

values for “overweight” and “obese” on the basis of height and weight measurements for about 100 000 children in Brazil, Great Britain, Hong Kong, the Netherlands, Singapore and the United States. Another common reference that is used for evaluating pediatric categories of “at risk of overweight” (BMI at or above the 85th percentile) and “overweight” (BMI at or above the 95th percentile) is a set of growth charts developed by the US Centers for Disease Control and Prevention.⁵ The latter reference was derived from height and weight measurements for US children collected over several decades as part of national nutrition and health examination studies.

The Dietitians of Canada, the Canadian Paediatric Society, the College of Family Physicians of Canada and the Community Health Nurses Association of Canada⁶ recently recommended that the Cole and colleagues² reference be used for group (national or international) comparisons and the CDC reference⁵ be used for monitoring the growth of individual children. To our knowledge, only one study⁷ has compared prevalence estimates of overweight obtained with these 2 methods; given this paucity of research, the Canadian recommendations⁶ were based on expert opinion rather than scientific evidence.

It is important to acknowledge that height and weight data for Canadian children were not included in either reference; this lack of Canadian data is particularly relevant to the situation for Aboriginal youth. Although available data show that many Aboriginal preschool and grade-school children are overweight on the basis of a non-Aboriginal reference,⁸ the validity of this approach has been questioned, since the growth pattern of many indigenous populations worldwide has not been studied.⁹

Until nationally representative data on measured height and weight (including Aboriginal children) are available, Canadian researchers and health professionals alike must rely on comparisons with references that may not be representative of our children because

of our geographic, cultural or ethnic uniqueness.

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[The authors respond:]

We agree with Geoff Ball and Noreen Willows that Canadian reference data are needed to accurately estimate the current prevalence of overweight and obesity. Unfortunately, standardized reference data based on measured heights and weights of Canadian children are not available. We calculated prevalence in our study population¹ using

the methods of both Cole and colleagues² (the International Obesity Task Force) and the CDC.³ To make the data more amenable for international comparisons, an editorial decision was made to report the prevalence estimates only in terms of the first method. Fig. 1 of this letter compares the prevalence rates as estimated by the 2 methods. Six points are noteworthy.

First, the prevalence estimates for overweight (termed “at risk for overweight” by the CDC) and obesity (termed “overweight” by the CDC) were high regardless of which method was used. Also, the analysis indicated no significant difference between boys and girls in the prevalence of overweight or obesity as estimated by either method. Third, there were no differences between age groups with either method. Fourth, the CDC method yielded significantly higher rates of overweight and obesity (combined), although this difference appears to be accounted for more by the difference in estimates of obesity (18.0% v. 8.0%) than by the difference in estimates of overweight (18.8% v. 17.6%). Further analysis indicated that a child was more than twice as likely to be classified as obese by the CDC method than by the method of Cole and colleagues. Finally, comparisons between the 2 methods with categorical modelling procedures indicated that they classified boys and girls differently. Boys were 2.85 times more likely to be classified as obese by the CDC method than by the method of Cole and colleagues, whereas girls were 2.20 more likely to be classified as obese by the CDC method.

Clearly, care must be taken in making comparisons, particularly of rates of obesity, when different methods of classification have been used.

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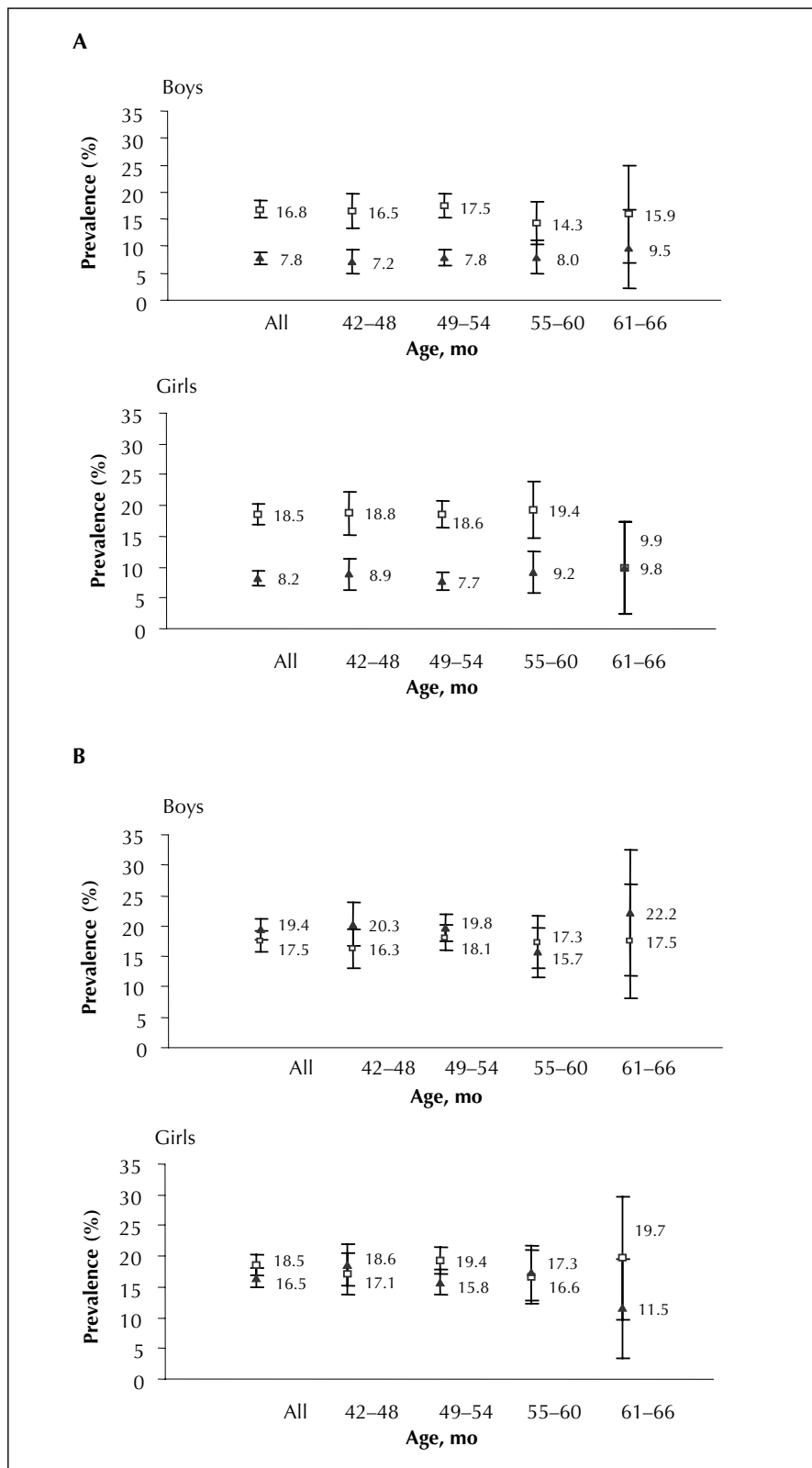


Fig. 1: Prevalence of overweight (squares) and obesity (triangles) among preschool children in Newfoundland and Labrador, by sex and age group, estimated by the methods of Cole and colleagues² (the International Obesity Task Force) (A) and the Centers for Disease Control and Prevention³ (B). Error bars represent 95% confidence intervals.

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Stats Can under-represents rural shortage

I suspect that Statistics Canada's interpretation of the data presented in a recent *CMAJ* news article¹ under-represents the shortage of rural practitioners. Marc Hamel of Stats Can feels that the data do not indicate that people in rural areas have more trouble finding a doctor. However, I think the data are misleading, in that practitioners in small communities cannot "close" their practices to new patients —there is simply nowhere else for patients to go. Thus, even though people in rural communities may report that they have a family doctor, there is no mention of how easy it is to get an appointment with that doctor. That rural doctor probably has a significantly longer patient list than the average nonrural practitioner, as well as other responsibilities that decrease the time available for office appointments.

A quick straw poll in my own region of northeastern British Columbia seems to support this. In the 2 larger communities of Fort St. John and Dawson Creek, with several medical clinics serving over 30 000 people each, very few doctors are taking new patients. In contrast, in the small communities of Chetwynd, Fort Nelson and Tumbler Ridge (each of which has only one clinic), all doctors are seeing new patients.

Therefore, although at a superficial level it may appear easier for patients to find a family doctor in smaller communities, these communities have significant physician understaffing relative to their larger counterparts and therefore inferior access to care. I don't think it is too much of a stretch to suggest that the apparent small difference in finding a GP between rural and urban settings