Letters

- Privatization of health care
- Spirometry in primary care practices

Privatization of health care

Marcia Angell has made a very timely and important statement on the privatization of health care.¹ There are only 2 objections that need to be addressed before they are raised by the proponents of private health care.

First, there is a strong argument that patients have the right to spend their disposable income as they choose and also that physicians have the right to choose their financial arrangements if they are in private practice. Clearly, the private system must not be allowed to undermine the public system. However, I believe that only a small minority of patients could afford to pay for private health care. Consequently, only a small number of physicians would be able to support themselves in private practice. Thus, this may well be a stable, self-regulating and acceptable arrangement. This needs to be researched.

Second, I am concerned that Angell's comparison of 2 very different systems may not be entirely valid. In the recent past the United States has been a much wealthier country than Canada, and, of course, it has a much larger population. These differences may make it difficult to make direct comparisons.

In Canada we have never had a definition of the "medically necessary care" mentioned in the Canada Health Act. When I was a medical student and a young physician in the 1950s and 1960s, the physician decided what care was medically necessary. With the welcome advent of medicare, the definition was increasingly set by the paying agency in negotiation with organized medicine. Now, with an increasing recognition of patient autonomy, the definition tends to be set by the patient.

As a result, there has been lobbying by patients for public funding of alternative medicine and other additional services.

My opinion is that the current so-called fee-for-service system is broken and most of it should be discarded. In family medicine the capitation system has much to recommend it, with the addition of a fee schedule for a short list of specific services, such as night services and services that require procedural skills beyond the usual ones.

Brian Dixon-Warren MBBS

Family physician (retired), Saturna Island, British Columbia

Competing interests: None declared.

REFERENCE

1. Angell, M. Privatizing health care is not the answer: lessons from the United States. *CMAJ* 2008; 179:916-9.

DOI:10.1503/cmaj.1080122

Spirometry in primary care practices

Matthew Stanbrook and Alan Kaplan recently discussed the merits and challenges of using office spirometry in primary care practices.¹ Their theme was driven to a large extent by a *CMAJ* research paper by Aaron and colleagues,² which reported that up to one-third of Canadian patients diagnosed as having asthma were misdiagnosed. The diagnosis of asthma in this study was confirmed in 16% of patients by postbronchodilator spirometry and in 72% of patients by bronchial challenge testing. Although I am able to appreciate Stanbrook and Kaplan's enthusiastic stand on this subject, I think they went too far in saying that "physicians who do not use spirometry for their asthma patients should not be managing asthma."

Given the results of Aaron and colleagues, one is tempted to advise busy family physicians to treat suspected asthma initially on the basis of the patient's history and physical findings and refer the patient for methacholine challenge testing. Unfortunately, such a recommendation does not take into ac-

count some of the limitations of the study, including the authors' strategy to perform only a single reversibility (bronchodilator challenge) test at the first study visit.² It is therefore not known whether more patients would have demonstrated an improvement in forced expiratory volume in 1 second (FEV₁) by at least 15% and at least 200 mL after salbutamol challenge during the period in which their asthma medications were reduced. Such information would have helped us to understand more fully the diagnostic potential of this strategy. Furthermore, the study by Aaron and colleagues included patients with an established diagnosis of asthma so their findings cannot be generalized to patients who typically present to their family physician for the first time with chest-related complaints.

I respectfully disagree with Stanbrook and Kaplan that asthma and chronic obstructive pulmonary disease can be reliably distinguished with objective testing. The study they cite to support this notion used a reduction of the ratio of FEV₁ to forced vital capacity (FEV₁/FVC) by less than 70% to establish a diagnosis of chronic obstructive pulmonary disease.³ Although the postbronchodilator FEV₁/FVC ratio provides important spirometric diagnostic information, it does not by itself confirm a specific clinical diagnosis because a reduced FEV₁/FVC ratio after bronchodilator administration can be observed in both patients with asthma and those with chronic obstructive pulmonary disease. To suggest otherwise may oversimplify the role of spirometry in clinical decision-making. The limitations of using reversibility to differentiate asthma and chronic obstructive pulmonary disease are known⁴ and were recently confirmed by the work of Tashkin and colleagues⁵ with a large cohort of patients with chronic obstructive pulmonary disease. Although a normalization of the postbronchodilator FEV₁/FVC ratio rules out chronic obstructive pulmonary disease, the data of Aaron and colleagues² suggest that spirometry provides a