FROM THE EDITOR-IN-CHIEF

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A Tour Across Vast Health Policy Terrain

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Our February 2011 variety issue stretches over vast health policy terrain, ranging from the health care workforce to research ethics, pharmaceutical R&D, and mental health. We also anticipate some key challenges in health care reform—separate and apart from efforts to repeal the law, as evident in House Republicans’ January 19 vote.

We begin with a stunner: an unexplained gap—averaging $16,819 in 2008—in the annual pay of male and female physicians leaving residency programs and entering full-time practice. That’s the conclusion of Anthony Lo Sasso and coauthors, based on their analysis of data from New York, home to the greatest number of medical residency programs in the nation (1,073).

The authors report that the gap isn’t explainable by predictable factors such as choice of specialties, work hours, or other characteristics. The gap shows up clearly within specialties: Female heart surgeons are paid $27,103 less on average than males; female otolaryngologists, $32,207 less.

PAY DISCRIMINATION?
This disparity is clearly shocking at a time when women represent nearly 48 percent of medical school students, according to statistics gathered by the Association of American Medical Colleges. Lo Sasso and coauthors cite possible explanations. Perhaps women are willingly trading off pay for “family friendly” practice patterns; another more sinister hypothesis, which the authors believe is unlikely, is that “discrimination, after a period of quiescence, has... been on the rise in recent years.” Whatever the case, understanding and addressing the causes should be at the top of “urgent-action” lists for physician and specialty groups nationwide.

NURSE DISINCENTIVES
Underpaid female docs are in good company, it appears. Matthew McHugh and colleagues examine survey data and find much higher job dissatisfaction and burnout among nurses who are actually engaged in nursing—that is, directly caring for patients in hospitals and nursing homes, rather than working in other jobs such as at health insurance companies or in the pharmaceutical industry. Ironically, a key complaint is about their health benefits, whose antiquated structure leaves nurses with packages inferior to those of other white-collar employees.

CASHLESS COMMISSION
As John Iglehart’s Entry Point reminds us, the need to reassess the nation’s health workforce policies—or lack thereof—doesn’t stop there. In classic tradition, the Affordable Care Act took many intractable workforce issues and handed them off to a new commission. Now, although commission members have been appointed, Congress hasn’t granted the panel a penny to do its work. It’s unclear whether the commission will ever get off the ground, given pressures to slash federal spending.

ISSUES IN RESEARCH
Research ethics and the payoff from federal R&D also come under scrutiny. Joseph Fins and his coauthors raise questions about using deep brain stimulation to treat neuropsychiatric conditions without benefit of clinical trials demonstrating whether it works. The Food and Drug Administration has allowed that under a humanitarian device exemption, which gives patients with rare conditions access to new or experimental therapies.

Meanwhile, Bhaven Sampat and Frank Lichtenberg put new data behind the question of the role that research funding plays in the discovery of new drugs. Their analysis sheds light on the merits of various proposals, such as those that would recapture a share of drug profits for the government.

HEALTH REFORM REALITY CHECKS
Health reform challenges are addressed in several articles. Benjamin Sommers and Sara Rosenbaum find that given frequent fluctuations in income, as many as half of Americans below 200 percent of the federal poverty level could shuffle back and forth between Medicaid and new health insurance exchanges within a year after 2014. They suggest strategies to cut the churning and minimize the effect on this population’s coverage and quality of care.

Another reality check is suggested by Tami Mark and colleagues, in their article on spending trends for mental health and substance abuse treatment. According to the latest available data, in 2005, 28 percent of all national mental health spending was borne by Medicaid. Now some states are retrenching on mental health programs—one is Arizona, site of the tragic January 8 shootings—even as others angle to cap or block-grant Medicaid. What all of this bodes for Medicaid expansion in 2014 remains to be seen.