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.

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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 account 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 (FEV_1) 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 FEV_1 to forced vital capacity (FEV_1/FVC) by less than 70% to establish a diagnosis of chronic obstructive pulmonary disease.[3] Although the postbronchodilator FEV_1/FVC ratio provides important spirometric diagnostic information, it does not by itself confirm a specific clinical diagnosis because a reduced FEV_1/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 known[4] and were recently confirmed by the work of Tashkin and colleagues[5] with a large cohort of patients with chronic obstructive pulmonary disease. Although a normalization of the postbronchodilator FEV_1/FVC ratio rules out chronic obstructive pulmonary disease, the data of Aaron and colleagues[2] suggest that spirometry provides a

much lower yield than methacholine challenge testing in terms of asthma diagnosis in treated patients.

My intuitive enthusiasm for spirometry use is dampened by the reality that there is a lack of strong evidence on how we might best use this simple and important test. The question of whether appropriate quality control of spirometry can be ensured at the primary care level requires further study. Until such data are available, we should beckon family physicians who are not yet regularly using spirometry with a more tempered call to task.

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The authors respond:

We thank Anthony D'Urzo for his thoughtful comments. Our editorial stated that "asthma and chronic obstructive pulmonary disease are routinely confused clinically in adults and can only be reliably distinguished with objective testing."[1] We did not mean to imply by this that objective testing is always successful in distinguishing asthma and chronic obstructive pulmonary disease. Indeed, we agree with D'Urzo that there are many cases in which spirometry cannot separate the 2 conditions. However, there are many other cases in which asthma and chronic obstructive pulmonary disease can be distinguished clearly and in such cases spirometry often provides the only objective means of doing so.

Because optimal treatments for asthma and chronic obstructive pulmonary disease are often different, it is important to distinguish between these 2 conditions if at all possible. As with any other diagnostic test, spirometry alone does not make the diagnosis. Instead, the results of spirometry must be interpreted within their clinical context to establish or rule out a diagnosis. Therefore, further diagnostic testing is often needed, but this does not justify omitting spirometry nor does it remove the necessity of making a firm diagnosis whenever possible for our patients at some point during their chronic illness.

D'Urzo challenges our recommendation that spirometry should be mandatory in the management of asthma and instead suggests a strategy of treating first and testing later with methacholine challenge. Although we respect D'Urzo's point of view, we stand by our position. The proposed alternative strategy, although it would ensure that truly asthmatic patients were treated promptly, would result in many other patients being treated unnecessarily with medications that would not benefit them. Also, methacholine challenge is not ideal as an initial test because it cannot reliably distinguish asthma from other obstructive lung diseases such as chronic obstructive pulmonary disease, it often produces false-positive results if done within 6 weeks of a viral respiratory tract infection, and it may produce false-negative results if a controller medication has already been initiated.[2] Moreover, as methacholine challenge testing is even less available than spirometry, we fear that we would be advocating unattainable standards if our recommendations matched those of D'Urzo.

Given that spirometry can be administered at the point of care to confirm or rule out the presence of airflow obstruction reliably before a treatment decision is made, why not use it? Where barriers exist that challenge the feasibility of this approach, we must overcome them rather than succumb to them, to ensure that we provide our patients with the best care.

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