**Letters**

We welcome your responses to papers that appear in Health Affairs. We ask you to keep your comments brief (250–300 words, including any endnotes) and sharply focused. Health Affairs reserves the right to edit all letters for clarity and length and to publish them in the bound copy or on our Web site. Letters can be submitted by e-mail, letters@healthaffairs.org, or the Health Affairs Web site, http://www.healthaffairs.org.

**Hope Is Not A Strategy**

I appreciated Leonard Schaeffer’s thoughtful review of my book, *The Long Baby Boom* (Jul/Aug 08). I do not believe that the fiscal challenges posed by the baby boom will simply “fix themselves.” I likened Medicare to a Camaro Z-28, a “high-powered fiscal gas guzzler.” Instead of increasing the age of eligibility or reducing benefits, the book argued forcefully for correcting the inflationary bias in the program’s fee-for-service payment system.

In my book what I objected to were forecasters who simply straightlined current Medicare cost growth trends applied to a larger beneficiary population. Such forecasts ignore the effect of fiscal cycles. What I said was absurd was the idea “that our political system is going to tolerate sustained hyperinflation in health costs for fifty years without doing anything.”

Medicare and Medicaid are balancing items in federal and state budgets. When state and federal governments run out of money, spending ground rules change materially. There have been two recent multiyear flattenings of Medicare’s trend, in the wake of the 1983 conversion to Part A prospective payment and the 1997 Balanced Budget Act, that had huge outyear cost implications.

With the 2009 federal budget deficit aiming at $500 billion, not counting Iraq, a third incursion into Medicare’s spending trend looms dead ahead. It’s time for another round of Medicare payment policy innovation. My book discussed several promising ideas: a primary care “medical home,” bundling Part A and Part B payment for hospitalizations, and active health management for chronic diseases like congestive heart failure and diabetes.

A sustained reduction of a couple of percentage points in Medicare’s annual per capita cost growth is needed to put the federal budget on a sound long-term fiscal foundation. I agree with Schaeffer: we would be foolish to wait until boomers flood the program before acting.

JEFF GOLDSMITH
Health Futures Inc.
Charlottesville, Virginia

**Malpractice In Massachusetts: Another View**

Marc Rodwin and colleagues’ highly publicized conclusion that Massachusetts does not have a malpractice insurance crisis (May/Jun 08) is not supported by the data in their paper.

First, the sole finding supporting the conclusion, that malpractice insurance rates declined 1 percent from 1990 to 2005, is an artifact of the Simpson Paradox. Rates for low-risk doctors increased 14 percent; rates for high-risk doctors increased 45 percent. The mean decreased entirely because the mix of doctors changed, and the percentage of insured doctors with expensive high-risk policies declined substantially—a change consistent with the American Medical Association allegation that the malpractice crisis is causing doctors to leave high-risk professions such as obstetrics because of insurance costs.

Moreover, the claim that insurance rates declined from 1990 to 2005 comes from the improper mixture of inflation-adjusted policy rates with the nominal dollar value of insurance policy coverage. If nominal dollars were used for both values, one would see insurance costs rising; if inflation-adjusted numbers were used for both, one would see that the same dollars were buying less coverage.

Even if one accepted that rates had declined
slightly between 1990 and 2005, this permits only the inference that the Massachusetts medical malpractice crisis in 2005 is no worse than it was in 1990, not that there is no crisis.

But the choice of 1990 as a reference point appears to be cherry-picking. If Rodwin and colleagues had chosen any other year in their data series as a reference point, one would see insurance costs increasing. A regression would show a long term increase over time. And although the study measures insurance costs from 1975 to 2005, the authors make no reference to the major constant-dollar increase in insurance premiums during 1975–2005: the entire set of data from 1975–1990, when the litigation explosion happened, is largely ignored.

Theodore H. Frank
AEI Legal Center for the Public Interest
Washington, D.C.

Malpractice: The Authors Respond

Ted Frank misstates our reported data and conclusion, and obscures our findings (May/Jun 08).

Frank claims that mean premiums fell entirely because the percentage of high-risk physicians declined and repeats the American Medical Association’s claim that rising premiums caused doctors to leave practice. No available data indicate a decline in high-risk physicians in Massachusetts since 1990. Our data reveal that in recent years, other insurers offered lower premiums for high-risk physicians than did ProMutual, which explains their decline in ProMutual’s rolls from 8 percent in 1990 to 4 percent in 2005. We reported premium changes by five tiers, which reveal a different picture than mean premiums for all physicians. Discount-adjusted premiums decreased for nearly all physicians since 1990. High premiums increased for only three practice specialties since 1990, but despite this, one-third of high-risk physicians paid less for insurance in 2005, due to rate discounts.

Frank also claims that we improperly compared inflation-adjusted rates with the nominal dollar value of coverage. In fact, we followed standard practice. Actuaries and economists gauge price changes in insurance by adjusting premiums for inflation while keeping coverage limits and policy types purchased constant. This method reveals cycles of pure price decrease and increase for the same product.

Frank claims that we cherry-picked by choosing 1990 as a reference point, that any other year would reveal premium increases, and that premiums increased over the long term. Not so. Our Exhibit 1 displays premiums for all five tiers over thirty years; it shows that mean Consumer Price Index (CPI)–adjusted rates increased from $7,095 in 1975 to $21,245 in 2005. But it reveals that all five premium tiers had cycles, rather than steady increases; for nearly all physicians, 1990 was the peak year, and 2005 was the second-highest year; 1980 and 2000 were the two lowest premium years. Our paper explains that ProMutual lacked data on the number of physicians in each rate group before 1990. Thus, we reported mean premiums adjusted by physician counts only since then. For $1 million/$3 million policies, count-adjusted mean premiums decreased from $17,907 in 1990 to $12,551 in 2000 and increased to $17,810 in 2005.

Marc Rodwin for the authors
Suffolk University Law School
Boston, Massachusetts

Questioning “Values” Research

Celinda Lake and colleagues (May/Jun 08) offer “seven observations on the key opportunities and pitfalls for health care reform advocates” based on “research [by] Lake Research Partners [LRP] and American Environics [AE] conducted for the Herndon Alliance.” According to Lake and colleagues, the “first phase” of this research was a report by AE that identifies the “core values that shape [Americans]’ views on health care.”

The AE report is dubious science. The first four parts of the report are devoted to platitudes about values, and the portion that does relate to health care (Part V and the appendix) reads like a horoscope and offers no explana-
tion of methodology, apparently because the methodology is “proprietary.”

The AE appendix lists 117 “values” along with short descriptions of each “value.” The “values” were taken from a “values survey” that has been used by “Fortune 500 companies from GM to Proctor and Gamble to L’Oreal.”

These “values” have titles such as “Brand Apathy,” “Confidence in Advertising,” “Look Good Feel Good,” “More Power for Business,” “Mysterious Forces,” “National Pride,” “Traditional Gender Identity,” and “Xenophobia.”

Seventeen of the 117 “values” are attitudes about advertising and buying (such as “Discount Consumerism,” defined as “preferring to buy discount or private label brands, often from wholesalers”). Only two of the 117 “values” (“Effort Toward Health” and “Holistic Health”) have “health” in their titles. Words like “insurance,” “premiums,” “doctor,” “prevention,” and “taxes” appear nowhere in the entire appendix. “Medicine” appears only once.

By another unexplained method, AE used these 117 “values” to divide Americans into eight “clusters of like-minded voters whose core beliefs about health care issues were similar.” How could this be done when only two or three of the 117 “values” were somewhat related to health care reform (none could be called “core beliefs”)? LRP then used these eight AE clusters to select their focus groups. Health Affairs readers should wait until Lake and colleagues publish a detailed methodology of the AE report and of their focus-group research before we take their advice seriously.

Kip Sullivan
Greater Minnesota Health Care Coalition
Minneapolis, Minnesota

NOTES
3. Ibid., 8.

“Values” Research: The Authors Respond

While Kip Sullivan may be displeased with some of the conclusions in our Health Affairs article on the public opinion environment surrounding health care reform (May/Jun 08), his attack on our methodology is unfounded.

The Social Values Roadmap developed by our partners at American Environics is based on a quantitative survey research tool that has been developed and refined over a period of three decades in Canada and the United States and has proved to be highly predictive of actual social, political, and consumer behavior on a wide range of issues. The article and Roadmap document did not include detailed descriptions of this methodology for reasons of brevity and intended audience.

Sullivan confuses specific attitudes toward health care with social values. The purpose of using social-values methods is to identify underlying drivers of specific attitudes that are often overlooked in traditional opinion research, which is typically limited to specific questions germane to the particular topic at hand (for example, health care). The underlying social-values data set used in this project is the American Values Survey (AVS), a sample of 2,700 Americans age fifteen and older who respond to more than 800 questions. The AVS data cover a wide range of specific issue attitudes, including attitudes about health care, in addition to the social-values constructs listed in the glossary that Sullivan references.

Notwithstanding Sullivan’s views on the sufficiency of the 117 social values in the American Environics data set, those values—indeed, a relatively small subset of them (fewer than twenty)—predict most of the variance in public support for universal health care. The segmentation solution was not defined using all 117 values but rather those that strongly predicted variance in support for universal health care. The strongest predictors included values
such as introspection and empathy, largesse oblige, social responsibility, national pride, acknowledgement of racism, anomie-aimlessness, community involvement, and obedience to authority. The remaining values were used to profile the segments once they were created but were not determinative of the actual segmentation solution.

Subsequent qualitative focus groups and quantitative survey research conducted by Lake Research Partners found significant variance in health care attitudes between segments consistent with the social-values profiles of the segments. Additional public opinion research that we have conducted, sponsored by Families USA, AARP, and the AFL-CIO in 2007 and 2008, has also reached findings consistent with those discussed in our article. Although some of this research is proprietary, a summary of public findings from part of this research is available online.¹

As professional researchers who are also committed progressives and supporters of health care for all, we hope that our progressive friends look at our work as an opportunity to understand the audiences we need to persuade, in the service of accomplishing our shared goals.

Celinda Lake and David Mermin
Lake Research Partners
Berkeley, California

Robert A. Crittenden
Herndon Alliance
Seattle, Washington

Ted Nordhaus
American Environics
Oakland, California

NOTE
1. D. Westen, "Memorandum: How to Talk about Health Care Reform: Summary of Research for Families USA, the Herndon Alliance, and the AARP," 9 June 2008, http://w w w . h e r h o n d a l l i a n c e . o r g / a l l i a n c e P a r t n e r s / r e s e a r c h F i n d i n g s / R e p o r t_ HealthCareMessaging_rf_060808.pdf (accessed 15 September 2008; Herndon Alliance login might be required).

Disclosing Bias In Book Review

I would like to bring to the attention of your readers the fact that Alan J. Gelenberg, the psychiatrist who reviewed my book, Side Effects: A Prosecutor, a Whistleblower, and a Bestselling Antidepressant on Trial (May/Jun 08), is a longtime colleague of Martin Keller, the chief of psychiatry at Brown University whose extensive ties to the drug industry I expose in my book. Indeed, a quick search of Medline reveals that Gelenberg and Keller coauthored at least twenty papers together on the treatment of depression with various antidepressants, among them Effexor, Zoloft, Prozac, and Serzone—all of which I write about in my book.

Gelenberg’s track record of collaboration with Keller goes back to at least 1989 and makes it very clear that Gelenberg is something less than an unbiased source when it comes to the facts in my book. In addition, Gelenberg has been a longtime consultant to GlaxoSmithKline, the maker of Paxil (the best-selling antidepressant in the title of my book), as well as Eli Lilly, Pfizer, Wyeth, and Forest Labs, all makers of other antidepressants that I discuss in my book. (Gelenberg was required to disclose these conflicts in a paper he coauthored with Keller in 2007 and in a psychiatry digest in 2008, but he didn’t disclose them in his review of my book.)

Gelenberg is now CEO of Healthcare Technology Systems, a company whose clients include pharmaceutical companies.

These are all financial interests that should have been disclosed in Gelenberg’s review of my book, as they are intimately related to the subject matter of the review.

Alison Bass
Mount Holyoke College
South Hadley, Massachusetts

Disclosing Bias: The Author Responds

Everything Alison Bass writes about me is true, in response to my review of her book, Side Effects (May/Jun 08). My relationship with
Marty Keller goes back even further—to 1973, when I taught him during his residency. Marty is my friend.

I was not asked to provide a declaration of interest. I did write in my review: “I have consulted to the pharmaceutical industry, given lectures they have funded, and taken educational and research funds from them.”

In the matter of physicians’ relations with the pharmaceutical industry and the process of drug discovery, I claim no disinterest. And I stand by every word in my review.

Alan J. Gelenberg
Healthcare Technology Systems
Madison, Wisconsin

Disorientation: Finding The North

In spite of many inequalities, for the most part, the world today is coming closer as never before. Migration across states and countries for various reasons has become frequent. Nonetheless, the diversity in cultures, political systems, and work environments will persist. An excellent essay by Alok Khorana (May/Jun 08) delightfully sums up the confusion of an international medical graduate (IMG) entering into the U.S. health care system. About 25 percent of the U.S. physician workforce is composed of IMGs, and I suppose many of them identify with the feelings and experiences narrated in the essay. I know that I did.

The United States has been welcoming to immigrants. The majority of students and professionals who come here receive some formal or informal introduction to their work, study, and have enough time to accustom themselves. (I even received a glossary of American slang!) Learning simple things like converting kilos into pounds or flipping electric switches upward do not take much effort or time. However, when you are dealing with human life, small details matter. Thus, it is surprising that most IMG interns do not receive a dedicated orientation to the U.S. health care system. A couple of days in the general orientation period could be dedicated to IMGs, specifically discussing differences and novelties in the U.S. health care system. This approach could make the transition into a new country easier and less stressful, and it would most likely prevent errors due to lack of information or miscommunication. Several universities have excellent orientation programs for incoming international students. Their expertise could be used in developing consensus guidelines and areas to focus on during this orientation. Again, thanks to Khorana for bringing this up.

Ashish Chintakuntlawar
Harvard Medical School
Boston, Massachusetts

NOTES

Applications Of Two-Part Pricing In Pharmaceutical Markets

In a recent paper Dana Goldman and colleagues proposed a two-part pricing scheme for pharmaceuticals. In return for an annual drug license fee, patients would get unfettered access to the drug over the course of a year. By keeping marginal costs (to patients) low while keeping drug companies’ profits high, the proposed model potentially eases the trade-off between the long run and the short run: higher prices today in return for higher innovation in the future, or lower prices today but less innovation in the future.

Even though the authors confine their analysis to a single drug and single insurance company, two-part pricing can be implemented in other circumstances as well. For example, national governments can pay annual drug license fees to drug companies in return for unfettered access to (with marginal manufacturing costs) the drug for their citizens. In this way, patients would have access to drugs with
relatively small costs while pharmaceutical companies would recoup their fixed research and development (R&D) costs.

Given that many national governments already regulate drug prices heavily, two-part pricing would not require much more administrative burden than already exists. Widespread implementation of that model not only solves the short-run/long-run welfare trade-off but also helps price drugs in an internationally equitable manner. Drug companies would license their drugs to countries according to their elasticity, which is more or less parallel to their incomes, without worrying about parallel importation.1

Another application of the model could be between sizable insurance agents, such as Medicare, and big pharmaceutical companies, which hold a wide variety of drug portfolios. In return for an annual license fee, an insurance company or institution would have the right to use all drugs in this portfolio for all of its customers.

However, the details of the model should be considered very carefully. It looks as though, when they illustrate their model, the authors assumed marginal manufacturing costs to be zero, which might or might not be a reasonable assumption.

Considering that recent research shows underuse of drugs, even if implementation of two-part pricing might involve substantial difficulties, it can provide solutions to many problems we face in pharmaceutical markets.

Abdulkadir Civan
Fatih University
Istanbul, Turkey

NOTE
1. This is sometimes called “Ramsey Pricing.”

Emphasizing Preventive Care

In the midst of this historic presidential election, health care has received much attention in the debate between the two presidential candidates, Sen. John McCain (R-AZ) and Sen. Barack Obama (D-IL), and it promises to be an important part of voters’ decisions at the polls.

While the issues of coverage and rising costs have been front and center in this debate, our preparedness for the various public health problems we face in the future has not been a point of focus. With the baby-boom generation about to start retiring en masse, coupled with bioterrorism and treatment of specific populations, our lack of preventive medicine physicians is a pressing issue. A recent Commentary by Martin Sepulveda and colleagues (Jan/Feb 08) raises this issue and puts it in the context of the health care burden on U.S. employers.

In 1965, when Medicare was created, Congress deemed the training of the physician workforce to be a “public good.” As such, federal funding for physician residency training was directed to teaching hospitals to help offset the costs of training. Unfortunately, preventive medicine residents do not qualify for federal support because training occurs outside hospital settings. As a result, preventive medicine is the only specialty whose residents do not benefit from Medicare's Graduate Medical Education (GME) payments, which covers the costs of residency training. Both training programs and residency graduates are rapidly declining at a time of unprecedented national, state, and community need for properly trained physicians in public health and disaster preparedness, prevention-oriented practices, quality improvement, and patient safety. To address this need, two bills (S 1120 and HR 3404) are pending in the U.S. Congress.

The security of our nation's public health is an important matter, and in this time of threats from bioterrorism, flu pandemics, and new virus threats, we must push the need for more preventive medicine physicians as a vital beginning for meaningful health care reform.

Michael D. Parkinson
American College of Preventive Medicine
Washington, D.C.
Errata

Exhibit 4 in the paper “Use and Costs of Care in Retail Clinics versus Traditional Care Sites” by Marcus Thygeson and colleagues (Sep/Oct 2008, pp. 1283–1292) contained three incorrect numbers. In the fourth row of Exhibit 4, “Urgent care facility,” the numbers should be $31, $125, and $155. The exhibit has been corrected in the online version of the article. The authors and Health Affairs regret any inconvenience these errors might have caused.

Exhibit 2 in the paper “Malpractice Premiums in Massachusetts, a High-Risk State: 1975 to 2005” by Marc A. Rodwin and colleagues (May/Jun 2008, pp. 835–844) reported the five-tier premium means as $2,551 in 2000. This was a typographical error. The correct number is $12,551. The authors and Health Affairs regret any confusion this error might have caused.

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Judie Tucker
Manager, Customer Service and Marketing