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, length, and tone 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. It is our policy to invite every author to respond to letters submitted in response to their work. If a response letter does not appear, it is because the author(s) chose not to respond.

Test The Primary/Specialty Care Hypothesis

Editor’s Note: This first group of letters are in response to the 4 December 2008 Web Exclusives. They first appeared online as comments and have been edited for print format.

To test Richard Cooper’s hypothesis (Web Exclusive, 4 December 2008) that it is simply more doctors, not the mix of specialty/generalists, that makes a difference in access, quality, and cost, why not close down all generalist training programs (which are well on their way toward that goal anyway, with the choices made by U.S. medical students) and see what happens? Managing complex multiple comorbidities, managing urgent and unorganized health complaints, or providing primary and secondary preventive care to large populations of chronically ill patients would be done by an increasing cadre of subspecialty providers. This would prove interesting for Cooper’s next analysis. (In his preface to these papers, deputy editor Philip Musgrove appears to be championing this hypothesis.)

The choice for the United States should either be developing a robust primary care base or allowing seemingly random professional movement of specialists to fill the gaps in care that would develop. Growing the physician supply in the current costly, market-driven, underperforming system seems a foolish way to resolve the debate.

John J. Frey
University of Wisconsin School of Medicine and Public Health
Madison, Wisconsin

Primary/Specialty Care: An Author Responds

The hypothesis regarding primary/specialty care mix (Web Exclusive, 4 December 2008) is Richard Cooper’s alone. My preface to his article and to the Perspectives by Katherine Baicker and Amitabh Chandra and by Jonathan Skinner and colleagues was intended only to introduce the issues in contention. It does not take a stand for or against Cooper’s reasoning. Cooper argues that more of both kinds of physicians per capita are good for health care quality, and the evidence supports that view. But this does not refute the original research by Baicker and Chandra, who showed that the existence of more specialists reduces quality if it comes at the expense of having fewer general practitioners (GPs). These are two distinct questions: Cooper looks at each type of physician separately, whereas Baicker and Chandra hold constant the total number of doctors and consider the effect of substituting one kind for the other. Cooper’s analysis actually agrees with theirs, since his own results show that the presence of more specialists has a much smaller (about one-tenth as large) effect on quality than the presence of more GPs has.

Two further points are worth mentioning but were not in my preface. First, although Cooper’s main finding concerned the relation between numbers of doctors and quality of care, he also found large differences among states that are independent of that relation and depend on socioeconomic or cultural factors that merit closer study. Second, both his analysis and that of Baicker and Chandra are
conducted at a very high level of aggregation (averages over entire states), whereas much more finely grained research on these relations has been done; by using each state's ranking on quality, both authors discard the cardinal information contained in the original quality data. Perhaps it is time to get beyond such relatively simple analyses.

Philip Musgrove
Health Affairs
Bethesda, Maryland

Doctors And Quality Of Care

I found the discussion of physicians and quality of care in Richard Cooper’s papers and the surrounding commentaries (Web Exclusive, 4 December 2008) fascinating but not conclusive. Given the wide disparity of views on this subject, it is very easy for policymakers to pick and choose which theory they would like to base their policies on. From a practicing physician's perspective, I assert that high-quality care can come only from high-quality doctors, whether generalists or specialists. And just like any other service, one only gets what one pays for. It is foolish to debate, as vigorously as the Harvard-Dartmouth group does, that one is better than the other.

Arvind R. Cavale
Feasterville, Pennsylvania

Geographic Analysis: Need For Better Data

The papers by Richard Cooper and others, including Jonathan Skinner and colleagues (Web Exclusive, 4 December 2008), that debate the relationship between physician supply, costs, and quality of care tend to ignore the need to look critically at these relationships and explore alternative ways to understand what is happening. These and related articles attempt to draw conclusions about the relationship between supply of physicians and rates of mortality and access indicators.

An overriding problem with any geographic analysis is that the aggregation of data into rates is usually done using some arbitrary geography based on political boundaries. These rates generate “error,” given that we do not restrict use. The creation of the Hospital Referral Regions (HRRs) in the Dartmouth Atlas approximated patterns of use and represented an estimate of what might be the underlying denominator. The use of state-level indicators is suggestive at best and ought to be viewed with skepticism.

By using analytical methods that loosen the constraints of boundaries, we have tried to replicate and advance the analysis of physician supply as it relates to outcomes. That analysis suggests that we might need to pay more attention to the variability and patterns of the associations to determine if there are alternative geographies. It appears that primary care physician supply is associated with lower mortality in some regions but with higher mortality in others. These regions do not overlay political or postal boundaries but tend to constitute subnational regions.

The authors of these papers need to continue to develop their analyses to account for these geographic issues. We certainly acknowledge that the preponderance of readily available data tends to be defined by political boundaries, often state-level, and that the lack of data useful for answering interesting questions is a real inhibitor in this line of inquiry.

Thomas C. Ricketts and G. Mark Holmes
University of North Carolina at Chapel Hill

NOTE


Geographic Analysis: An Author Responds

I agree with Tom Ricketts and Mark Holmes when they note the importance of defining the right geographical regions in studying the association between physician supply...
and health outcomes. However, even perfect geographic areas won’t solve the problem of untangling causality from simple correlations in cross-sectional aggregated analysis.

So why do cross-sectional analysis at all? My view is that it provides a reasonable check on our theories and models. Suppose one’s view of the world is that more specialists (or health care intensity) lead to better health outcomes. But if we find in the real world a zero association (or positive in some areas while negative in others), then it suggests going back to the drawing board and making an attempt to explain why we should observe the correlation. In other words, these associations can be used to test hypotheses but can never be used to make inferences about causal pathways.

By the same token, I don’t find the association between the proportion of specialists and health care quality to say anything about the causality of whether specialists are “better” than primary care physicians, and thus I am sympathetic to Arvind Cavale’s concerns about the interpretation of the results. If after this exchange we can agree that the empirical record indicates a positive association between generalists and process quality, and an essentially zero association between specialists and quality, then we can also agree that any theory of physician workforce should at least attempt to explain why this is so.

Jonathan S. Skinner
Dartmouth College
Hanover, New Hampshire

NOTE
1. Some studies using good statistical methods suggest that specialists are quicker to adopt some important innovations; for example, see A.M. Fendrick, R.A. Hirth, and M.E. Chernew, “Differences between Generalist and Specialist Physicians regarding *Helicobacter pylori* and Peptic Ulcer Disease,” *American Journal of Gastroenterology* 91, no. 8 (1996): 1544–1548.

Physicians And Quality: Answering The Wrong Question

Richard Cooper (Web Exclusive, 4 December 2009) has come up with an answer ("more is better") to the wrong question. The issue is the impact of health services on health, not on the quality of care. On average, higher physician density is inconsistently related to better health outcomes. However, there is consistent evidence that what really matters in improving population health is not the number of physicians but, rather, what those physicians do. The availability of an adequate supply of primary care physicians has been consistently identified with better health; simply put, person-rather than disease-centered care matters.

Cooper’s work does little to challenge the existing evidence for the benefits of primary care on health, which relies on a strong methodological foundation of multivariate, time-series, and quasi-experimental evidence and based not only on measures of primary care physician-to-population ratios. In fact, evidence from studies examining health outcomes of people whose regular source of care is a primary care physician, and from studies showing that the stronger the achievement of primary care functions, the better the outcomes, is even more persuasive than evidence regarding workforce numbers. That is why it is critical to take seriously the importance of essential primary care functions (including person-focused, not disease-focused, care over time; comprehensiveness of services; and coordination of care) and to use populationwide health outcomes rather than indirect disease-specific proximate ones as measures of the overall impact of health services resources. Suboptimal practice does harm, no matter the number of physicians. Too few true primary care physicians and a surfeit of specialists is bad for population health, bad for the economy, and even worse for health equity.

Barbara Starfield, Leiyu Shi, and James Macinko
Johns Hopkins Bloomberg School of Public Health
Baltimore, Maryland

NOTES
Physicians And Quality: Cooper Responds

I agree with Tom Ricketts and Mark Holmes that units of analysis are critical. ZIP codes, hospitals, Hospital Referral Regions, counties, states, and multistate regions all provide different information, and each must be understood in the context of the others, as Philip Musgrove suggests. Moreover, as Jonathan Skinner cautions, the failure to observe differences where they actually exist should not be taken to indicate that they do not exist but, rather, that the methodology employed may not have been capable of discerning them.

I also agree with Barbara Starfield and colleagues and with John Frey that primary care has value, but I don’t need evidence of decreased mortality from cancer, heart disease, and stroke to prove it, nor would it. These statistics simply reflect the favorable sociodemographic characteristics of states in the upper Midwest that happen to have more family physicians and fewer internists and pediatricians. Patients already know the value of primary care.

As to Arvind Cavale’s question of how conclusive the arguments were, let me summarize two. First, Medicare is anomalous and cannot be taken to represent health care spending overall. Total health care spending correlates closely with the number of health care workers (a proxy for volume of service), but Medicare does not. More total spending correlates with better quality, but Medicare does not. Second, Katherine Baicker and Amitabh Chandra never examined the relationship between quality and the actual numbers of specialists, or even the actual percentage of specialists. Their notion about poor quality came from a theoretical statistical exchange of family physicians for specialists, which has no real-world equivalent. Their statement that “states with more specialists have lower quality,” which refers to what is, has no basis, and what might occur theoretically is unknowable.

In actuality, states with more specialists have better quality.

Richard A. Cooper
School of Medicine, University of Pennsylvania
Philadelphia, Pennsylvania

Coordination Of Care In Medicare

In her paper on Medicare Advantage (MA), Marsha Gold (Web Exclusive, 24 November 2008) misses the mark considerably. Based on our experience, her assertions that little care coordination occurs in MA private fee-for-service plans (PFFS) are decidedly not true.

With more than 200,000 MA PFFS members, we provide essentially the same robust care management services for these members as we do for MA health maintenance organization (HMO) or preferred provider organization (PPO) members. For example, repeated calls are made to all new members each year to complete a health risk assessment, so that we can quickly offer members with high-risk conditions care management services to help improve outcomes. In 2008, 32,000 PFFS members, or 17 percent of our PFFS membership, received personal evaluations and case management services from a dedicated team of nurses, behavioral health specialists, and social workers helping them address their challenges and improve their personal care. Our result: program participants experienced 17 percent fewer acute hospital days than matched unmanaged Medicare beneficiaries.

Our coordinated disease management program provides nurse engagement and management through a single point of contact for members with multiple conditions, to an additional 5 percent of our PFFS members in 2008. That year, MedQuery, our program to identify actionable gaps in care, identified 100,000 member-specific opportunities to improve care and shared them with members or physicians, or both. The list of private program benefits is long, including personal health records, preventive care, and the Aetna Compassionate Care end-of-life care management program.
We take pride in offering our Medicare members access to programs that provide value and frequently better outcomes. More than 75 percent of our MA PFFS members in our most recent survey said that they were satisfied with their plan, and MA, overall, has grown swiftly. The additional services and benefits we provide are a key driver in such member satisfaction and membership growth.

Lonny Reisman and Randall S. Krakauer
Aetna
Hartford, Connecticut

Coordination Of Care: The Author Responds

Aetna is to be commended for using the same care management tools across all of its Medicare Advantage (MA) products. However, that does not mitigate my key point: that we’ve spent a lot of money expanding choice through MA with little evidence of gains in quality and efficiency, particularly outside of the most tightly managed plans (Web Exclusive, 4 November 2008).

Although sponsors often believe otherwise, the sad fact is that effectively managing care to improve quality and promote efficiency has been a challenge in both MA and traditional Medicare. There is limited evidence that third party–administered disease management programs have reduced costs, and there are many flaws in existing studies that suggest that they do. Targeted approaches at care management focused on high-risk patients have been difficult to translate to typical settings of community practice. Medicare’s coordinated care demonstration involving fifteen chronic care programs serving beneficiaries in traditional fee-for-service (FFS) Medicare found few costs savings and only limited and scattered impacts on quality. Better outcomes typically involved many in-person contacts, proximity to patients’ physicians, using the same care coordinator for all of a physician’s patients, timely notification of hospital admission, and other features often absent in vendor-supplied programs. Indeed, a recent Government Accountability Office (GAO) report questioned whether prior notification programs are even authorized for private fee-for-service (PFFS).

Making the case for care management in PFFS plans is particularly challenging when they were explicitly established as a non-managed alternative. Today’s PFFS plans do not use provider networks, cannot put providers at risk, and are extremely limited in how they may influence provider practice. Some PFFS sponsors say that care management is not consistent with PFFS. Reducing hospitalizations and costs in PFFS plans is closely akin to doing so in Medicare FFS, and the lessons from the Coordinated Care Demonstration should apply. PFFS plans also are not required to provide the kinds of quality data required of other MA plans, so the quality of care they provide cannot even be assessed (this will change in 2010).

Marsha Gold
Mathematica Policy Research
Washington, D.C.

NOTES
Some Facts On Rapid Imaging Growth

Although their paper solely addresses imaging growth in a particular health maintenance organization (HMO), Rebecca Smith-Bindman and colleagues (Nov/Dec 08) suggest that legislation focused on self-referral will not sufficiently limit the drivers of rapid imaging growth nationwide. They state, without supporting data, that imaging growth in HMO systems “closely parallels” that in fee-for-service systems. They suggest that self-referral is therefore not a primary driver of escalating overall imaging costs. Neither the scope of their paper nor the published results support these claims.

Self-referral, by which providers refer patients to imaging centers or equipment they own, presents a significant conflict of interest and has been identified by private insurers and government agencies as a primary driver of spiraling costs. There is no financial incentive for ordering physicians to increase imaging utilization unless they self-refer.

Government Accountability Office (GAO) reports and published research document that imaging skyrockets when providers directly profit from ordering scans.1 As much as half of self-referred imaging may be unnecessary and may cost the health care system up to $16 billion annually.2

Self-referred imaging also presents significant quality and safety issues for patients. The Medicare Payment Advisory Commission (MedPAC) cited a major insurer study that found that 78 percent of nonradiologist imaging facilities had at least one serious deficiency—many of which could have “tragic” consequences.3 Also, the National Council on Radiation Protection and Measurements cited self-referral as a primary driver of a fivefold increase in Americans’ exposure to radiation over the past twenty years.4

Imaging is increasingly replacing more invasive procedures—enhancing and extending the lives of patients. Any imaging policy should curb growth in inappropriate imaging, not imaging that has clearly benefited patients. Efforts to discourage self-referral are the most direct and sensible way to reach this goal.

James H. Thrall
Board of Chancellors, American College of Radiology
Boston, Massachusetts

NOTES

Diagnostic Imaging: The Authors Respond

We appreciate the interest of James Thrall and the American College of Radiology in our study (Nov/Dec 08) and welcome the opportunity to respond. We reported a dramatic rise in the rates of diagnostic imaging over the past decade at a large nonprofit health maintenance organization (HMO). What we found to be striking about this rise is that it closely parallels the rise in imaging in fee-for-service set-
tions reported in several studies cited in our paper (Notes 1 and 3). In fact, a paper by Laurence Baker and colleagues in the same *Health Affairs* issue as our study provides further evidence of the similarities between the increases in imaging utilization in these two settings. Baker and colleagues documented that the number of computed tomography (CT) scans among Medicare beneficiaries approximately doubled between 1997 and 2005 (from 260 to 547 CTs per thousand), rates comparable to Group Health enrollees age sixty-five and older during the same years (from 214 to 476 CTs per thousand). Our results are presumably not affected by issues of self-referral or the high profitability associated with imaging in fee-for-service settings, given that our study was conducted at a nonprofit HMO.

We argue that more research is needed to demonstrate whether this increase in imaging is leading to improved health outcomes or efficiencies. Self-referral is clearly an issue of great concern, but it is not the main issue raised by our paper. We need to know more about the benefits and potential harms associated with the growing use of imaging. Ideally, efforts should be made to use imaging as efficiently as possible with the expectation that more judicious and evidence-based utilization would lead to cost savings and improved health.

In addition to self-referral, we believe that a large driver of increased imaging is clinical uncertainty and lack of evidence-based guidelines on when imaging should be used. The American College of Radiology guidelines have started to address this issue, but these guidelines are typically based on expert opinion instead of outcomes studies. Such studies are crucial for identifying when imaging benefits patients and when imaging is useless or potentially harmful. We hope that Thrall and the American College of Radiology will support investment in the conduct of outcomes studies and in the dissemination of those results, so that patients can have access to beneficial imaging at a cost we can afford.

**Rebecca Smith-Bindman for the authors**

*University of California, San Francisco*

**Comparative Effectiveness Research: A Useful Tool**

Brian Firth and colleagues (Nov/Dec 08) use the decision by the National Institute of Health and Clinical Effectiveness (NICE) on drug-eluting stents (DES) in the British National Health Service (NHS) as an example of why comparative effectiveness research (CER) leads to “erroneous” coverage decisions. However, the authors also identify five reasons why this research is a useful tool in reducing waste and maximizing health outcomes from investment in health technology.

CER allows the following: (1) The synthesis of good-quality randomized controlled trials (RCTs) in establishing clinical effectiveness. NICE’s Appraisal Committee considered twenty-five RCTs and meta-analyses pooling the results from more than 7,000 patients, which allowed comparisons of DES with bare metal stents (BMS). (2) The assessment of effectiveness during routine clinical practice by synthesizing different forms of evidence including national epidemiological data. (3) The consideration of value for money; even when improved performance is demonstrated, a decision has to be made as to whether the additional clinical benefit is worth the additional cost. NICE’s Appraisals Committee considered ten full economic evaluations from peer-reviewed publications, three models submit-
ted by stent manufacturers, and an independently commissioned model. (4) Payers, whether they be the British NHS, Medicare, private insurers, or individual consumers spending out-of-pocket, to take advantage of price competition—a core feature of the free market. CER empowered the British NHS to use its collective purchasing power to renegotiate regional contracts with DES manufacturers based on evidence of comparative value for money with BMS. (5) Decisionmakers to make their coverage decisions in a fair, contestable, and transparent way, based on a robust analysis of the best scientific evidence and on broad expert consultation. This is what NICE’s Appraisal Committee did in its evaluation of DES through several rounds of consultation, appeal hearings, and stakeholder meetings.

We fully concur with these five principles. They are all taken into account in the decisions made by NICE’s advisory bodies.

David Barnett, Kalipso Chalkidou, and Michael Rawlins
National Institute of Health and Clinical Effectiveness
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Comparative Effectiveness Research: The Authors Respond

David Barnett and colleagues state that we used the National Institute for Health and Clinical Effectiveness (NICE) decision on drug-eluting stents (DES) “as an example of why comparative effectiveness research (CER) leads to erroneous coverage decisions.” As the abstract to our paper states (Nov/Dec 08), we used NICE’s DES appraisal as an example of the challenges faced when using cost-effectiveness analysis to make coverage decisions on rapidly evolving medical technologies. Our contention is that cost-effectiveness analysis may lead to erroneous conclusions when a broader perspective and the impact on health outcomes and costs are considered.

We cautioned against overreliance on incremental cost-effectiveness ratios based on quality-adjusted life-years (QALYs) when making what are essentially policy decisions about patients’ access to particular medical technologies. We argued that coverage decisions should not be overreliant on the cost-effectiveness ratio; they should be examined for their wider impact on the health system. In the case of DES, a decision not to recommend DES would have resulted in the referral of large numbers of patients back for coronary artery bypass surgery, with consequent increases in waiting times, lengths of hospital stay, and procedural costs. These consequences would have been in contradiction to recent National Health Service policy priorities and were fed into NICE’s consultation process by health care professionals, patients, and industry alike. Economic models do not necessarily capture such consequences; hence our urge for caution against overreliance on the cost-effectiveness ratios such models generate. Put simply, QALY-based incremental cost-effectiveness ratios should be “a tool, not a rule” in health policy decisions.

Of course, NICE’s final decision was to retain its previous clinical indications for the use of DES, and patients therefore continue to benefit from innovation, choice, and quality of care, all of which are U.K. policy priorities.

Liesl M. Cooper for the authors
Covidien
Mansfield, Massachusetts

Online Consumer Information In Pennsylvania

I was heartened to read Michael Rothberg and colleagues’ paper on “Choosing the Best Hospital” (Nov/Dec 08). The authors point to several key issues impeding greater public acceptance and understanding of hospital quality-reporting Web sites, correctly stating that “information must be accessible, interpretable, and consistent” and that hospitals must work with rating agencies and others to develop consensus on what quality data are most relevant and actionable for patients.

Over the past two years, the Pennsylvania Health Care Quality Alliance (PHCQA) has
pursued this strategy and focused on developing a uniform and consistent approach to hospital quality measurement. Its Web site, http://www.pahealthcarequality.org, is the first such site in Pennsylvania that compiles hospital quality data from a variety of sources and allows consumers to search and compare quality data (process and outcome measures) on acute care hospitals in the state. It includes representation from Pennsylvania’s four Blues insurers, its hospital association, its medical society, and representatives from state and federal governments. Much of its work has been spent on developing consensus on what quality measures are most indicative of overall quality and meaningful for patients, as well as how those data can best be displayed for interpretation by consumers.

We recently surveyed more than 900 Pennsylvanians to gain insight into consumers’ awareness and attitudes toward hospital quality-reporting Web sites. The results indicate that although most consumers continue to cite physician recommendation as the most influential and trustworthy source of information, about a third reported visiting a quality-reporting Web site and using its data to make a hospital selection decision.

Although hospital quality reporting is still in its relative infancy, the PHCQA and similar groups in other states are working hard to establish greater consistency and clarity in reporting data on quality.

Erik Muther
Pennsylvania Health Care Quality Alliance
Philadelphia, Pennsylvania

Telephone Interpreters: Vital Link

I wanted to offer a personal “thanks” for Nataly Kelly’s Narrative Matters essay on telephone interpreting (Nov/Dec 08). We have made strides over the past decade in raising awareness of the role that the culture and language of the patient and provider play during medical encounters. However, these issues remain to be widely integrated in quality improvement and patient safety efforts. Kelly’s narrative provided a reminder of the many settings in which language barriers can threaten patient safety, the intricate relationship between culture and language, and the challenges an interpreter is faced with when bridging communication gaps over the telephone.

Although all of these are crucial issues, Kelly’s insight into the challenges and necessary qualifications to interpret over the telephone deserves particular attention. Unfortunately, we know that many practitioners are reluctant to use telephone interpreter services for a variety of reasons, including lack of equipment (such as the dual handset), doubts about interpreters’ qualifications, preferences for in-person interpreters, and even the sense that a third-party presence impedes the building of rapport in the exam room. Regardless of the underlying rationale, this reluctance is worrisome, because telephone interpreters are not only the most commonly available language service in U.S. hospitals today, but are often the only qualified interpreters available.

Kelly’s essay helps readers understand why assessed and trained telephone interpreters should always be used in favor of less qualified in-person interpreters, whether they be family members, friends, or the casual bilingual staff member. I have circulated this narrative to several of my colleagues and leadership to share this point. As a member of that casual bilingual group, I understand that safe and effective interpreter services require far more skill than many of us have, whether interpretation occurs over the telephone, from an office one thousand miles away, or at an arm’s reach inside the same exam room.

Erica Galvez
Joint Commission
Oakbrook Terrace, Illinois

Physicians’ Motives In Imaging

As a new subscriber to Health Affairs, I was taken aback at the editor-in-chief’s apparent indictment of physicians’ motives in ordering computed tomography (CT) scans for their patients (Nov/Dec 08).

I am aware of the large increase in the num-
ber of imaging studies nationwide. The recent decision by Medicare to require accreditation in the future for certain imaging tests as a requirement for reimbursement is a major step in the right direction. Any test or procedure ordered for purely financial profit is reprehensible, and physicians should be prosecuted if proven guilty. However, as I read Susan Dentzer's editorial, I perceived the tone of her comments about "physicians' wallets" and physicians' "feeling right with their patients and God" as unfair. Laurence Baker and colleagues correctly (and rationally) question cost versus benefit of CT and computed tomography angiography (CTA) in the issue. Similarly, Julie Appleby's Report from the Field presents both sides of the CTA controversy.

Physicians and insurers are very often at odds over utilization. We fight the battle over appropriate tests for our patients every day. As pointed out, there are other more obvious reasons for using CT scans and CTA, such as rapid and more precise information (compared to a cheaper alternative such as ultrasound), the evolving standard of care, patient demand, and, based on personal experience: defensive medicine. In my specialty (vascular diseases and surgery), CTA has become a valuable tool in avoiding invasive arteriography and planning of minimally invasive endovascular procedures. And no, we do not own a CT machine.

My object in subscribing to this journal was to learn more about how scientific methods are applied in analyzing health policy issues. I look forward to enjoying future issues of Health Affairs, but perhaps with less pointed editorial language.

Bhagwan Satiani
Ohio State University College of Medicine
Columbus, Ohio

Imaging: The Editor Responds

As I mentioned in my "From the Editor" note (Nov/Dec 08), "the benefits of many medical technologies are real," and this includes the enormous benefits of medical imaging, as Bhagwan Satiani suggests. However, it is difficult to conclude based on the available evidence that all imaging that is being performed by doctors in their offices is either cost-effective or clinically necessary. As the Government Accountability Office (GAO) reported in its 13 June 2008 analysis of Medicare Part B and imaging, analysis over a six-year period showed "certain trends linking spending growth to the provision of imaging services in physician offices. The proportion of Medicare spending on imaging services performed in-office rose from 58 percent to 64 percent. Physicians also obtained an increasing share of their Medicare revenue from imaging services. In addition, in-office imaging spending per beneficiary varied substantially across geographic regions of the country, suggesting that not all utilization was necessary or appropriate. By 2006, in-office imaging spending per beneficiary varied almost eight-fold across the states—from $62 in Vermont to $472 in Florida." That language rather pointedly suggests that the problem I referenced in my note—"that many doctors find ample reason to do more lucrative scans and still feel right with their patients and God"—has been noted by the GAO, as it also has been on a number of occasions by the Medicare Payment Advisory Commission.

Susan Dentzer
Editor-In-Chief, Health Affairs
Bethesda, Maryland

Hip And Knee Implants In Bulgaria

We read with interest the paper by Natalia Wilson and colleagues (Nov/Dec 08) about ongoing policy considerations for hip and knee implants. Summarizing recent evidence on hip-spine syndrome (HSS) management, we contribute recent results from a university hospital in Plovdiv, Bulgaria. HSS is chronically progressing and, if untreated appropriately, leads to deterioration of functional fitness and quality of life. In prior research, surgery (laminectomy) had multiple advantages over nonsurgical therapy in lumbar spinal stenosis (LSS) at the third month in prospective cohorts. A 7.8-point difference from baseline in bodily pain (according to the SF-
also was evidence of its effectiveness.1 Supporting these findings, we found that total hip replacement, alone or after laminectomy, was highly effective in aged patients with both lumbar and hip pain. Combined findings from our unique observational prospective data indicated very high efficacy levels of THR (in fifty-eight HSS patients).2

In particular, twenty-nine patients with hip osteoarthritis underwent THR; hip pain disappeared in 68.97 percent of them. Lumbar pain remained in eight who also had LSS. Seventeen out of another twenty-five patients with LSS underwent laminectomy. Lumbar pain decreased, but hip pain persisted. Thirteen patients had hip osteoarthritis (bilateral in six of them). Our most important advantage was targeted, patient-level decision making by a panel of highly-specialized experts (neurologist, neurosurgeon, orthopedic surgeon, roentgenologist) acting together to choose the best surgical intervention in each case. Assessing their own quality-of-life improvement, many patients reported relief from pain. Undoubtedly, our individualized surgery showed very high effectiveness as both clinical effects and patient-reported outcomes, especially in LSS combined with hip osteoarthritis. Interestingly, similar improvements in both patient-reported outcomes and clinical measures were reported in comparable prospective cohort of forty-two Japanese patients with LSS.3

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Borislav D. Dimitrov
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NOTES

Grim Prognosis For Massachusetts Reform

Jon Gabel and colleagues (Web Exclusive, 28 October 2008) hope that favorable employer attitudes mean that Massachusetts' 2006 health reform will succeed where the state's similar 1988 health reform failed. In truth, the demise of the 1988 law had more to do with economic cycles—the collapse of the Massachusetts Miracle—than with corporate attitudes. Unfortunately, this history, along with the recent downturn in the economy, implies a grim prognosis for the current Massachusetts reform.

The 1988 reform died because health care costs continued to soar, while a recession shrunk tax revenues just as tens of thousands lost their jobs and private coverage. (Unemployment rose from 3.2 percent in 1988 to 9.1 percent two years later.) Neither massive expansion of state funding to subsidize coverage for the poor nor a costly mandate—the two main mechanisms to expand coverage under both the 1988 and 2006 laws—was tenable in a cooling economy.

Despite costs of $1.1 billion this year, the 2006 law has covered only half of the uninsured and has left many more with inadequate coverage. A recent Boston Globe/Blue Cross Blue Shield of Massachusetts Foundation survey found that 9 percent of Massachusetts residents avoided or postponed care within the past year because of costs; 14 percent had failed to fill a prescription; and 14 percent had run up medical debts.1 The inadequacy of the new coverage is also evident in Robert Blendon and colleagues' survey (Web Exclusive, 28 October 2008); those directly affected by the reform were actually more likely to say that reform had hurt than helped them. This seemingly paradoxical result probably reflects
the fact that most of the newly insured had previously been eligible for completely free care at safety-net hospitals and clinics paid for by Massachusetts’ free-care pool.

Even the partial gains of the 2006 reform are now in jeopardy, and its collapse may well leave patients worse off than ever. The reform was partly financed by draining funds from the free-care pool, and hence from safety-net providers. Now, with tax revenues plummeting, the governor plans to pull another $100 million from funds owed to the safety-net hospitals in the Boston area (disclosure: we work as primary care doctors at one of them, where these cuts are projected to require hundreds of layoffs and the closure of critical services and community clinics). Further budget cuts likely lie ahead, and the ranks of the uninsured will doubtless swell.

In the end, Massachusetts’ 2006 reform may be remembered as a short-lived expansion of publicly subsidized coverage that served as political cover for the permanent destruction of institutions that have provided care and advocacy for New England’s poor for decades.

Steffie Woolhandler and David U. Himmelstein
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Cambridge, Massachusetts

NOTE

Massachusetts Reform: The Authors Respond

We concur with Steffie Woolhandler and David Himmelstein in their response to our paper (Web Exclusive, 28 October 2008) that the current economic downturn and rising cost of health care jeopardizes Massachusetts reform. However, we think that their “grim prognosis” misinterprets the historical record.

After 1988 passage, political opposition from employers, rising health care costs, and an economic recession contributed to suspension of the legislation. Although Massachusetts data are not available, the Health Insurance Association of America (now America’s Health Insurance Plans, or AHIP) reported an 18 percent national increase in premiums in 1989.1 Premium increases remained at double digits until 1993. From 1994 to 1998, premium increases were at record lows.2 Concurrently, Massachusetts unemployment rose from 3.5 percent in December 1988 to 9.1 percent in April 1992. By December 1993, unemployment fell to 6.3 percent and to 4.3 percent three years later.3 Hence, conditions for implementing the 1988 legislation were highly favorable when it was repealed in 1996.

We believe that Woolhandler and Himmelstein don’t sufficiently credit progress achieved in Massachusetts over the past two years. Compared to national statistics, the figures they cite from the Boston Globe/Blue Cross Blue Shield of Massachusetts Foundation survey are favorable. From a 2007 national household survey of adults ages 19–64, researchers reported that 31 percent of Americans “had a medical problem but did not visit the doctor,” 31 percent “did not fill a prescription,” and 27 percent “had problems paying medical bills.”4

In the face of an economic downturn, public and employer support and a sympathetic Obama administration render the future of the Massachusetts plan “stable,” not “grim.”

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NOTES
Segmented Approach For China And India

Responses to our paper on a segmented approach to health care financing gaps in China and India (July/Aug 08) underscore the great contrasts public and private-sector decision-makers seek to balance: world-class health care facilities exist, yet they are sadly out of the economic reach of the majority (Tom Miller and Aparna Mathur, Letters, Jan/Feb 09). Low-cost public health care facilities are available, yet the quality of care provided leaves little confidence among most consumers. Undefined regulatory systems allow for experimentation, yet they also encourage perverse behavior (Chris Conover, Letters, Jan/Feb 09). While attempting to balance these contrasts, policymakers and consumers are asked to make difficult choices on how to pay for health care among a long list of other pressing needs (Michael Cannon, Letters, Jan/Feb 09).

In expanding health care financing, we do not advocate that a one-size-fits-all strategy (for example, centralized health care) would be effective or sustainable. We prescribe combining essential market foundations with a segmented approach to health care financing. Admittedly, public- and private-sector leaders in India and (to a lesser extent) China have taken steps in this direction. In view of this, the suggestion by Miller and Mathur that we are endorsing an overregulated or centralized approach is rather perplexing.

In implementing our approach, health care regulators and commercial payers in India and China should first establish a minimum base of reference in the form of a mix of regulatory and market-based “rules of the game” for health care financing markets. As Cannon correctly suggests, this may be the “best thing those governments could do.” The segmented approach to health care financing provides market-appropriate payment mechanisms based on consumers’ needs. For example, a segmented approach to address India’s financing gaps may involve government- or community-funded health care financing for the rural poor or needy and private health insurance for those who are better off. A similar analysis of China’s financing gap may involve segmenting along coverage levels, given the country’s expansive basic care health care coverage programs.

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Errata

The January/February 2009 issue of Health Affairs contained several errors. All of these articles have been corrected online. The authors and Health Affairs regret any inconvenience these errors might have caused.

Paez et al., pp. 15–25. A programming error caused several errors in “Rising Out-of-Pocket Spending for Chronic Conditions: A Ten-Year Trend,” by Kathryn Anne Paez and colleagues (Jan/Feb 2009, pp. 15–25). On page 22, the second and third full paragraphs have been revised. The new text reads as follows:

An out-of-pocket expenditure index (EI) was created to measure the overall increase in out-of-pocket spending comparing 2005 to 1996 spending, holding disease prevalence constant (Exhibit 5). The change seen is due solely to increasing out-of-pocket spending. The EI for the overall population was 1.19, indicating that expenditures were 19 percent higher in 2005 than in 1996, when chronic condition prevalence was held constant. The younger-old had the greatest increase, with an EI of 1.30, followed by young adults, those in midlife, young adults, and the old-old.

All insurance categories, including Medicaid recipients, had a sizable increase in out-of-pocket spending over the ten-year period. The largest increase was experienced by those in the “other public” insurance category, followed by the uninsured and Medicare-only beneficiaries. Although smaller, the EI for Medicaid recipients was substantial when controlling for rising chronic condition prevalence.

Also on page 22, the last full paragraph has
Our study found that out-of-pocket spending and chronic disease prevalence are increasing among not only the old-old but among people in midlife and early old age, without regard to sex, race, ethnicity, or income. The greatest growth occurred in the number of people reporting multiple chronic diseases; this is also the group with the most substantial out-of-pocket spending. Overall, out-of-pocket spending increased by 39.4 percent per person over the ten-year period. The growth in out-of-pocket spending was not evenly distributed across the population. Spending increases were 19 percent higher overall when holding the rising prevalence of chronic conditions constant, with the greatest increase among those in early old age, the “other public” insured, the uninsured, Medicare beneficiaries, the poor, and people who take prescription drugs. Medicaid continued to provide financial protection for people with chronic conditions from high out-of-pocket spending. When poverty status was considered, it became evident that Medicaid is not available to all poor people with chronic conditions.

On page 23, all of the data in Exhibit 5 have been replaced. This exhibit, as well as the corrected text, is available at http://content.healthaffairs.org/cgi/content/full/28/1/15.

- **Coye et al., pp. 126–135.** Three minor corrections have been made to “Remote Patient Management: Technology-Enabled Innovation and Evolving Business Models for Chronic Disease Care,” by Molly Joel Coye and colleagues (Jan/Feb 09, pp. 126–135). On page 131, the word “potential” has been inserted at the end of the second full paragraph, as follows: “...and also to prepare for the CMS's potential decision not to reimburse for certain admissions after 2009.” On page 132, three lines from the top, the following revision was made: “...patients admitted for heart failure, pneumonia, and acute myocardial infarction in 2009, and described options for modifying or denying reimbursement in 2010.” Finally, at the end of the first full paragraph on page 132, the final sentence has been modified as follows: “It is unclear, however, how models based on the financial imperative...” The corrected article is available at http://content.healthaffairs.org/cgi/content/full/28/1/126.

- **Grabowski, pp. 136–146.** An endnote was inadvertently left out of “Special Needs Plans and the Coordination of Benefits and Services for Dual Eligibles,” by David G. Grabowski (Jan/Feb 09, pp. 136–146). On page 139, endnote 15 should be inserted at the end of the second sentence below the subheading “For Medicare and Medicaid.” On page 146, this note (new note 15) reads as follows: Saucier and Burwell, The Impact of Medicare Special Needs Plans. Every note after this, starting with the old note 15, is renumbered one higher. In addition, to make room for the added text, the first sentence has been deleted from note 14.

- **Etheredge, pp. 148–159.** Note 10 in “Medicare's Future: Cancer Care,” by Lynn M. Etheredge (Jan/Feb 09, pp. 148–159), contained an inadvertent error. The title of the book in Note 10 is Ensuring Quality Cancer Care.

- **Ham, pp. 190–201.** Note 32 of “Chronic Care in the English National Health Service: Progress and Challenges,” by Chris Ham (Jan/Feb 09, pp. 190–201), contained a typographical error. The volume and issue number should be 288, no. 15.

- **Anderson, pp. 202–205.** Note 7 in “Missing in Action: International Aid Agencies in Poor Countries to Fight Chronic Disease,” by Gerard F. Anderson (Jan/Feb 09, pp. 202–205), contained two typographical errors. In the second citation, the author's name is “Gaziano,” and the volume and issue number should be 26, no. 1.

- **Hartman et al., pp. 246–261.** There were several minor errors in “National Health Spending in 2007: Slower Drug Spending Contributes to Lowest Rate of Overall Growth since 1998,” by Micah Hartman and colleagues (Jan/Feb 09, pp. 245–261). On page 251, the phrase “the continued shift toward lower-cost mail order channels” has been deleted from the second sentence in the first full paragraph. The title of Exhibit 6 (page 259) has been changed to “Expenditure Levels For, And Average Annual Growth In, Health Services And Supplies...” Finally, the second source in Note 9, page 260, has been removed. The corrected article is available online at http://content.healthaffairs.org/cgi/content/full/28/1/260.