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  
1. L. Chen et al., “Human Resources for Health: Overcoming the Crisis,” Lancet 364, no. 9449

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.