary risk is given combination treatments in order of their cost effectiveness, the incremental cost per event prevented rises with each additional treatment. Compared with placebo, clopidogrel is more cost effective than simvastatin. However, clopidogrel as a replacement for aspirin

provides little additional benefit at substantial extra cost. It is therefore the least cost effective in an incremental analysis. Incremental costs per event prevented are £3500 for aspirin, £12 000 for initial antihypertensive treatment, £33 900 for enalapril, £122 400 for simvastatin, and £527 200 for clopidogrel (table 2).

I carried out a sensitivity analysis to investigate the effects of varying the costs and effectiveness of treatments. The most favourable assumption for simvastatin is that relative risks for all other treatments are at the upper 95% confidence limit and for simvastatin is at the lower 95% confidence limit. If this is the case, the incremental costs per event prevented are £8700 for aspirin, £18 800 for initial antihypertensive treatment, £243 000 for intensive antihypertensive treatment, £65 800 for simvastatin, and £177 300 for clopidogrel. Even under these assumptions, the price of simvastatin would have to fall by 70%, and the price of clopidogrel by more than 90%, to be of similar cost effectiveness to initial antihypertensive treatment.

Further analysis

Under the base case analysis, the cost effectiveness rankings of all five treatments are the same for any patient with a five year coronary risk greater than 1.5%. The incremental cost per event prevented in a patient at 5% five year coronary risk is £7900 with aspirin and £24 000 with initial antihypertensive treatment. This is less than the incremental cost per event prevented with simvastatin (£40 800) in a patient at 30% five year coronary risk (see table 3)

The most extreme assumptions we can make are to assume that relative risk on all treatments is at the upper 95% confidence limit (least effective) and assume that the relative risk with simvastatin is at the lower 95% confidence limit (most effective). Under these assumptions, the cost per event prevented with aspirin in a patient at 7.5% five year risk would be £12 900 and the cost per event prevented with simvastatin in a patient at 15% five year risk would be £13 200.

Discussion

This analysis confirms the poor cost effectiveness of statins and clopidogrel compared with aspirin and antihypertensive treatment.^{18 19} By quantifying the treatments' cost effectiveness, the analysis suggests it is likely to be more cost effective to treat patients at 5% five year coronary risk with aspirin than to prescribe further antihypertensive treatment or statins to patients at 30% five year risk.

Limitations of study

A weakness of this analysis is that some of the findings are sensitive to the choice of drug. This is particularly true of the cost effectiveness of initial antihypertensive treatment, where drug prices range from £10 to £290 a year. However, consideration of

Table 2 Incremental costs of preventive treatments in combination per event avoided in a patient at 10% risk of a coronary event over five years

Additional treatment	Incremental relative risk with treatment (A)	Adverse event rate per five years (B)	5 year coronary risk with this treatment (C=10%×(cumulative product of A))*	Incremental risk reduction		Incremental cost	
				Simple (D=C×A-B)	Discounted (E=D×(discount factor))	Discounted (F)	Per event prevented (G=F/E)
Aspirin 75 mg + follow up	0.72	0.3%	7.2%	2.5%	2.4%	£85	£3 500
Bendrofluzide 2.5 mg + atenolol 50 mg	0.83	0.0%	6.0%	1.2%	1.2%	£143	£12 000
Enalapril 20 mg	0.81	0.0%	4.8%	1.1%	1.1%	£374	£33 900
Simvastatin 40 mg	0.69	0.0%	3.3%	1.5%	1.5%	£1783	£122 400
Clopidogrel 75 mg (replaces aspirin)†	0.88	0.0%	2.9%	0.4%	0.4%	£2051	£527 200

*10% (risk with no treatment) multiplied by cumulative product of A (A for each of the rows above (the effects of all previous treatments)).

†Because clopidogrel is not prescribed with aspirin, it replaces aspirin in the incremental analysis; this results in clopidogrel having the highest incremental cost per event prevented even though it had only the second highest individual cost per event prevented.

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Table 3 Incremental cost per event prevented of treating patients at a range of pretreatment risks of a coronary event over five years

Treatment	Pretreatment coronary risk over 5 years						
	5%	7.5%	10%	15%	20%	25%	30%
Aspirin 75 mg + follow up	£7 900	£4 900	£3 500	£2 200	£1 600	£1 300	£1 100
Bendroflumazide 2.5 mg + atenolol 50 mg	£24 000	£16 000	£12 000	£8 000	£6 000	£4 800	£4 000
Enalapril 20 mg	£67 800	£45 200	£33 900	£22 600	£16 900	£13 600	£11 300
Simvastatin 40 mg	£244 800	£163 200	£122 400	£81 600	£61 200	£49 000	£40 800
Clopidogrel 75 mg	£1 054 400	£702 900	£527 200	£351 500	£263 600	£210 900	£175 700

every possible antihypertensive regimen is beyond the scope of this paper.

The analysis may overestimate the benefits of some interventions. Estimates of the effects of intensive antihypertensive treatment are derived from studies comparing less intensive with more intensive treatment.¹⁴ But the estimate of the benefits of initial antihypertensive treatment include all blood pressure lowering, not just less intensive treatment.¹³ The additional benefits of intensive antihypertensive treatment may therefore be exaggerated.

Apart from major bleeding due to aspirin, the analysis takes no account of adverse effects of treatment. Adverse effects may be considered as minor and reversible on stopping treatment or as major and irreversible. However, major adverse event rates would have to be 0% with a statin and to exceed 2.5% per five years with aspirin and 1.3% with initial antihypertensive treatment for the statin to be more cost effective than the latter two treatments. Minor, reversible adverse effects have little impact on the analysis because patients who stop treatment incur neither further costs nor further benefits. Even if all patients who experience adverse effects discontinue treatment but continue to be followed up, these differences make no differences to the cost effectiveness rankings. Evidence suggests that patients taking a statin report fewer adverse effects than those taking a placebo.²⁰ Among patients taking two low dose antihypertensive drugs, 7.5% reported adverse effects, but few (<1%) were sufficiently severe to stop treatment and almost all were reversible.²¹ With aspirin, 3.9% of patients report adverse effects,²² but excess risk of major bleeding is under 0.5%.¹⁰

Conclusion

Incremental cost effectiveness analysis of treatments produces robust, practical cost effectiveness rankings. Authors of guidelines should take account of this when making treatment recommendations. If the aim of treatment is to maximise prevention of coronary disease, these results have clear implications for current treatment recommendations. They cast doubt on the wisdom of present policy, which emphasises achievement of target blood pressures and the use of statins for people at 15% five year risk of a coronary event.²³ A more efficient prevention strategy would be to offer aspirin and initial antihypertensive treatment to all people at over 7.5% five year coronary risk before offering statins to patients at 30% five year risk. According to national survey data, 87% of men and 56% of women aged over 65 are at over 7.5% five year risk.²⁴

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Competing interests: None declared.

Ethical approval: Not applicable.

- 1 Department of Health. Chapter 2: Preventing coronary heart disease in high risk patients. In: *National service framework for coronary heart disease*. London: DoH, 2000:1-32.
- 2 Law MR, Wald NJ. Risk factor thresholds: their existence under scrutiny. *BMJ* 2002;324:1570-6.
- 3 Marshall T, Rouse A. Resource implications and health benefits of primary prevention strategies for coronary disease in people aged 30 to 74: mathematical modelling study. *BMJ* 2002;325:197-9.

What is already known on this topic

Aspirin, antihypertensive treatment, statins, and clopidogrel are all effective in preventing coronary heart disease

These drugs vary in their cost effectiveness, and a rational prevention strategy would offer the most cost effective treatments first

What this study adds

Most of the benefits of prevention can be achieved with aspirin and antihypertensive treatment at a fraction of the cost of simvastatin or clopidogrel

Treating a patient with a five year coronary risk of 7.5% with aspirin and low cost antihypertensives is more cost effective than treating a patient with 30% coronary risk with a statin

Clinical guidelines should be informed by analysis of the incremental costs and incremental benefits resulting from each additional treatment

- 4 National Institute for Clinical Excellence. *NICE technical guidance for manufacturers and sponsors on making a submission to a technology appraisal*. London: NICE, 2001.
- 5 Netten A, Curtill L. *Unit costs of health and social care 2001*. Canterbury: Personal Social Services Research Unit, University of Kent, 2001.
- 6 British Medical Association, Royal Pharmaceutical Society of Great Britain. *British national formulary*. London: BMA, RPS, 2002. (No 44.)
- 7 Prescription Pricing Authority. *Drug tariff*. London: Stationery Office, 2002.
- 8 Anderson KM, Wilson PWF, Odell PM, Kannel WB. An updated coronary risk profile. A statement for health professionals. *Circulation* 1991;83:356-62.
- 9 British Cardiac Society, British Hyperlipidaemia Association, British Hypertension Society, endorsed by British Diabetic Association. Joint British recommendations on prevention of coronary heart disease in clinical practice. *Heart* 1998;80(suppl 2):S1-29.
- 10 Hayden M, Pignone M, Phillips C, Mulrow C. Aspirin for the primary prevention of coronary events: a summary of the evidence for the US Preventive Services Task Force. *Ann Intern Med* 2002;136:161-72.
- 11 Hankey GJ, Sudlow CLM, Dunbabin DW. Thienopyridine derivatives (ticlopidine, clopidogrel) versus aspirin for preventing stroke and other serious vascular events in high vascular risk patients. *Cochrane Database Syst Rev* 2000;(2):CD001246.
- 12 Song F, Altman DG, Glenny AM, Deeks JJ. Validity of indirect comparison for estimating efficacy of competing interventions: empirical evidence from published meta-analyses. *BMJ* 2003;326:472.
- 13 Gueyffier F, Boutitie F, Boissel JP, Pocock S, Coope J, Cutler J, et al, for the INDANA Investigators. Effect of antihypertensive drug treatment on coronary outcomes in women and men. A meta-analysis of individual patient data from randomized, controlled trials. *Ann Intern Med* 1997;126:761-7.
- 14 Blood Pressure Lowering Treatment Trialists' Collaboration. Effects of ACE inhibitors, calcium antagonists, and other blood pressure-lowering drugs: results of prospectively designed overviews of randomised trials. *Lancet* 2000;356:1955-64.
- 15 LaRosa JC, He J, Vupputuri S. Effect of statins on risk of coronary disease: a meta-analysis of randomized controlled trials. *JAMA* 1999;282:2340-6.
- 16 Heart Protection Study Collaborative Group. MRC/BHF heart protection study of cholesterol lowering with simvastatin in 20 536 high-risk individuals: a randomised placebo controlled trial. *Lancet* 2002;360:7-22.
- 17 Yusuf S. Two decades of progress in preventing vascular disease. *Lancet* 2002;360:2-3.
- 18 Gaspoz J-M, Coxson PG, Goldman PA, Williams LW, Kuntz KM, Hunink MGM, et al. Cost-effectiveness of aspirin, clopidogrel, or both for secondary prevention coronary heart disease. *N Engl J Med* 2002;346:1800-6.
- 19 Ebrahim S, Davey Smith G, McCabe C, Payne N, Pickin M, Sheldon TA, et al. What role for statins? A review and economic model. *Health Technol Assess* 1999;3(19):i-iv, 1-91.
- 20 Law MR, Wald NJ, Rudnicka AR. Quantifying effect of statins on low density lipoprotein cholesterol, ischaemic heart disease, and stroke: systematic review and meta-analysis. *BMJ* 2003;326:1423.
- 21 Law MR, Wald NJ, Morris JK, Jordan RE. Value of low dose combination treatment with blood pressure lowering drugs: analysis of 354 randomised trials. *BMJ* 2003;326:1427.
- 22 Wald NJ, Law MR. A strategy to reduce cardiovascular disease by more than 80% *BMJ* 2003;326:1419.

23 Department of Health. *National service framework for coronary heart disease*. London: DoH, 2000.

24 *Health Survey for England 1998*. London: Stationery Office, 2000.

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these qualities. However, we saw no differences in previous academic performance by group (table 2).

A further argument against selection bias being a serious limitation in this study is the school's selection procedure. The three elements that contribute to this process are performance in a national admission test of reasoning and problem solving in the basic sciences and humanities, performance in a previous undergraduate degree, and performance at a standardised interview that rewards evidence of self directedness, teamwork, communication skills, compassion, resourcefulness, and broad life skills. Thus, all medical students at Flinders are likely to be resourceful and talented high achievers.

Other qualities that could be over-represented in students in the rural programme and Darwin groups, such as seeking adventure, interest in rural medicine as a career, being suited to rural life, and having fewer ties with the city, show only the student centred benefits of offering different environments to suit the needs of different students. There is no suggestion that such qualities inherently affect academic performance, but when a student's self perceived traits are matched to an environment that supports them, their academic performance may be enhanced. This should, however, have been equally true for students who chose to study in the tertiary centre.

Our analysis accounted for the other possible biases of student age, sex, year 2 score, and cohort effect. The results cannot be explained by the Hawthorne effect as they have been sustained over five years and during this time the rural and Darwin programmes have become a routine part of the school's study options. The results may also be criticised for reflecting the effect of group size rather than location. However, on a day to day basis, students in all of the locations were allocated to practices or wards in pairs or alone, and tutorial group sizes were also similar.

Future of community learning

When the rural and Darwin programmes were initiated, the university had some concerns that student learning would be compromised in pursuit of the longer term workforce aims. The quality of the students' examination performance in the regional hospital, and, in particular, in the community setting, has allayed this concern. Our findings challenge the orthodoxy of a tertiary hospital being the most appropriate location for all undergraduate medical students.

In 2001, the Australian Commonwealth government announced a national programme that will require each medical school to enable a quarter of its students to undertake half of their clinical education in rural or remote settings. Although some students will learn better in large urban settings, our findings should give students confidence that they do not have to sacrifice academic performance when taking advantage of such learning opportunities.

Contributors: PW conceived and led the research and manuscript preparation. AE led the statistical analysis of the data. DP contributed to the study design and to the analysis of the educational implications of the findings. PW is the guarantor.

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- Oswald N, Alderson T, Jones S. Evaluating primary care as a base for medical education: the report of the Cambridge community-based clinical course. *Med Educ* 2001;35:782-8.
- Murray E, Jolly B, Modell M. Can students learn clinical method in general practice? A randomised crossover trial based on objective structured clinical examinations. *BMJ* 1997;315:920-3.
- Irby DM. Teaching and learning in ambulatory care settings: a thematic review of the literature. *Acad Med* 1995;70:898-931.
- Undergraduate general practice [editorial]. *Lancet* 1989;i:702-3.
- Finucane P, Nichols F, Gannon B, Runciman S, Prideaux D, Nicholas T. Recruiting problem-based learning (PBL) tutors for a PBL-based curriculum: the Flinders university experience. *Med Educ* 2001;35:56-61.
- Worley P, Silagy C, Prideaux D, Newble D, Jones A. The parallel rural community curriculum: an integrated clinical curriculum based in rural general practice. *Med Educ* 2000;34:558-65.
- Prideaux D. Researching the outcomes of educational interventions: a matter of design. *BMJ* 2002;324:126-7. (Accepted 10 October 2003)

Corrections and clarifications

Coronary heart disease prevention: insights from modelling incremental cost effectiveness

Our complex ELPS (electronic long, paper short) system got the better of us in this paper by Tom Marshall (*BMJ* 2003;327:1264-7). In the full (bmj.com) version, the figure shows the average cost effectiveness of preventive treatments based on a patient at 10% risk [not 10.5% risk, as stated in the caption] of a coronary event over five years. The value was correct in the abridged version (both in print and on bmj.com).

Meadow faces GMC over evidence given in child death cases

A statement in this News article by Owen Dyer about a new working party set up to produce a national protocol for investigating sudden infant deaths was wrong (3 January, p 9; doi:10.1136/bmj.328.7430.9). The working party was not set up by the government. It was set up jointly by the Royal College of Pathologists and the Royal College of Paediatrics and Child Health, although the Department of Health is represented on it.

Obituary

In this obituary of Allan J Erslev by Janice Hopkins Tanne (3 January, p 52; doi:10.1136/bmj.328.7430.52), we should have said that Dr Sandor S Shapiro [not Jaime Caro] succeeded Dr Erslev as director of the Cardeza Foundation for Hematologic Research at Jefferson Medical College of Thomas Jefferson University in Philadelphia, Pennsylvania. Dr Shapiro gave up that position in 2000 and is now research professor of physiology at the college.

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