The eLetter that follows was published on the Health Affairs Web site in March 2005 after the posting of the Web Exclusive by Barbara Starfield and colleagues, “The Value of Health Care Information Exchange and Interoperability”; and Perspectives by David C. Goodman, Robert L. Phillips Jr. and colleagues, and Edward Salsberg, 19 January 2005. Several critical issues were published in those Perspectives, but time constraints prohibited Starfield and colleagues from responding to those criticisms in simultaneous publication. Starfield and colleagues respond to Salsberg’s Perspective in this eLetter.


It was gratifying to see that although Ed Salsberg complained about our approach, he came to the same conclusion that we did: that we need more information before making decisions about specialty composition in the health professions. Moreover, he did not refute a central concept of our paper: that there is little evidence to link the supply of specialist physicians to health outcomes for populations.

We were disappointed that many of our points were missed in his comments: We specifically discussed system shortcomings; we counted only physicians reporting themselves primarily in patient care; we discussed the issue of lumping specialists together; and we controlled for socioeconomic and demographic factors.

We continue to maintain that much more is known about primary care practice than about specialist practice. We do not even know the relative proportions of specialist’s time spent in routine follow-up (which could be done by primary care physicians), second opinions and short-term consultations, and long term follow-up care for rare or unusual problems.

The notion that primary care physicians could “maintain expertise in several specialty areas” by greatly limiting their practice size flies in the face of everything we know about competence; outcomes of care are dependent on a sufficient volume of patients to maintain competence.

We agree that some health systems (including Kaiser) are trying to increase the supply of at least certain specialists, but they all started from a level much lower than that in the United States as a whole and still will not aspire to the overall ratios the United States has at a national level. The point of the efforts of other countries is that they are making informed decisions based on studies and evaluations of the relative roles of primary care physicians and specialists; we cited some of those studies. We lack such efforts in the United States; unfortunately, the “observations” of allergists and immunologists do not appear in a peer-reviewed publication and thus do not satisfy the criterion of “evidence.”

On the other hand, the evidence on the association between primary care providers and health outcomes is robust. Studies of larger geographic units including urban counties, metropolitan statistical areas (MSAs), and U.S. states as well as at the individual level have confirmed the significant relationship between primary care and better health outcomes, including improved self-perceived health status; reduced infant mortality and low birthweight; and lower all-cause and cause-specific mortality from cancer, heart disease, and stroke. The ecological relationship between specialists and health outcomes remained insignificant or even negative when analyses were conducted using larger geographic units than counties or when multiple years of data were used. All of these studies have controlled for socioeconomic and demographic determinants of health.

Indeed, we need more information and knowledge about what specialists do in the context of health system characteristics, as Salsberg agrees. We sincerely hope that he uses his considerable influence to press for understanding before urging educators and
policymakers to increase the supply of various aspects of the health professions.

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**NOTES**

