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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 and length 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.*

Reform, Then Better Financing

Health care reform is destined—deserves—to fail if we do not diagnose and treat the right problem: the dysfunctional health care delivery system. William Sage's paper (Nov/Dec 07) hits the nail on the head when he writes, "It's the delivery system, stupid."

Although Americans enjoy some of the best health care in the world, we also experience extraordinary deficits and poor outcomes. Finding better ways to finance, access, or measure results within the current paradigm is not the good news or the right answer. An anonymous quote applied in this context sums it up: "There is nothing more wasteful than doing better that which shouldn't be done at all." What is needed is to move from the physician-dependent, hospital-based, acuity-oriented system to one that is safe, convenient, effective, efficient, and personalized. Our current system does not consistently deliver that—just ask the people who work in it.

We should also listen carefully to what the average American is telling us: (1) "I want convenience and quality." (Witness the growth of "minute clinics" despite fierce resistance by the American Medical Association.) (2) "I want choice." (More than one-third of Americans use complementary therapy.) (3) "I want efficiency." (After public outcry, Congress is considering banning restrictive distribution of contact lenses, potentially eliminating unnecessary eye doctor visits.) (4) "I want personalized care." (Americans are using, and often paying for, community-based, low-cost, high-quality, personalized care alternatives.)

To educate the public and policymakers, the American Academy of Nursing is gathering proof that solutions do exist and that by changing the fundamental way in which care is delivered, health care reform is happening, patient by patient and community by community. Let's support these innovative approaches, truly reform the delivery system—and then finance that.

JOANNE DISCH
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Looking Back At Health Surveys

In their thought-provoking paper (Nov/Dec 07), Marc Berk and colleagues conclude that it is unclear whether policymakers today are basing decisions on health survey data that are of higher quality than—or even the same quality as—those from twenty-five years ago. They suggest that one way (among others) to improve the quality of federal health surveys is to devote more resources to exploring and assessing the methods of the collected data. Although supporting more methods research might well be money well spent, my sense is that if more of the findings of earlier health survey methods research had been applied, the quality of today's data would be better.

Berk and colleagues note that an investigation specifically designed to inform the development of the 1977 National Medical Care Expenditure Survey (NMCES) was "the first major effort to undertake wide-ranging methodological work on focused collecting health spending data." In fact, a methodological study titled *Total Survey Error: Efforts to Improve Health Surveys* (Jossey-Bass, 1979), which I undertook with Judith Kasper, Martin Frankel, and other colleagues, based on the earlier 1970 National Health Survey of Use and Expenditures undertaken by the Center for Health Administration Studies and NORC at the University of Chicago, also explored the quality of health spending data.

On the basis of comparisons between sur-

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vey findings and physician, hospital, and insurance records, we suggested that the quality of survey estimates might be improved by greater emphasis on correction of bias instead of the traditional focus on random error. We showed differential bias in some survey estimates of disparities in use, spending, and insurance coverage according to respondents' ethnicity, poverty level, and health status. We also proposed different models for using bias assessments for improving survey estimates.

The limited extent to which the early findings of *Total Survey Error* and other later methodological studies have been used to improve the quality of health survey data suggests that more attention might be given as to how to use what we already know—as well as doing more methodological research.

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SCHOOL OF PUBLIC HEALTH

Looking Back: The Authors Respond

Ron Andersen correctly notes important methods work completed before the National Medical Care Expenditure Survey (Medical Economics Survey) was conducted in 1976 and published in 1977. The 1976 effort, however, was the first health spending study devoted exclusively to the study of methods. It was conducted in only two sites and wasn't used in any policy analysis that we are aware of.

Anderson is correct, though, that the study by the Center for Health Administration Studies and NORC at the University of Chicago was conducted in 1970 and, thus, predates the 1976 effort. The 1970 study made important contributions to our knowledge about collecting health spending data; it also had a major impact on the conceptual way in which access to care is measured.

Although we agree that the field hasn't always made maximum use of what is already known, the contribution of *Total Survey Error* to the design of the surveys preceding the Medical Expenditure Panel Survey (MEPS) was substantial, particularly with respect to developing provider surveys used to verify household-reported information. Indeed, the federal government provided all members of the original MEPS design team with a copy, and staff members were expected to be familiar with it. One such member was Steve Cohen, who, along with Carolyn Clancy, wrote a second letter responding to our paper, which follows.

MARC L. BERK, CLAUDIA L. SCHUR, AND
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AHRQ And Data Collection

The paper on twenty-five years of health surveys (Nov/Dec 07) by Marc Berk and colleagues provides an informative overview of the diverse set of increasingly complex and competing challenges that health surveys confront, as well as raising important considerations for future improvements.

As the U.S. Department of Health and Human Services' (HHS's) data council cochair, the Agency for Healthcare Research and Quality (AHRQ) strives to ensure that HHS's investments in collecting data are efficient and well coordinated and that core data systems generate information to address and anticipate high-priority policy data needs.

In sponsoring major health care surveys—such as the Medical Expenditure Panel Survey (MEPS)—AHRQ is committed to ensuring the integrity, timeliness, and use of these surveys to inform health policy and practice, at the same time ensuring that they are designed according to high-quality, effective, and efficient statistical and methodological practices. Many of the survey innovations and design improvements in MEPS have come about through survey integration and our ongoing, targeted investments in methodological and statistical research.

Although difficulties encountered by declining cooperation levels, privacy concerns, technological changes, and an increasingly complex health care environment aren't likely to dissipate in the short term, emerging innovations in health information technology, more pervasive adoption of standardized electronic health records, and more systematic applications of Web-based surveys with enhanced data security features might serve as additional venues for future data quality improvements. Additionally, the research and development undergirding surveys will also facilitate continued efforts to improve the validity of information about populations of greatest concern to researchers and policymakers.

Steven B. Cohen and Carolyn M. Clancy
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AHRQ And Data Collection: The Authors Respond

Steve Cohen and Carolyn Clancy correctly note the importance that the Agency for Healthcare Research and Quality (AHRQ) places on producing accurate and timely estimates. AHRQ has not only conducted important methodological work, it has also made major efforts to disseminate study results. The Medical Expenditure Panel Survey (MEPS) findings related to survey methods are a staple at many visible research conferences, are published in peer-reviewed journals, and are available through the MEPS Web site. MEPS data have proved to be of enormous value to policymakers. The innovations that Cohen and colleagues incorporated into MEPS have also influenced the way in which other surveys are conducted.

Because of the increased need for better data, we believe that additional investments are warranted. We agree that the innovations and improvements in MEPS have come about through "survey integration and…ongoing, targeted investments in methodological and statistical research." Given the usefulness of this research, however, we believe that the U.S. Department of Health and Human Services would be well served by less "targeting."

There is still much we don't know, and our paper describes the changing environment that has made these challenges difficult. Issues that need to be dealt with include declining response rates, concerns about privacy, the growth of cell phone–only households, and so on. Whether or not new research will "include continued efforts to improve the validity of information" on populations of most concern is ultimately an empirical question that will depend, in part, on the funds allocated for such research.

Since MEPS contains extensive validation data from provider surveys, it is ideally suited to supporting additional work. In our paper, we raise the possibility that data quality might be worse today than in previous years. MEPS is the ideal vehicle to use to test this proposition. By comparing the congruency between household- and provider-reported data, we can look beyond response rates (an overly simplistic measure of quality) and instead focus on how data accuracy has changed over time. We remain confident that AHRQ and other agencies will be well served if policymakers take a longer-term perspective and increase investments in survey methods research.

Marc L. Berk, Claudia L. Schur, and Jacob Feldman
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The Uninsured And Affordability

In their paper about mandating health insurance (Nov/Dec 07), Sherry Glied and colleagues offer suggestions for making such a mandate more effective in increasing the number of people with health coverage: compliance should be easy and relatively inexpensive, penalties for noncompliance should be large enough to matter but not too burdensome, and enforcement should be aggressive. An additional requirement, not mentioned by the authors, is widespread agreement by the public that the mandate is necessary and desirable—even when it is applied to them.

On all of these counts, a mandate is likely to fail if it is a prerequisite to reform and unnecessary if more difficult steps are taken to lower the cost of coverage and improve the value offered by health insurance. By focusing narrowly on the mechanics of a mandate, Glied and colleagues do not consider whether the coverage itself is affordable and attractive. Massachusetts' $219 tax penalty for 2007 for being uninsured pales into insignificance compared with a premium for single coverage, which ranges from $2,100 to more than $6,000 annually.[1] The 2008 penalty jumps to as much as half the cost of the premium—too severe to be levied on many uninsured people. By exempting nearly 20 percent of uninsured adults, the state's Connector Board recognized that the mandate would be a continuing source of political controversy and ineffective in increasing unsubsidized coverage unless the cost of insurance could be brought down.

When a mandate appears necessary because people are not willing to buy insurance, it is unsustainable. The solution is not tougher noncompliance penalties or higher taxes to finance more-generous subsidies or more-restrictive insurance regulation. Instead of attempting to micromanage the health sector, sensible policy would take advantage of market incentives to reduce inefficiency and promote a high-value health care system.

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NOTE

[1] Premium for a 30-year-old individual living in Boston, Massachusetts, taken from the Commonwealth Connector's Web site, http://www.mahealthconnector.org/portal/site/connector/menuitem.55b6e23ac6627f40dbef6f47d7468a0c/?fiShown=default (accessed 17 December 2007).

The Uninsured: An Author Responds

Joe Antos is correct in asserting that a mandate will not be effective unless the public views it as appropriate and the coverage mandated as affordable and desirable. But, as the experience of childhood immunization and seat belt mandates suggest, a mandate might be necessary even if these conditions are met. In a world where people have many choices and little time, mandates provide an indication of urgency and importance that can lead those who are indifferent about coverage—the negligent procrastinators among us—to reprioritize and move health insurance higher up on their to-do list. As we argue in our paper, mandates are no substitute for subsidies, high-quality coverage, or administrative simplicity, but they remain attractive because they have an important, albeit limited, role to play.

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Protecting The Veracity Of Practice Guidelines

The well-grounded conclusion of Brooke Herndon and colleagues (Nov/Dec 07) that expanding the disease definition for osteoporosis provides some benefit but also increases the risks and costs of therapy is true for many diseases. Given the recent lackluster drug development on the part of the pharmaceutical industry, drug companies would like nothing more than to expand indications for existing products. By issuing practice guidelines, professional societies—inadvertently or intentionally—are abetting industry's desires.

Because practice guidelines are the basis for many therapeutic recommendations, their veracity is critical. Unfortunately, guidelines produced by several professional societies have been tainted not only by industry support, but also by heavily conflicted guideline committee membership.[1] Minimizing industry-favorable bias in practice guidelines is essential to attaining objective recommendations and protecting patients. Professional organizations usually "manage" such conflicts by disclosing the conflicts of sponsors and panel members; few disclose the dollar amounts. But because disclosure is a necessary but insufficient method of preventing industry-favorable bias, other methods must be used.

Asking the Institute of Medicine (IOM) to redo treatment guidelines, as Herndon and colleagues suggest, is impractical. What then?

Medical organizations must find sources to support their guideline development other than companies that would benefit from their recommendations. Guideline panels should have a minimal representation of conflicted members; if, as recent data show, only about one-quarter of senior academic physicians have financial conflicts, there should be plenty of talent to go around. Conflicted experts should be allowed to testify on guideline panels but not to vote. An outside, nonconflicted ombudsman could be asked to participate or to screen potential panelists. Experts in data analysis without specific domain knowledge should be impaneled. If the guidelines are cleaned up, rational conclusions should follow.

Jerome P. Kassirer
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NOTE

1. J.P. Kassirer, "Professional Societies and Industry Support: What Is the Quid Pro Quo?" *Perspectives in Biology and Medicine* 50, no. 1 (2007): 7–17.

Practice Guidelines: The Authors Respond

We agree with Jerome Kassirer about the importance of minimizing industry-favorable bias in practice guidelines. And we think that Kassirer's suggestions—independent funding of guideline panels and minimal representation (and voting) of conflicted members—make a lot of sense.

But we also suspect that there is a need for some higher-level oversight of these panels. A credible, independent organization—such as the Institute of Medicine (IOM)—could serve as critical infrastructure to help ensure that the process is both consistent and independent. Possible roles include facilitating access to unconflicted methodologic and content experts and establishing a standardized mechanism for reviewing new guidelines (and disease definitions) as they emerge.

M. Brooke Herndon, Lisa M. Schwartz, Steven Woloshin, and H. Gilbert Welch
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Caring About Geriatric Care

Jerald Winakur's Narrative Matters essay about his father (Nov/Dec 07) resonates so profoundly because millions of Americans—doctors, nurses, and family members—are doing their best to provide compassionate care for aging spouses, parents, and grandparents who suffer from a chronic illness or disability and, in the process, are bumping up against the inadequacies of the U.S. health care system. There is a widespread and unmet need for better geriatric care, care that encourages patient/family communication, interdisciplinary teams, and responsibility for the patient across settings from hospitals to long-term care and rehabilitation facilities to home care.

Instead, health policy debates focus on pay-for-performance, evidence-based benefit design, and information technology, which largely will not respond to the complex needs of those struggling to cope with multiple chronic conditions, descent into dementia, or the challenging issues with end-of-life care. Even expanding traditional primary care will not meet this need unless it is reformulated to include geriatricians.

This is not rocket science. The right direction can be found in large, multispecialty groups with salary-based physician compensation. We need to look at the answers that are right in front of us and base the focus of health care reform on what patients need, what families desperately want for their loved ones, and the kind of care most physicians trained in geriatrics want the privilege of providing.

Christine K. Cassel
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Caring About Geriatric Care: The Author Responds

Christine Cassel recognizes what few with policy-shaping power do: today's health policy debates are misguided and won't improve the lot of many patients and their families. Her book, *Medicare Matters: What Geriatric Medicine Can Teach American Health Care* (University of California Press, 2005), is a ray of hope to doctors like me.

Thirty-two years into my medical career, the logistics of my practice remain pretty much the same. A real person answers my phone 24/7; my patients don't see physician extenders, hospitalists, intensivists, or proceduralists. Yes, they see specialists when needed, under my cautious and overseeing eyes, and, of course, other geriatric "team" members whenever necessary.

The largest reimbursement I ever receive—my "big-ticket procedure"—is for seeing a new patient. When I respond to the "complex needs" (to which Cassel refers) of my patients and their families, I do so—now as in the past—with no expectation that my time will be reimbursed at all, let alone fairly. But I do it because it's the best way I know to get the job done correctly.

Many of my primary care colleagues haven't survived the penuriousness of the Centers for Medicare and Medicaid Services (CMS) regarding the services we provide. We have been disrespected by the false assumptions of "relative value units" (RVUs) and backstabbed by specialty-dominated organizations. These men and women—my former colleagues—went back and specialized, or now practice "boutique" or "aesthetic" medicine, or turned their offices into lucrative "research mills." Some, in desperation, joined the "large, multispecialty groups" Cassel advocates—and were then sucked dry by capitated managed care insurance scams and parasitical practice management companies. (I assume that Cassel had other models in mind.)

What matters in medicine—especially in geriatrics—is what has always mattered: worrying about and advocating for our patients. If these attitudes are nurtured in medical schools, emulated by compassionate mentors, demanded by advocacy groups, and valued enough by society to be compensated fairly by third parties—and Medicare/Medicaid sets the standard here—then they will survive, and our health care system will once again restore the patient to the center of the paradigm. If not, there will be few to minister to us in our golden years. Only those trained to "do things" to us will remain.

JERALD WINAKUR
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Piping A Different Tune

This journal continues its tradition of publishing hostile reviews about Harvard University professor Regina Herzlinger's books with the one by Alan Maynard (Nov/Dec 07). After introducing her book, *Who Killed Health Care: America's $2 Trillion Medical Problem—and the Consumer-Driven Cure*, by gratuitously attempting to stir controversy with another Harvard academic, he goes on to ignore the central argument of Herzlinger's book, misrepresent her views on important issues (such as pay-for-performance), and conclude with a backhanded slap at the morality of Americans even as he misrepresents—or simply completely misunderstands—American public opinion.

A review of all of the problems with Maynard's s review would require more ink than the original, so I will confine my comments to clarifying what Herzlinger actually advocates. As in all other areas of society, she sees progress coming from the bottom up, not the top down, with empowered consumers and entrepreneurial providers creating profitable arrangements, structures, and institutions that will improve quality and convenience while decreasing actual prices and costs. (Costs are larger than just the dollar price, as any person who has waited for, or simply been denied, care because of budget constraints in socialized medical systems knows.)

Progress has been slower than Herzlinger originally expected when she wrote *Market-Driven Health Care* in 1997, largely because of the efforts of established interests, both those that profit from delivering the status quo (such as hospitals that go to the government to block competition) and academics and policy mavens who earn their keep by providing justification for centralized systems. This book, like her others, makes bold claims, moves swiftly, and offers solutions to reform U.S. health care.

Although I do not support individual mandates, the book and author deserved better treatment. Such treatment could have started by assigning the review to someone who understands U.S. health care, not just the European view of it.

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Piping: The Author Responds

Sally Pipes' riposte to my review of Regina Herzlinger's book, *Who Killed Health Care*, offers rhetoric and faith-based posturing but little evidence. Whilst it can be intellectual fun and politically advantageous to repeat the principles of bottom-up, market-oriented health care, the practice is usually inflationary, inefficient, and inequitable.

The outcomes of public health care systems can be similarly unattractive if poorly incentivized. The lesson to be learnt is that faith-based policy advocacy from market libertarians and public-sector collectivists has to be challenged and policymakers "confused" with evidence rather than rhetoric.

Sadly, the supply of evidence in health care is poor. Physicians practice the art of medicine and fail to reveal to consumers that more than half of what is offered to patients has no evidence base. Patients allow themselves to be experimented on in hope, closing their eyes and minds to the possibility of continuing disability and the inevitability of death.

Where evidence of effectiveness exists, public and market health care systems condone variations in clinical style and the failure to deliver required and worthwhile care to patients. These behaviors are defended in the name of "clinical autonomy," which private insurers and public-sector regulators fear to challenge, even when the clinical emperors have no clothes with which to disguise their unethical practices.

Evidence-based health care reform requires greater transparency and honesty through improved outcome measurements to demonstrate whether investing billions makes patients better. This has to be complemented by developing improved incentives in public and private markets. Quasi-religious advocacy of the "market solution" might assure the converted but bring little solace to long-suffering patients denied both appropriate care and the protection of their wallets from avaricious health care providers marketing modern-day snake oil.

ALAN MAYNARD
UNIVERSITY OF YORK (ENGLAND)

Self-Sufficiency In A Complex Society

I appreciate Gregg Bloche's closely reasoned article on consumer-directed care (Sep/Oct 07). As the chief medical officer of a health plan, I struggled with the issues he raises; it was with a mixture of pride and distress that I assisted in developing our plan's high-deductible health plan/health savings account (HDHP/HSA) option.

Bloche suggests some ways to reduce an HDHP/HSA plan's "reverse Robin Hood" effect (redistributing money from the less advantaged to the prosperous), including first-dollar, copayment-exempt coverage for "preventive services" and "high-value" services related to chronic diseases. As a physician, I have particularly struggled with these ideas.

The difficulty with a definition of *preventive services* is easily taken care of by adopting the recommendations of the U.S. Preventive Services Task Force, the independent panel of experts convened by the Agency for Healthcare Research and Quality (AHRQ). The problem is translating the recommendations into plan benefits. For example, mammography is billed under three different codes: "screening mammogram," "diagnostic mammogram," and "breast MRI." Clearly, the screening mammogram is the preventive test. That is, except for some whose breast structure cannot be adequately visualized on just two views, who routinely require the diagnostic mammogram—three views per breast—as a screening technique. It appears that we will soon identify a group for whom breast MRI is the best screening technique. If we exempt only the screening mammogram, those who need the others won't receive the benefit of the screening exemption.

High-value chronic care is more problematic. An exemption can't be merely on the basis of diagnosis and appropriate service. Physicians will lie about diagnosis to benefit their patients financially. Every chronic disease will require instituting a high-value care protocol to differentiate which care deserves advantaged treatment. This brings two problems: the need for clinical record review to assess adherence to protocol, and the flexibility to allow for changes in individual need away from protocol.

HDHP/HSA plans reflect a certain American ethos about individual self-sufficiency that flies in the face of the complex web that is our society.

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Integrated Practice Units Are Bridges, Not 'Archipelagoes'

I do not agree with the opinion of Alain Enthoven and colleagues (Sep/Oct 07) that freestanding integrated practice units (IPUs) as proposed by Michael Porter and Elizabeth Teisberg are unlikely to be an effective approach to improving the health of people with multifaceted chronic diseases, such as diabetes. I would characterize an IPU for diabetes not as an "archipelago to navigate" but as a bridge over the troubled waters of the uncoordinated and non-value-based U.S. approach to chronic care.

Our multispeciality group practice here in Minnesota cares for 17,000 patients with diabetes, and I consider our diabetes center an IPU. It is not a silo or archipelago, but a mobile group of endocrinologists, educators, psychologists, and clinical researchers who serve as the glue uniting and coordinating the various teams providing patient-centered diabetes care across our twenty-five practice sites and hospital. Our diabetes IPU continually updates primary care providers and specialists dealing with the complications of diabetes; advocates for point-of-care A1C testing; embeds IPU-certified diabetes educators in primary care to review glucose monitoring data; explores lifestyle and psychosocial issues interfering with glucose, blood pressure, or lipid control; and ensures that high-risk patients are supported between visits. It also provides regional group education and support groups.

Patients with type 2 diabetes certainly have a home in primary care (as Enthoven and colleagues advocate), but our goal is for patients to also know their diabetes educator and endocrinologist. Patients with type 1 diabetes have a home in endocrinology, but they are seen regularly in primary care, where other medical needs are met. A hospital-based IPU educator can assist a hospitalist by communicating with diabetes patients and their primary care team until a return clinic visit.

I believe that patients with diabetes, employers, and insurers will all find value in a medical group or integrated delivery system with an established diabetes IPU that helps ensure results-driven, patient-centered team care.

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Integrated Practice Units: An Author Responds

In characterizing the Michael Porter and Elizabeth Teisberg model as an "archipelago," we were referring to the isolated, freestanding, integrated practice unit (IPU) that Porter and Teisberg were advocating in their recently published *Redefining Health Care: Creating Value-Based Competition on Results* (Harvard Business School Press, 2006). An IPU is unattached or, in their view, unhindered by the kind of integrated, comprehensive care system that they put down as "second best."

Richard Bergenstal's diabetes IPU is embedded in Park Nicollet Health Services, one of the largest multispecialty group practices in the United States, providing care in forty-five medical specialties and subspecialties. It is fully capable of providing integrated, comprehensive care to its patients and serving as a well-furnished medical home for them.

Alain Enthoven for the authors
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Poland's Nursing Brain Drain To The West

Linda Aiken and colleagues wrote in this journal in 2004 about trends in international nurse migration (May/Jun 04); during that same year, the European Union (EU) expanded. Since then, challenging work conditions and low salaries in the new EU countries in Eastern Europe have resulted in a great many nurses' moving across national borders within the EU to practice in Western Europe, creating a change in nurse migration patterns in the process.

In Poland, the migration of Polish registered nurses within the EU increased greatly after the country joined the EU in 2004. During the period from 1 January 2004 to 31 March 2007, a total of 2,139 Polish nurses (1.5 percent of the country's employed nurses) obtained authorization to practice in five European Economic Area countries: Great Britain, Ireland, Italy, the Netherlands, and Norway. In comparison, during 2000–2003, only 386 Polish nurses received authorization to practice in four of those same countries.[1]

During the 2004–2007 period, the largest number of Polish nurses (1,013) registered in Great Britain, with the second largest number (820) registering in Italy. After Great Britain and Italy in the ranking of receiving countries were Ireland (158 Polish nurses), Norway (111), and the Netherlands (37). This ranking is also a change from 2000–2003. In those years, the countries (minus Great Britain) that received the highest number of nurses from Poland had been Italy (244), Norway (125), the Netherlands (11), and Ireland (6).[2]

Since the EU expansion in 2004, implementing the principle of free movement within the EU has been creating a nursing brain drain in Poland, as the number of nurses employed in Poland is systematically decreasing.

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NOTES

1. The Nursing and Midwifery Council in Great Britain does not have data on Polish nurses arriving and registering in the country during 2000–2003; the data from Italy on Polish nurses come from 22 of the country's 100 regional nurses' chambers.
2. Ibid.

Errata

(1) The paper "National Health Spending in 2006: A Year of Change for Prescription Drugs" by Aaron Catlin and colleagues (Jan/Feb 08) contained minor errors in Exhibits 1, 2, and 5. In Exhibit 1, real GDP for 1970 should be 3,772; for 1980, 5,162; for 1990, 7,113; and for 2004, 10,676. Also in Exhibit 1, real NHE, 1980 should be $469, and 2000 should be $1,354. In Exhibit 2, for 2003, implicit price deflator should be 2.1; real GDP, 1.6; real NHE, 6.4; and personal health care deflator, 3.8. In Exhibit 5, employer contributions to private health insurance premiums, 2006, should be 381.1. Also, on page 22, third full paragraph, growth in physician prices should be 1.8 percent, not 1.9 percent. These errors do not affect the estimates or analysis in the text. Corrected text and exhibits are available online at http://content.healthaffairs.org/cgi/content/abstract/27/1/14. The authors and *Health Affairs* regret any inconvenience these errors might have caused.

(2) The abstract in "Measuring the Health of Nations: Updating an Earlier Analysis" by Ellen Nolte and C. Martin McKee (Jan/Feb 08) contained a typographical error. In the third sentence, the figure 17 percent should be 16 percent. The authors and *Health Affairs* regret any confusion this error might have caused.