Show me the proof, Dr. Avery

The fall 1998 meeting during which US editorial writers met Dr. Granger Avery and Michael Decter reflects the abyss separating those who want more private care and those who support medicare's principles and see solutions not in its dissolution but in better management.[1]

Avery, a well-known devotee of expanded privatization, repeated statements that have become part of the mantra of privatizers. When these are used by those who favour a parallel private system, they should either be defended with objective data or discounted.[2–4]

For instance, Avery should present the data to support his statement that Canadians spend $1 billion annually buying health care in the US, not because they fall ill while visiting but because they have specifically sought care that is unavailable in Canada or lack trust in the Canadian system. Given that this number is quoted so often, it should not be too difficult for Avery to present the source of his information.

His contention that Canada, Cuba and North Korea are the only countries with single-payer systems is completely misleading. The Scandinavian countries and The Netherlands may have various sources of payment for health care services, but — irrespective of the source of payment — access to the system is the same, other than for marginal services such as hospital accommodation. That result is not substantially different from the Canadian system, where private insurance pays for non-core services, but health care benefits are paid from general taxation revenues rather than by a mixture of public pay and work-related insurance policies.

The real test is whether the system promotes as part of its essential premise and structure a person's ability to "buy" his way to preferential care. This is not part of the basic framework on which medicare is based. Canada's single-payer system can continue to provide Canadians with quality care that is equitably accessible. The challenge for us is to use our resources creatively rather than to expand the private tier to include core clinical services within our health care system.[5,6]

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References

1. Gray C. US editorial writers put Canadian health care under microscope. *CMAJ* 1998;159(11):1395-7.
2. Dirnfeld V. The benefits of privatization. *CMAJ* 1996;155:407-10.
3. Sky K. Should specialists support Canada's single-payer system? *Ann R Coll Physicians Surg Can* 1997;30:12-3.
4. Gunton RW. It's time to reintroduce a private component to the funding of health care. *Ann R Coll Physicians Surg Can* 1997;30:9-11.
5. Gordon M. A system worth saving. *CMAJ* 1996;154(9):1395-6.
6. Gordon M, Berger PB. The alluring myth of private medicine. *CMAJ* 1996;155(4): 404-6.

More than milk, eggs and orange juice

In his editorial on maternal nutrition,[1] Michael S. Kramer argues that the evidence does not strongly support the importance of maternal nutrition in determining the outcome of pregnancy in industrialized countries such as Canada. However, there is clear evidence to support the importance of nutritional risk factors in the prevention of both broad subgroups of low birth weight: small-for-gestational-age births (which result from intrauterine growth retardation) and prematurity (which accounts for most low-birth-weight births in developed countries).

Low birth weight, which Kramer calls "*not* a very useful outcome" (emphasis in the original) has been described as "one of the most important biologic predictors of infant death and deficiencies in physical and mental development during childhood among those babies who survive."[2] The World Health Organization recommends the use of Williams' birthweight curve to diagnose small-for-gestational-age births. The cut-off for a small-for-gestational-age term infant is 2900 g, and mounting evidence indicates that infants whose birth weight is above 2500 g but below about the 10th percentile still have higher health and nutrition risks than those whose birth weight is above the 10th percentile.[2]

In a 1987 meta-analysis[3] Kramer concluded that in developed countries the most important risk factors for intrauterine growth retardation were low maternal energy intake or weight gain and low pregravid weight, and that low pre-pregnancy weight was the only important nutrition-related risk factor for preterm birth. A more recent study found that both preterm labour and small-for-gestational-age births were associated with several factors, including low pre-pregnancy weight and low weekly maternal weight gain.[4] Other studies have found a relation between gestational weight gain and preterm delivery.[5–7] In 2 of these,[6,7] inadequate weight gain during the last half of pregnancy or the third trimester was associated with a higher risk of preterm birth.