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The editors will decide as before whether to also publish it in a future paper issue.

Siberian live birth sex ratios and the SPpRoO hypothesis

Melnikov and Grech found a highly significant seasonal pattern of the sex ratio (SR) at birth in western Siberia, namely, a peak in the second and a trough in the fourth quarter of the year. This peak and trough are in line with the seasonal preovulatory overproduction hypothesis (SPpRoO), which states (1) that men are more likely to be born in the “ovulatory” seasons, (2) that preferential fertilisation of optimally matured oocytes by Y-bearing sperm during the “anovulatory” season in spring, and (3) that SR reverses because of excess of male biased fetal loss during the “anovulatory” season in spring. This mentioned peak would correspond, just like in non-human mammals with the breakdown of the “ovulatory” season in spring; the trough with SR reversal during the “anovulatory” season in winter.
(ORs) was modest, and confidence intervals (CIs) overlapped considerably (African American women: OR 1.77, 95% CI 1.12 to 2.79; white women: OR 1.29, 95% CI 1.01 to 1.63). Secondly, the authors did not consider residual confounding by factors such as maternal infection and previous preterm birth, which differs by ethnic group.1 Their assumption that the smoking-preterm birth association is linear seems biologically unlikely and problematic, as African American women in their study population smoked more than white women.

Such analyses raise a more fundamental issue: the limitations of using ethnicity/race in epidemiological studies of causality. There is no consensus as to what “ethnicity” means. To some, “ethnicity” describes cultural differences between populations definable by phenotype, while “race” signifies differences strictly under genetic influence. This separation is imperfect—“ethnic groups” differ in genetic mix, culture, and socioeconomic situation. The “catch all” quality of ethnicity makes its use in epidemiological research attractive, but it is an obstacle to causal inference. Ethnic groups have qualitative and contextual differences that do not make them directly comparable. Ethnic differences in biological effects will be difficult to uncover, as cultural, social, and economic factors that act as causes and intermediates are too numerous and divergent to be adequately controlled.

Finally, ethnicity is not a singular exposure that can be turned on and off. The observation of higher preterm birth rates among black than among white women smokers is not simply the answer to the question “what would rates of preterm birth among white women who smoke be, if they were black?” Social inequity and deprivation, however, are amenable to change in a way that ethnicity is not. In the paper by Ahern et al, African American women delivering preterm clearly were more often single, working class, receiving public insurance, and had lower level of education. Yet their analysis stratified by ethnic group does little to explain these great disparities between African American and white women, concentrating instead on preterm delivery. Focusing on preterm delivery by race, suggested in our analysis, may be one such underlying factor contributing to racial disparities.

Authors’ reply
In their letter, Tam et al present several critiques of our analysis of smoking and preterm delivery in African American and white women and then broadly criticise the use of race and ethnicity as factors in epidemiological research. We address each issue in turn.

First, Tam et al object to the fact that the odds ratios (ORs) for the effects of smoking on preterm delivery for African American women and white women in our analysis were only modestly different and that their confidence intervals overlap. However, even a small difference in risk can translate to a very large difference in the number of people affected on the population level. In addition, the ORs presented in our paper were for 10 cigarettes per day. The ORs for a pack of 20 cigarettes per day were 3.13 for African American women and 1.55 for white women, a more substantial difference. More importantly, the key difference worth examining is that of the parameter estimates on the log odds scale. Specifically, the log odds of preterm delivery for every cigarette smoked per day was 0.057 for African American women, while it is only 0.022 among white women—a difference of more than twofold. Ultimately, while there was some overlap in the confidence intervals presented, this observation is not equivalent to a statistical test of the difference between the values. Such a test was not used because of the stratified nature of our sample; we chose a stratified sample for methodological reasons that we address below. We believe the interpretation of point estimates is still appropriate in our study.

Next, the authors suggest our effect estimates may be subject to residual confounding. This clearly may be the case with any observational study. However, in this particular instance, the factors that Tam et al discuss as omissions on our part are potentially on the causal pathway between our exposures and outcomes of interest, and thus, should not be adjusted for in our models. If prior cigarette smoking contributed to an earlier preterm delivery, adjusting for prior preterm delivery might have washed out the very effect we were interested in studying. The issue of maternal infections was explicitly discussed in our paper as a factor that may interact with smoking in its relation to preterm delivery. While we were unable to examine this in our analysis, as we lacked data on maternal infections, we hope that this work and our discussion will encourage others to look at this question.

Tam et al also question the linearity of the relation between smoking and preterm delivery. In our analysis, we found no evidence of non-linearity in the relation between smoking and preterm delivery. The fact that African American women smoked more on average does not affect the validity of the risk estimates, as cigarette smoking was modelled as cigarettes per day and the overall range of values was similar for African American and white women.

Finally, Tam et al criticise our decision to examine effects of neighbourhood and individual risk factors for preterm delivery within, rather than across, racial groups. Our decision to do so was inspired by the lack of such prior research and the fact that an expert conference on the problem of racial disparities in preterm delivery had called for just such an analysis.1

We agree with Tam et al that race encompasses social, economic, and cultural factors. Of course this makes the study of race complex. However, complexity has never before been a reason to abandon the study of an issue. In the context of the United States, the history of racial oppression and strife makes this a crucial issue in the hope of understanding its effects on people’s lives. The differences in the rates of preterm delivery between African American and white women are independent of socioeconomic status1 making racial differences even more important to understand. The complexity of the question, far from scaring us away, should draw us in. While race is not amenable to change, there may be underlying reasons for a racial disparity in health that may in fact be amenable to change. A differential effect of smoking on preterm delivery by race, suggested in our analysis, may be one such underlying factor contributing to racial disparities. We hope our analysis will lead to studies that help us intervene on one aspect of this important health problem and cause of racial disparities in health.

References

J Ahern, K Pickett
New York Academy of Medicine, 1216 5th Avenue, Room 553, New York, 10029, USA; jahern@nyam.org

Spending more, feeling worse: medical care expenditures and self rated health

International comparisons show that the United States spends more on health care than other industrialised nations.1 According to 2000 data, the United States led the way in per capita healthcare spending at $4651, more than other Organisation for Economic Cooperation and Development (OECD) median of $1983 (in purchasing power parities based on the US dollar).2 Despite massive medical care expenditures, the US lags behind its industrialised counterparts in important indicators of population health. For example, researchers have reported that the US has lower life expectancy at birth and higher maternal and infant mortality rates than other countries.3 Equally important, a broad range of studies consistently show that US citizens are less satisfied with their healthcare system than Canadians or Europeans.4

Another key indicator of population health, not previously used in cross national comparisons, is self rated health (SRH). As a broad measure of health status, SRH focuses on a person’s subjective perceptions of their
health. This popular single item measure on both sides of the Atlantic is related to mortality and to rates of recovery from episodes of illness across the life span.4 Drawing on comparable datasets, we asked whether the prevalence of poor self rated health is higher in the US than in Canada or the European Union.

Data (weighted) were obtained from the 1996/97 Canadian National Population Health Survey—NPHS (n = 66 435), the 1996 US National Health Interview Survey—NHIS (n = 63 402), and the 1996 European Commission Eurobarometer (n = 16 235). Age specific self rated health was assessed using the NPHS and NHIS questions “In general would you say your health is excellent, very good, good, fair, or poor?” In the Eurobarometer, self rated health was assessed with “Over the last 12 months, would you say your health has on the whole been very good, good, fair, bad or very bad?” In our analysis, “poor health” refers to responses of “fair” or “poor” in the NPHS and NHIS and to “bad” or “very bad” in the Eurobarometer. Data for national healthcare expenditures were obtained from the OECD (http://www.oecd.org/health/healtdta).

Figure 1 shows that the US, Canada, and the European Union (EU-15) differ in terms of the prevalence of poor SRH. While outspending Canada on a per capita basis by 1.8 to 1 and the EU-15 by 2.2 to 1,6 the US had higher prevalences of poor self rated health across the age span.

Overall, Canadians and Europeans spend about half of what Americans spend on health care yet feel better in nearly all age categories. As an approximate significance test for differences in average SRH, we computed t values pooling the standard errors across studies. The results indicated there were no significant differences between samples at the youngest age groups, but for middle age and older groups, beginning with age 50, Americans had significantly (p<0.05) higher prevalence of poor SRH. Interestingly, disparities in SRH seem to increase with advancing age, underscoring the need for better care and more complete coverage across the entire life span.

Our study confirms and complements earlier research indicating that the expensive and technologically advanced healthcare system in the US does not yield population health outcomes (including SRH) comparable to those in countries with much lower spending whether measured per capita or as a percentage of gross domestic product (GDP).7,8 Unequal and uncoordinated provision of care along with other inefficiencies in the US health system may explain why Americans spend more but feel worse.

References

BOOK REVIEWS

Reducing the burden of headache


Although not specifically stated this book represents the proceedings of the 11th international headache research seminar held in Copenhagen in March 2002. This 11th volume in the series Frontiers in Headache Research aims to bring the reader up to date on studies of the burden of headache. All the books in the series follow a similar structure: “Each topic is introduced by one or more overview chapters by leading experts. Thereafter, data from new studies are presented in short articles. Finally, each topic closes with a summary of discussion by the chairpersons.” This volume of 68 chapters is divided into six sections. In the preface the editors state that migraine, according to WHO, is number 20 of all diseases with regard to years lived with disability. They also state that migraine has more impact on quality of life than many other diseases generally considered to be more serious. In section I and II, headache related disability and quality of life are discussed in more detail. Section III deals with family burden, comorbidities, and healthcare utilisation for headache. Section IV discusses economic aspects of headache, whereas the two last sections describe and analyse guidelines and intervention aimed at improving health care for headache.

The studies presented at the 2002 Copenhagen meeting, and subsequently published in this volume, are described comparatively briefly and with variable quality. The most interested readers will probably need to search for more detailed information from...
those studies also published elsewhere. However, an interesting summary discussion highlights key points at the end of each section. From my point of view, this book should be on the reading list of everyone involved in headache research, and may also be of interest to epidemiologists as well as primary healthcare workers.

K Hagen

The making of a global controversy


Experts in different social and scientific fields have been coordinated by editors Martin W Bauer and George Gaskell with the aim to analyse, from different angles, one of the more important and dynamic socioeconomic phenomenon of the recent years: the biotechnology. As the editors expose in the volume presentation: “This book takes up themes explored at a conference at the Science Museum London, in 1993, which was convened to explore the structures and functions of resistance in the development of new technologies”. The volume holds the main thesis of the conference, which could be resumed as follow: “resistance is not a problem of the public opinion rather it is a signal that acts as a catalyst for organisational and institutional learning”.

The book comprises a total of 13 chapters gathered in five parts, which include the results of a four year international research project conducted between 1996 and 1999 and called “Biotechnology and the European public”. In part I, named “The framing of a new technology: 1973–1996”, the authors go over bioethics debate and biotechnology regulation during the past 25 years in Europe, throughout five contributions. Part II, deals with “Public representation in 1996”; it includes four chapters about traditional blue and green resistance, the structure of public perceptions, and the image of the genetic engineering such as a way of nature manipulation. Part III highlights “The watershed years 1996–97” describing two emblematic examples: the modified soya and the cloned Dolly. In part IV, and under the attractive title of “The transatlantic puzzle”, the authors analyse how genetically modified seed, food, and pharmaceuticals became a reality, in which great companies like Mosanto emerged from USA, although when extended to Europe, they found a controversial socio-political atmosphere. Finally, part V includes a unique chapter dealing with the biotechnology movement that integrates all the book contents under the highline “Towards a social theory of new technology”.

M A Peinado

PREDICTING THE NUMBER OF SARS CASES

Mathematically, the predicted number of incident cases on day $t_i$, that is, $C_t$, where $t$ is time expressed in the number of incubation periods, is

$$C_t = R_0^t.$$  

The predicted total number of cases ($C$) is

$$C = \sum C_t.$$  

PREDICTING THE NUMBER OF SARS DEATHS

Mathematically, the predicted number of deaths on day $t_i$, that is, $D_t$, where $t$ is time expressed in the number of incubation periods, is

$$D_t = C_t \times F.$$  

The predicted total number of deaths ($D$) is

$$D = \sum D_t.$$  

Two typographical errors in the equations occurred in this paper by Drs Choi and Pak (2003; 37: 831–5).

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<tr>
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<th>Correct equation</th>
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<td>$C_t$</td>
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<td>$D_t = C_t \times F$</td>
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The complete set of correct equations is therefore:

$$C_t = R_0^t.$$  

$$C = \sum C_t.$$  

$$D_t = C_t \times F.$$  

$$D = \sum D_t.$$