our ignorance of whether spending billions on it makes patients better, payers will get poor value for money, and patients will be victims of the largely unproven arts of professionals. Consumer-driven health care in this environment might be little more than institutionalized swindles.

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NOTE

Vulnerable In More Than One Way

The paper by David Mechanic and Jennifer Tanner about vulnerable populations (Sep/Oct 07) makes an important contribution to the literature by elaborating on major sources of vulnerability across population groups and a society-level strategy for addressing disparities.

Needed further still is an explicit call for researchers, practitioners, and policymakers to recognize that vulnerable populations often share common traits. For example, minority groups (a vulnerability trait) tend to be of lower socioeconomic status (second trait) and are less likely to be insured (third trait). These overlapping traits contribute to gradients in health status and the receipt of health care.

The single-trait approach continues to be the primary mechanism for documenting and addressing health disparities. Only recently have we begun to see vulnerability traits regularly reported in combination. It remains rare, however, that interventions address multiple traits, although this is needed and possible.

Community health centers, for example, have long been reducing barriers to accessing care for vulnerable families. Health centers offer low- or no-cost services (targeting financial barriers), are located in high-need areas (geographic barriers), and provide translation services (language barriers).

With no single intervention available to raise the health of vulnerable populations on a par with the nonvulnerable, our country’s future success in resolving disparities might lie in our ability to effectively recognize and intervene simultaneously with multiple, overlapping vulnerability traits.

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NOTES

Correcting Hatch-Waxman

The paper by Ernst Berndt and colleagues (May/Jun 07) about authorized generic (AG) drugs states that AGs don’t affect drug prices, while the letter by Donald Moran and colleagues (Jan/Feb 08) suggests that a ban on AGs will increase federal spending. Both groups of authors focus on revenue projections, but they don’t distinguish between increased competition and unfair competition.

An AG is a generic version of the brand released by the original “innovator company.” For a generic drug company that produces commodity products, filing an abbreviated new drug application (ANDA) for generic drug approval on an existing drug and a paragraph IV challenge to the patent is a major and risky investment. After approval, if the successful generic drug company needs to compete against the innovator company’s AG during the 180-day market exclusivity period, then there is no reward for risk. To major pharmaceutical companies, returns on an AG are minuscule and transient. Could the real reason for AGs be to nullify competition by deincetivating generic drug companies? The result