As one highly respected health care analyst has written in *CMAJ*, "Canadians [should] re-embrace the core concept of a universal health care system in which the vast majority of services are provided by non-profit institutions with public accountability."[5]

So yes, we should ban kickbacks and limit self-referrals. But if we really want to get to the root of the problem (and perhaps improve quality at the same time), we should encourage policymakers to prohibit for-profit independent health facilities from providing medically necessary care.

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Elective cesarean section

It was with utter dismay and surprise that I read Mary Hannah's commentary on planned elective cesarean section.[1] Given that there has never been any scientific proof of benefit from unindicated surgery, how can the literature for indicated procedures be used to justify our willingness to acquiesce to the wishes of the consumer? And just because indicated procedures have low rates of complications and appear safe, we should not use those data to bend to current trends in consumerism. Are we physicians so afraid of disappointing the consumer that we are willing to perform unnecessary procedures? I find it rather hypocritical that we misuse and contort the literature to justify this approach and then turn around and call ourselves scientists practising evidenced-based medicine. If we want to practise what amounts to cosmetic surgery, then by all means, let's do so and bill patients for these services independently.

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Mary Hannah concludes her commentary on elective cesarean section[1] by suggesting that if, after appropriate counselling, a woman continues to perceive that the benefits of such a procedure outweigh the risks, her health and welfare "will be promoted by supporting her request."

In this regard, it is important that all evidence on the benefits and harms be presented to the prospective mother. The UK's National Institute of Clinical Excellence (NICE), which provides authoritative, robust and reliable guidance on current "best practice" to patients, health care professionals and the public,[2] is currently developing clinical guidelines on cesarean section,[3] expected to be released in April 2004 [the guidelines have now been published; see *CMAJ* 2004;170(12):1779.—Editor].

According to the draft document (page 27),[3] "maternal request is not on it's [sic] own an indication for [cesarean section]," and "pregnant women should be supported in whatever decision is made following these discussions." The draft (pages 19–21) provides current evidence on length of stay, abdominal pain, perineal pain, postpartum hemorrhage, infection, breastfeeding, bladder and urinary tract injuries, need for further surgery, risk of thromboembolic disease and many other clinical outcomes, the majority of these data favouring vaginal birth over cesarean section.

Women should have a right to exercise their choice on the mode of delivery even when there are no clinical indications for cesarean section. However, providing this procedure in a publicly funded system such as the UK's National Health Service would increase the overall cost, and the opportunity cost thus incurred might deny services that would be of benefit to other users of the service.

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I was disturbed to read Mary Hannah's commentary[1] outlining the possibility of the Society of Obstetricians and Gynaecologists of Canada (SOGC) supporting the option of medically unnecessary cesarean sections. I am disappointed that cesarean section would be offered when little consideration is given to options at the other end of the spectrum.