mentioned the "detailed list of quibbles" put forward by the US Department of Health and Human Services,[5] questioning the scientific basis of the new WHO strategy on diet and physical activity.[6] As Dyer[4] has pointed out, "[w]henever you hear the government or the industry talking about scientific rigour . . . it's code for self interest." Food fights, therefore, constitute an unequal struggle between the common good, represented axiomatically by public health, and the individual interests of food manufacturers, who are so powerful as to influence and shape government policies.[2-4]

Morality, in its original meaning,[7] suggests that the individual interests of food industrialists should no longer be privileged over the innumerable human lives that could be saved by preventing obesity and its tragic consequences.[8] Strict regulations on food production and its advertising are urgently needed worldwide and should be respected by market forces. Otherwise, to contain increasingly catastrophic epidemics of nutrition-related disorders, many governments will probably be compelled to turn food companies into nationalized, nonprofit organizations.

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Medical privacy is important

As noted in a recent "News @ a Glance" item,[1] the use and abuse of oxycodone is a growing concern in Canada, particularly in Nova Scotia.[2] The lay press has reported that police and pharmacists in that province would like a province-wide database to be established to track users of narcotic medications prescribed for pain relief, especially drugs containing oxycodone;[3] it is believed that such a database would help to prevent "double-doctoring."

Drug databases can certainly be used by primary care physicians to improve the quality of patient care and to ensure that patients are not exposed to dangerous drug interactions.[4] However, it is important that patients' privacy be protected. If patients think that the police may have access to such a database, those suffering from legitimate chronic pain may be less likely to seek appropriate medical care.

Before consideration is given to violating patients' privacy, a good first step would be a study to determine the effectiveness of such a database in detecting double-doctoring. The seriousness of the problem of drug addiction does not justify the unethical violation of medical privacy, even when it is done with the best of intentions.

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Genetics and ARMD

Thank you for Erica Weir's Public Health article on age-related macular degeneration (ARMD).[1] The term for this condition sounds like an apology for our inability to identify a better cause, but in fact genetics plays a large role in a person's predisposition to macular degeneration. Several genes may be associated with macular degeneration, including *ABCA4*, *VMD2*, *EFEMP1*, *TIMP3*,[2] *ELOVL4*[3] and *CRX*.[4] However, a search for mutations in these genes in patients with a diagnosis of ARMD has been disappointing, except in the case of *ABCA4*. Patients who carry mutations in both *ABCA4* alleles have an autosomal recessive disorder called Stargardt disease.[5] Allikmets[6] has shown a significantly higher incidence of mutations in the *ABCA4* gene among patients with ARMD than in a control population. These mutations may contribute to the higher risk of vision loss from ARMD among first-degree relatives of patients with the condition, estimated at 4 times the risk for the general population.[7]

How can ARMD be prevented? As mentioned by Weir, stopping smoking and eating a healthy diet are both important. In particular, eating fish at least twice a week reduces the risk.[8] Fish is an excellent source of omega-3 fatty acids, in particular docosahexaenoic acid, the predominant highly unsaturated fatty acid of the retina. With people now living into their 80s, a healthy lifestyle and a healthy diet are important not only for general well-being but also for good vision.

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Universal care

Noralou Roos and associates[1] report mean per capita physician and hospital expenditures for Winnipeg residents for 1999–2000. Although they do not supply overall mean expenditures, the means for the middle socio-economic quintile ($286/person for physician costs and $333/person for hospital costs) are probably close to the overall means.

Data from the Canadian Institute for Health Information (CIHI)[2] suggest that Roos and associates omitted a significant proportion of physician and hospital expenditures from their calculations. According to CIHI data for Manitoba,[2] public expenditures for physicians were $382/person in 1999 and $420/person in 2000; for hospitals these figures were $895/person in 1999 and $944/person in 2000.[2] Total public health expenditures for the province were $2380/person in 1999 and $2621/person in 2000. Overall, it appears from this comparison that Roos and associates[1] included only about a quarter of all public health expenditures in their analysis.

Given evidence from other comparisons of funding and patterns of health care use among regional health authorities,[3,4] it is unlikely that the costs for Winnipeg reported by Roos and associates[1] were that much lower than those for the rest of Manitoba (as in the CIHI data); hence, other reasons for the higher values reported by CIHI are more likely. For example, the analysis by Roos and associates might not have captured salary costs for physicians on salary, and it appears that the majority of hospital costs were not included.[1]

The fact that Roos and associates incorporated only a minority of public health care costs in their calculations does not necessarily reduce the validity of their conclusions, which were based on comparisons among socioeconomic groups and among groups of individuals with different levels of use of health care services. Nevertheless, some caution is needed in the interpretation of their results.

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Noralou P. Roos and associates[1] document the role of poverty as a justifiable factor for increased utilization of health care services, because those of low socioeconomic status have poorer health status. However, the authors do not appear to prove that universal comprehensive insurance does not increase utilization.

For years, during informal discussions at work, continuing medical education courses and social events, I have been hearing family physicians readily acknowledge that their rate of referral to specialists is probably excessive and that they have ordered questionable investigations under perceived pressure from patients and fear of legal action. In these situations, universal health insurance has undoubtedly freed both physician and patient from financial accountability.

To reduce the present financially unsustainable rate of annual growth in health care, Canadian politicians should follow the suggestions of Roos and associates[1] by focusing on evidence-based medicine, physician practice patterns and hospital management, but not user fees and medical savings accounts. Fortunately, recent proposals that might moderately reduce utilization[2] inspire optimism that sufficient funds will be generated justly and fairly. Such funds are urgently required for the financial sustainability of Canada's health care system. Modest annual premiums could be introduced, calculated as a fair percentage of income above the poverty line. In addition, health care services could be treated as a taxable benefit on income above the poverty line, with a maximum calculated as a fair percentage of income.

Canadians accept average annual expenses of more than $1000 for car insurance,[3] $700 for gambling[4,5] and (for anyone who indulges in a large coffee and a doughnut each weekday) $500 at Tim Hortons, but, remarkably, they appear reluctant to preserve health care by paying for a modest portion of their physician and hospital services!

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