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The Health of the Medical Home

In your discussion of the “medical home”—a doctor’s office where every patient has a physician-led support team—you cite the supposed success story of Washington State’s Group Health Cooperative (“Collaborative Care,” Winter 2010).

I have a number of concerns about Group Health’s model of care, but regardless, it’s important to recognize the practical limitations in generalizing from it. It took 15% more physicians to staff the medical home despite the fact that each physician’s panel was reduced to fewer than 1,800 patients. But there are not 15% more primary care physicians available to allow all of the primary care physicians in America to reduce their panels. And when there are too few, the poor come in last.

If we want high-performance primary care, it will have to be delivered in high-performance systems that use scarce physician resources more efficiently. Most of all, if we want to lower health care spending, we will have to recognize that the major remedial costs are associated with the added care that is provided to low-income patients. It’s time to stop talking about wasteful medical homes for college graduates and start talking about safe neighborhoods, high-quality schools and workable systems of care for a diverse and needy nation.

Richard Cooper // Professor of Medicine, University of Pennsylvania, Philadelphia

Questioning the Evidence

I have always strongly supported using scientific evidence to guide medical decision-making, but “Burden of Proof” (Spring 2010) used a bad example in citing the U.S. Preventive Services Task Force’s

new recommendation against routine mammography for women younger than age 50. The data clearly support screening beginning by age 40. Because the Task Force included no one with expertise in mammography screening, it ignored much of the evidence that the death rate from breast cancer has, since 1990, decreased by about 30% in the United States, primarily thanks to mammography. That’s 15,000 to 20,000 lives saved each year.

Daniel B. Kopans // Senior Radiologist, Breast Imaging, Massachusetts General Hospital


A Better System for Free Drug Samples

Free drug samples, as you note in “The Cost of Free Drugs” (Winter 2010), are newer, brand-name medications, so the patient will likely be subject to a higher co-pay if he or she continues on the drug.

To solve this problem, an insurance carrier could compile a list of common conditions for which effective generic medications are available and provide prescribers with vouchers for 30-day supplies of these medications. The patient would take the voucher to a pharmacy, where it would be processed like any other prescription but without a co-pay.

If it turns out that the sample is appropriate for the patient, he or she will end up with a prescription with a low co-pay, and the insurance company, too, will save money, as reimbursements for generics cost far less than do brand names.

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 **WHAT’S YOUR TAKE?** Write to protoeditor@mggh.harvard.edu to comment on a story—or offer suggestions for future topics.