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Health care reform in the US – possible but not likely

Over the past few months, both in the US and the UK, I have been asked about the prospects of health care reform in the U.S. My thoughts:

The US continues to struggle with health care as a right or privilege. Until we decide it is a privilege, meaningful reform is unlikely. Health care should be treated just like fire and police services and primary education—it should be free to all members of a society.

Cost has once again become a prominent part of the health care debate in the US. Every 10 years or so, the US realizes that it spends far too much money on health care—about 40% more than any other country—with virtually no data that health outcomes are any better in the US than anywhere else.

Managed chaos is likely to continue—250 of 300 million Americans have health insurance and are relatively happy with it.

The US continues to treat health care as a commodity—it is traded and bartered. Profit is critical. Sadly, beginning with Reagan and continuing with the Clinton and Bush presidencies, profit drove American business, regardless of ethics or risk. Some Scandinavian countries have universal health care embedded in for-profit healthcare systems, but because maximizing profit, regardless of ethics, is not a central tenet of their society, these systems work. Unfortunately, some hospitals, academic health centers, insurers, device and drug manufacturers, and physicians, emphasize profit rather than providing high-quality, cost conscious care.

The US is moving toward health insurance for all children. As a paediatrician and child health advocate I obviously support this development, unfortunately, as detailed by UNICEF, health care is only a small contributor to the overall well-being of children— poverty, education, and family structure—are far more important. I worry that if all children in the US become insured, than certain groups will claim that the US has insured its ''most vulnerable'' population, and there will be less pressure on providing health care for all. Certainly I want all children in the US to be insured, but in fact, insurance for other groups maybe more important.

Finally, there is growing recognition that universal health insurance has many benefits. First, without universal insurance, restraining costs is virtually impossible. Second, if everyone is insured, families have more discretionary income and can spend it in other sectors of the economy. Third, Americans have become very scared about changing jobs because of the lack of health insurance. Some form of national health insurance will give people greater flexibility in the work place. Fourth, businesses are finally clamouring for health care reform. High costs are making them less competitive in the world economy. Lastly, I believe that much of the malpractice crisis in the US is attributable to lack of universal health insurance. Individuals who feel that they have been wronged by the health care system are more likely to sue if they are uncertain that their health care needs will be met.

So where does this leave the US? I am not certain that the world really cares if the US moves to universal health insurance. Although, it is certainly sad that one of the richest countries in the world does not have national health insurance.

Children with UTIs

The NICE UTI guidelines have certainly stirred up controversial.[1,2] For the past 20 years we have operated under the assumption that early identification of children with UTI, followed by detection of vesicoureteral reflux and antibiotic prophylaxis if indicated, would lead to the prevention of renal scarring, and ultimately renal failure. In understanding this scenario, it is clear that no single study is capable of answering the question—too many patients would need to be enrolled, randomized, treated, and followed for decades. So like many issues in medicine, multiple studies that examine various and very specific aspects of the question, are amalgamated in order to produce recommendations.

In this issue of ADC, Coulthard and colleagues, question one of the underlying assumptions of the NICE guidelines, that the presence of severity of systemic symptoms at the time of diagnosis of UTI is associated with mild or multiple scarring. They conclude that this is not true.

So where do the recent spate of articles [3,4] on UTI leave us? First, it seems clear to me that antibiotic prophylaxis does not prevent either recurrent UTI or the development of renal scars. One critical caveat to this statement, very few of the children in these studies have grades 4 or 5 VUR. Second, I cannot tell when a child is first diagnosed with a UTI, without some form of imaging, whether he or she has VUR or renal scarring. Third, it does not appear that parenteral antibiotics for children with pyelonephritis impacts on the development of renal scars. Having just finished my ''take'' on the wards for two weeks, and caring for 4 children under the age of three years with UTIs what did I recommend? First, for the young children with newly diagnosed UTIs, I still wanted to know if they had VUR. So depending upon their age, I recommended that they have some type of imaging. If they had no or mild reflux nothing else was necessary—no antibiotic prophylaxis or follow-up studies. For the child I saw with complicated disease, in this case, he had a history of grade 3-4 VUR detected on previous imaging, a recurrent UTI, and was still febrile at 48 hours—I was more conservative, recommending administration of parenteral antibiotics until he was afebrile for 24 hours. Why? I wanted to ensure that the child's kidneys were exposed to high doses of antibiotics until he was better. For me it is always a balance between risk, possible benefit, and societal cost. I see very few children who are like the second child, few children have significant VUR and those that do respond quickly to antibiotics—so this child was an outlier—somewhere on the other side of the 95% confidence interval. Hence, I relied on what I know of the data (or the lack thereof), my clinical judgment, and what I would want for my own child.

References

1. **National Institute for Health and Clinical Excellence**. Urinary tract infection in children: diagnosis, treatment, and long-term management. http://www.nice.org.uk/micemedia/pdf.
2. **Coulthard MG.** Is reflux nephropathy preventable, and will the NICE childhood UTI guidelines help? *Arch Dis Child* 2008;**93**:196–199.
3. **Conway PH,** Cnaan A, Zaoutis T, *et al*. Recurrent urinary tract infections in children: risk factors and association with prophylactic antimircrobials. *JAMA* 2007;**298**:179–186.
4. **Montini G,** Rigon L, Zucchetta P, *et al*. Prophylaxis after first febrile urinary tract infection in children? A multicenter, randomized controlled, noninferiority trial. *Pediatrics* 2008;**122**:1064–1071.