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The folly of healthcare reform in the USA

As most of you are aware, the USA spends more money on healthcare than any other country in the world, and sadly, one in every six Americans is uninsured. Remedying this problem has led to intensive debate in the States. Unfortunately, any notion of a "single-payer" was discarded early in the discussion, and currently the only possible option for increased government involvement appears to be a "public insurer". Conservatives have protested for two reasons, first, it would have an unfair advantage over its private counterparts, because it could negotiate deep financial discounts with doctors, hospitals, device manufacturers and the pharmaceutical industry. Second, it would be inefficient. President Obama has succinctly pointed out that it is impossible to reconcile these two concerns. Interestingly we already have a successful public health care plan—Medicare—which provides health insurance for all elderly Americans. Administrative overhead is approximately 3-5%. This compares quite favourably to the 15–17% administrative costs of private insurers. Some have suggested that the best approach to insuring more citizens is to reduce the age of eligibility for Medicare each year. But why pursue such a relatively simple solution?

Former President Clinton was roundly criticised for a rather secretive process that led to his healthcare reform bill. President Obama has pursued a much more open process, asking all interested parties to participate, and although there was initial cooperation, the last few months have been characterised by acrimonious debate and widespread misrepresentation of any reform legislation. No group, including physicians, hospitals, academic health centers, insurers, or industry, want to surrender control and/or income. As I have said numerous times, treating healthcare as a commodity, with misaligned incentives, and profit as a goal, does not work.

What genetic variation is valuable?

In a highly informative and very provocative leading article, Brian Skotko helps us peer into the future. Shortly it will be possible to detect, using blood only, Down syndrome in the first trimester of pregnancy. Dr Skotko provides information about the worldwide effects of prenatal testing on the birth incidence of Down syndrome in 14 countries. For example, despite advancing maternal age in England and Wales, between 1989 and 2006 the observed increase in Down syndrome incidence was 4%, the expected increase was 52%, with a realized decline of 48%. Realised decline ranged between 14% in Northern Netherlands to 247% in Paris, France. Dr Skotko concludes by asking a series of questions: "Should expectant parents be able to select out fetuses with an undesired sex? Should fetuses with genes that predispose them to adult breast cancer be prenatally identified?" I wonder if we are prepared to have a public discussion about the "ethics of our genetic futures," or will we stumble along and avoid the very difficult questions that have accompanied the genetic revolution. ***See page 823***

Acquired cryptorchidism in the UK

In January 2007 we published a study from Dr Hack which reported that the prevalence of acquired undescended testis in 6-year, 9-year and 12-year old Dutch schoolboys was 1.2%, 2.2%, and 1.1%, respectively.[1] A report from Sweden in the same year suggested that the treatment of undescended testis before puberty reduced the risk of testicular cancer.[2] In this issue, Acerini *et al* from Cambridge indicate that the cumulative incidence of acquired cryptorchidism in 742 infants was 7.0% at 24 months of age. In the past I have thought that once the testes have descended I no longer needed to "worry" about them. Now I am not sure—my practice has changed over the past 2-3 years—when I examine prepubertal males of all ages I carefully palpate the testes. ***See page 868***

Early infant nutrition

The worldwide obesity epidemic, and the recognition that adult cardiovascular disease maybe programmed during infancy, has led to renewed interest in early infant nutrition. How long should infants be exclusively breastfed? Does the type and timing of the introduction of solids impact on child health? Should infants be fed all they can eat? Does the composition of infant formula impact on fatty acid profiles? In a double-blind randomised clinical trial, Schwartz *et al* from Germany found that complementary foods rich in n-3 alpha-linolenic acid favorably impact on fatty acid profile at 10 months of age. I find these types of studies difficult to understand—not the methodology—but rather the content of the formula and/or complementary foods, and the various outcomes measured. I also worry that we are assessing very proximal outcomes, and the real question is the development of cardiovascular risk over an entire life time. ***See page 876***

This month in *F&N*

- With aging populations, and concern about end of life health care costs, interest in palliative care has risen dramatically over the last decade. In paediatrics, end of life decisions are limited to a few specialty areas, although I suspect the majority of these discussions occur in the NICU. The Dutch have been more open about end-of-life decisions than most societies. Verhagen and colleagues describe the use of analgesics, sedatives and neuromuscular blockers in the deaths of 340 newborns over a 12-month period in the Netherlands.
- Altman *et al* from Sweden describe the significant impact of written fixed discharge criteria on length of stay of moderately preterm infants.
- Das compares the birth outcomes of macrosomic infants born to diabetic mothers and non-diabetic mothers—although non-IDMs were more likely to be born vaginally, they had a higher incidence of birth injury.

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