Contribution of major diseases to disparities in mortality.

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BACKGROUND: Mortality from all causes is higher for persons with fewer years of education and for blacks, but it is unknown which diseases contribute most to these disparities. METHODS: We estimated cause-specific risks of death from data from the National Health Interview Survey conducted from 1986 through 1994 and from linked vital statistics. Using these risk estimates, we calculated potential years of life lost and potential gains in life expectancy related to specific causes, with stratification according to education level and race. RESULTS: Persons without a high-school education lost 12.8 potential life-years per person in the population, as compared with 3.6 for persons who graduated from high school (ratio, 3.5; P<0.001). Ischemic heart disease contributed most (11.7 percent) to the difference according to education in potential life-years lost (with all cardiovascular diseases accounting for 35.3 percent). All cancers accounted for 26.5 percent, including 7.7 percent due to lung cancer; other lung diseases and pneumonia contributed 10.1 percent of the total, whereas human immunodeficiency virus (HIV) disease accounted for none of the difference according to education. The pattern of disparities according to level of income was similar to that according to level of education. Blacks and whites lost 7.0 and 5.2 potential life-years per person, respectively, as a result of deaths from any cause (ratio, 1.35; P<0.001). Cardiovascular diseases accounted for one third of this disparity, in large part because of hypertension (15.0 percent); HIV disease (11.2 percent) contributed almost as much as ischemic heart disease (5.5 percent), stroke (2.8 percent), and cancer (3.4 percent) combined; trauma and diabetes mellitus accounted for 10.7 percent and 8.5 percent, respectively. CONCLUSIONS: Although many conditions contribute to socioeconomic and racial disparities in potential life-years lost, a few conditions account for most of these disparities - smoking-related diseases in the case of mortality among persons...
with fewer years of education, and hypertension, HIV, diabetes mellitus, and trauma in the case of mortality among black persons. These findings have important implications for targeting efforts to reduce existing disparities in mortality rates. Copyright 2002 Massachusetts Medical Society

PMID: 12432046 [PubMed - indexed for MEDLINE]

Cash and compassion: profit status and the delivery of hospice services.

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OBJECTIVES: To evaluate the relationship of hospice profit status to patient selection and service delivery. DESIGN: We analyzed responses to the 1997 California Office of Statewide Health Planning and Development (OSHPD) annual home care and hospice survey. Outcomes included the percentages of patients with noncancer diagnoses, referred from long-term care, and with government payers; average length of stay (LOS); the intensity and skill mix of nursing services; and potential availability of chemotherapy and radiotherapy. Reduced models controlled for facility type, profit status, urbanicity, and patient-days. Complete models additionally controlled for patient gender, age, race/ethnicity, diagnosis, referral source, and primary reimbursement source. PARTICIPANTS: All 176 licensed California hospices in 1997. RESULTS: We report comparisons of for-profit and not-for-profit hospices as the absolute difference in percentage points between outcomes (e.g., a difference of 40% vs. 50% is reported as a 10 percentage point difference). In reduced models, for-profit hospices reported 17 percentage points more discharges with noncancer diagnoses, 15 percentage points more long-term care referrals, and 8 percentage points more patients with government payers. Average LOS did not differ by profit status. In reduced models, for-profit hospices delivered 0.20 more daily nursing visits on average; this difference was attributable to patient characteristics. The ratio of skilled to total nursing visits was 11 percentage points lower for for-profit hospices compared to not-for-profit hospices in reduced models (7 in complete models). Profit status was unrelated to the potential availability of chemotherapy and radiotherapy. CONCLUSION: For-profit hospices compared to not-for-profit hospices serve a higher percentage of persons with noncancer diagnoses, residents of long-term care, and persons with government insurance. Differences in patterns of nursing services among hospices were related to patient characteristics. The potential availability of complex palliative services did not differ by profit status.
Long bones from the senescence accelerated mouse SAMP6 have increased size but reduced whole-bone strength and resistance to fracture.

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The senescence accelerated mouse strain P6 (SAMP6) has emerged as a useful model of senile osteoporosis because it has many features of the disease, including low trabecular bone formation and low areal bone density. We further characterized the SAMP6 model of senile osteoporosis by comparing morphological, mechanical, and densitometric properties of femurs and tibias from SAMP6 mice to those of the control strain (SAMR1) at 4 months and 12 months of age. SAMP6 long bones had increased periosteal width and endosteal area (p < 0.05), resulting in an average increase of 30% in moments of inertia (p < 0.05), but no difference in bone area (p > 0.05) compared with control. Despite their increased moments of inertia, long bones from SAMP6 mice were relatively weak and brittle. Ultimate bending moment was reduced by 25%, and both postyield displacement and energy-to-fracture were reduced by 60% compared with SAMR1 controls (p < 0.001). Average cortical ash fraction was increased slightly from 0.74 in SAMR1 to 0.76 in SAMP6 bones (p < 0.05), indicating that increased mineralization may have contributed to the brittleness of SAMP6 bones. The relative differences we observed--increased endosteal and periosteal dimensions, reduced bending strength, increased brittleness, and increased mineralization--are analogous to changes that occur in the aging human skeleton. Moreover, these features were consistently observed in young (4-month) and old (12-month) animals. These findings extend the previous descriptions of the SAMP6 mouse and identify key mechanical features that further validate its relevance as a unique and functionally relevant model of senile osteoporosis.

PMID: 12211429 [PubMed - in process]
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OBJECTIVE: This study examined trends in the prescription of antipsychotic drugs in a nationally representative sample of physicians in nonfederal office-based clinical practice during the 1990s. METHODS: The authors analyzed physician-reported data from annual National Ambulatory Medical Care Surveys between 1989 and 1997 using weighted national estimates of physician visits during which antipsychotic drugs were prescribed. Prescription rates for antipsychotic drugs were compared between periods and among demographic, organizational, and clinical subgroups. RESULTS: Prescription of antipsychotic drugs in office-based practice increased significantly between 1989 and 1997. In 1989 antipsychotics were prescribed during 3.2 million office visits (.46 percent of all visits), compared with 6.9 million visits in 1997 (.88 percent). The atypical antipsychotics risperidone and olanzapine were the most widely prescribed antipsychotics in 1997. Risperidone was prescribed during 22.8 percent of all visits that involved prescription of an antipsychotic, and olanzapine during 17.1 percent. Psychiatrists were more likely than other physicians to prescribe an atypical agent (37.1 percent of visits involving prescription of an antipsychotic compared with 14.2 percent). Psychiatrists were also more likely than other physicians to schedule a follow-up visit after prescribing an antipsychotic (96.6 percent of visits compared with 73 percent). No evidence was found of a broadening of diagnostic indications for use over time. CONCLUSIONS: The rate of prescription of antipsychotic drugs among office-based physicians increased sharply during the 1990s after a nine-year decline. The increase was accounted for by growth in the use of atypical antipsychotics; the overall prescription rate of conventional agents did not change. Psychiatrists were more likely to prescribe atypical agents and to monitor more closely patients who were taking antipsychotics.

PMID: 11919355 [PubMed - indexed for MEDLINE]

Insurance coverage, medical conditions, and visits to alternative medicine providers: results of a national survey.

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BACKGROUND: In 1997, patients made an estimated 629 million visits to complementary and alternative medicine (CAM) providers; however, little is known about factors associated with visits to CAM providers. OBJECTIVE: To examine the effect of insurance coverage on frequency of use of CAM providers. METHODS: We conducted a nationally representative, random household telephone survey of 2055 adults. MAIN OUTCOME MEASURE: The number of visits made to CAM providers. RESULTS: An estimated 44% of the US population used at least 1 CAM therapy in 1997. Of those using CAM, 52% had seen at least 1 CAM provider in the last year. Among those who used a CAM therapy, factors independently associated with seeing a provider were having been in the upper quartile of visits to conventional providers in the last year (adjusted odds ratio [AOR], 2.00; 95% confidence interval [CI], 1.33-3.01), female sex (AOR, 1.67; 95% CI, 1.17-2.38), and having used the therapy to treat diabetes (AOR, 5.20; 95% CI, 1.40-19.40), cancer (AOR, 2.99; 95% CI, 1.04-8.62), or back or neck problems (AOR, 1.51; 95% CI, 1.02-2.23). Factors independently associated with frequent use ( or = 8 visits per year) of a CAM provider were full insurance coverage of the CAM provider (AOR, 5.06; 95% CI, 2.45-10.47), partial insurance coverage (AOR, 3.26; 95% CI, 1.72-6.19), having used the therapy for wellness (AOR, 2.85; 95% CI, 1.63-4.98), and having seen the provider for back or neck problems (AOR, 2.6; 95% CI, 1.29-3.94). Conservative extrapolation to national estimates suggests that 8.9% of the population (17.5 million adults) accounted for more than 75% of the 629 million visits made to CAM providers in 1997. CONCLUSIONS: A small minority of persons accounted for more than 75% of visits to CAM providers. Extent of insurance coverage for CAM providers and use for wellness are strong correlates of frequent use of CAM providers.

PMID: 11822920 [PubMed - indexed for MEDLINE]

Information superhighway or billboards by the roadside? An analysis of hospital web sites.

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OBJECTIVES: To determine the prevalence of hospital web sites, the types of information provided within these sites, and the relationship of information to institutional characteristics. DESIGN: Online search of hospital web sites over a 6-week period in late 1999. Web sites were abstracted for content. Bivariate comparisons were made of hospital profit status and ownership or operation by a multihospital network.
PARTICIPANTS: California acute care hospitals and their web sites. MAIN OUTCOME MEASURES: Operation of web sites and web site content. RESULTS: Among 390 California hospitals, 242 (62%) had easily identifiable web sites, 59 (15%) had no web sites, and 89 (23%) had sites identified only after telephone follow-up. Hospitals without sites were more likely not-for-profit, small, rural, or unaffiliated. The presentation of information was inconsistent, although most (93%) provided basic contact information. Many hospitals provided health content information (70%) or mentioned health classes (65%), but few guaranteed the quality of this information. Patient care features (online health profiles, risk identification, e-mail) were infrequent (13%) and rudimentary. Product advertising was frequent (54%) but was often nonhealth-related and unobtrusive. Of the 36% of hospitals that reported information on quality, few of the designated measures were valid and reliable measures of quality. Overall, 21% of hospitals reported accreditation (Joint Commission on Accreditation of Healthcare Organizations) status, and for-profit hospital web sites were more likely to report this accreditation. CONCLUSION: Consumers should be aware of current limitations in using information on hospital web sites. In the future, hospitals may better realize the potential of web sites for the delivery of health care information and patient care.

PMID: 11733428 [PubMed - indexed for MEDLINE]

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INTERNATIONAL LITERATURE

Risk adjustment alternatives in paying for behavioral health care under Medicaid.

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OBJECTIVE: To compare the performance of various risk adjustment models in behavioral health applications such as setting mental health and substance abuse (MH/SA) capitation payments or overall capitation payments for populations including MH/SA users. DATA SOURCES/STUDY DESIGN: The 1991-93 administrative data from the Michigan Medicaid program were used. We compared mean absolute prediction error for several risk adjustment models and simulated the profits and losses that behavioral health care carve outs and integrated health plans would experience under risk adjustment if they enrolled beneficiaries with a history of MH/SA problems. Models included basic demographic adjustment, Adjusted Diagnostic Groups, Hierarchical Condition Categories, and specifications designed for behavioral health. PRINCIPAL FINDINGS: Differences in predictive ability among risk adjustment models were small and generally insignificant. Specifications based on relatively few MH/SA diagnostic categories did as well or better than models controlling for additional variables such as medical diagnoses at predicting MH/SA expenditures among adults. Simulation analyses revealed that among both...
adults and minors considerable scope remained for behavioral health care carve outs to make profits or losses after risk adjustment based on differential enrollment of severely ill patients. Similarly, integrated health plans have strong financial incentives to avoid MH/SA users even after adjustment. CONCLUSIONS: Current risk adjustment methodologies do not eliminate the financial incentives for integrated health plans and behavioral health care carve-out plans to avoid high-utilizing patients with psychiatric disorders.

PMID: 11508640 [PubMed - indexed for MEDLINE]

Impact of expanding SSI on Medicaid expenditures of disabled children.

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Supplemental Security Income (SSI) expansions for disabled children in the early 1990s provoked criticism that eligibility criteria were too lax and motivated the subsequent retraction of benefits for many children. However, little evidence exists on whether the clinical needs of SSI children declined during this period. The authors used Medicaid data to examine changes in average expenditures between 1989 and 1992, using an Aid to Families with Dependent Children (AFDC) comparison group to control for confounding time trends (e.g., in access). Results showed declines in average expenditures in Georgia and Tennessee but increases in California and Michigan, which are thought to have started with more liberal eligibility policies.

PMID: 11481755 [PubMed - indexed for MEDLINE]

Resource utilization of patients with hypochondriacal health anxiety and somatization.

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OBJECTIVES: To examine the resource utilization of patients with high levels of somatization and health-related anxiety. DESIGN: Consecutive patients on randomly chosen days completed a self-report questionnaire assessing somatization and health-related, hypochondriacal anxiety. Their medical care utilization in the year preceding and following completion of the questionnaire was obtained from an automated patient record. The utilization of patients above and below a predetermined threshold on the questionnaire was then compared. PATIENTS AND SETTING: Eight hundred seventy-six patients attending a primary care clinic in a large, urban, teaching hospital. OUTCOME MEASURES: Number of ambulatory physician visits (primary care and specialist), outpatient costs (total, physician services, and laboratory procedures), proportion of patients hospitalized, and proportion of patients receiving emergency care. RESULTS: Patients in the uppermost 14% of the clinic population on somatization and hypochondriacal health anxiety had appreciably and significantly higher utilization in the year preceding and the year following completion of the somatization questionnaire than did the rest of the patients in the clinic. After adjusting for group differences in sociodemographic characteristics and medical comorbidity, significant differences in utilization remained. In the year preceding the assessment of somatization, their adjusted total outpatient costs were $1,312 (95% CI $1154, $1481) versus $954 (95% CI $868, $1057) for the remainder of the patients and the total number of physician visits was 9.21 (95% CI 7.94, 10.40) versus 6.33 (95% CI 5.87, 6.90). In the year following the assessment of somatization, those above the threshold had adjusted total outpatient costs of $1,395 (95% CI $1243, $1586) versus $1,145 (95% CI $1038, $1282), 9.8 total physician visits (95% CI 8.66, 11.07) versus 7.2 (95% CI 6.62, 7.77), and had a 24% (95% CI 19%, 30%) versus 17% (95% CI 14%, 20%) chance of being hospitalized. CONCLUSIONS: Primary care patients who somatize and have high levels of health-related anxiety have considerably higher medical care utilization than nonsomatizers in the year before and after being assessed. This differential persists after adjusting for differences in sociodemographic characteristics and medical morbidity.

PMID: 11458135 [PubMed - indexed for MEDLINE]

Workers' perceptions of how jobs affect health: a social ecological perspective.

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A national sample of 2,048 workers was asked to rate the impact of their job
on their physical and mental health. Ordered logistic regression analyses based on social ecology theory showed that the workers' responses were significantly correlated with objective and subjective features of their jobs, in addition to personality characteristics. Workers who had higher levels of perceived constraints and neuroticism, worked nights or overtime, or reported serious ongoing stress at work or higher job pressure reported more negative effects. Respondents who had a higher level of extraversion, were self-employed, or worked part time or reported greater decision latitude or use of skills on the job reported more positive effects. These findings suggest that malleable features of the work environment are associated with perceived effects of work on health, even after controlling for personality traits and other sources of reporting bias.

PMID: 11326723 [PubMed - indexed for MEDLINE]


The setting of psychiatric care for medicare recipients in general hospitals with specialty units.

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This study examined the patient and hospital characteristics associated with whether patients with psychiatric disorders were treated on the psychiatric unit or on medical wards after admission to general hospitals with psychiatric units. Medicare data for 169,798 beneficiaries who had psychiatric disorders and were admitted to general hospitals with psychiatric units were used to estimate logistic regressions of the probability of treatment on the unit. Results showed that beneficiaries who had more than one psychiatric diagnosis (except for substance use disorders), state buy-in coverage such as Medicaid, or previous psychiatric hospitalizations or who had ever been eligible for Medicare through disability were more likely to be treated on the unit. Those who were older, admitted through the emergency department, or had greater medical morbidity or primary diagnoses other than schizophrenia or bipolar or major affective disorders were less likely to be treated on the unit.

PMID: 11157127 [PubMed - indexed for MEDLINE]

The role of profit status under imperfect information: evidence from the treatment patterns of elderly medicare beneficiaries hospitalized for psychiatric diagnoses.

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Medicare claims for elderly admitted for psychiatric care were used to estimate the impact of hospital profit status on costs, length of stay (LOS), and rehospitalizations. No evidence was found that not-for-profits (NFPs) treated sicker patients or had fewer rehospitalizations. For-profits (FPs) actually treated poorer patients. Longer LOS and lower daily costs of NFPs were attributable to their other characteristics, e.g. medical school affiliation. Instrumental variables (IV) estimates suggested that NFP general hospitals actually have lower adjusted costs. These findings fail to support concerns that FP growth leads to declining access and quality or contentions that NFPs are less efficient.

Publication Types:
- Evaluation Studies

PMID: 11148870 [PubMed - indexed for MEDLINE]

Confidentiality and adolescents' use of providers for health information and for pelvic examinations.

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OBJECTIVE: To examine the relationship between adolescents' perception of the confidentiality of care provided by their regular health care provider and their reported use of this provider for private health information and for pelvic examinations. DESIGN: Anonymous, self-report survey. SETTING: Thirty-two randomly selected public high schools in Massachusetts. PARTICIPANTS: Of 2224 students in systematically selected 9th and 12th grade classrooms, 1715 (50% male) had a regular provider and a checkup within the last year. RESULTS: Of teens surveyed, 76% wanted the ability to obtain confidential health care, but only 45% perceived their regular provider to provide this, and only 28% had discussed it explicitly. Logistic regression analyses revealed strong relationships between confidentiality
and all outcomes studied. Among adolescents, the likelihood of having discussed sexually transmitted diseases, pregnancy prevention, and/or facts about sex with their provider was greater among teens who received a confidentiality assurance than that for teens who did not (odds ratio [OR] = 2.7; 95% confidence interval [CI], 2.2-3.4). A similar relationship for teens' likelihood of having discussed substance use with the provider was found (OR = 1.8; 95% CI, 1.4-2.3). Among sexually active females, the likelihood of a recent pelvic examination for those who received a confidentiality assurance was greater than for those who did not (OR = 3.3; 95% CI, 2.1-5.5).

CONCLUSIONS: This study furthers evidence of an important link between teens' perception of confidentiality and use of health care services and information. Because teens' health risks lie largely in potential risks from health-related behaviors, confidentiality in health care may be a critical factor in disclosure and discussion of risky behaviors, and ultimately in appropriate use of health care services. Efforts should be made to increase teens' access to confidential health care sources.

PMID: 10980791 [PubMed - indexed for MEDLINE]

Risk adjustment of capitation payments to behavioral health care carve-outs: how well do existing methodologies account for psychiatric disability?

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This study used 1994-1995 administrative data from a large public employer to examine the viability of commercial risk adjustment systems for setting capitation payments to competing behavioral health care "carve-outs". The ability of Hierarchical Condition Categories and Adjusted Diagnostic Groups to predict psychiatric expenditures was improved by controlling separately for psychiatric disability. However, even the best models underpredicted expenditures of patients with psychiatric disability by 15%. Relative to full capitation, "mixed" payment systems and soft capitation reduce the ability of carve-outs to earn disproportionate profits by enrolling healthy patients and avoiding sick ones, yet also diminish incentives for cost containment.

PMID: 10780284 [PubMed - indexed for MEDLINE]
Differences between generalists and mental health specialists in the psychiatric treatment of Medicare beneficiaries.

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OBJECTIVE: To examine differences between the general medical and mental health specialty sectors in the expenditure and treatment patterns of aged and disabled Medicare beneficiaries with a physician diagnosis of psychiatric disorder. DATA SOURCES: Based on 1991-1993 Medicare Current Beneficiary Survey data, linked to the beneficiary's claims and area-level data on provider supply from the Area Resources File and the American Psychological Association. STUDY DESIGN: Outcomes examined included the number of psychiatric services received, psychiatric and total Medicare expenditures, the type of services received, whether or not the patient was hospitalized for a psychiatric disorder, the length of the psychiatric care episode, the intensity of service use, and satisfaction with care. We compared these outcomes for beneficiaries who did and did not receive mental health specialty services during the episode, using multiple regression analyses to adjust for observable population differences. We also performed sensitivity analyses using instrumental variables techniques to reduce the potential bias arising from unmeasured differences in patient case mix across sectors. PRINCIPAL FINDINGS: Relative to beneficiaries treated only in the general medical sector, those seen by a mental health specialist had longer episodes of care, were more likely to receive services specific to psychiatry, and had greater psychiatric and total expenditures. Among the elderly persons, the higher costs were due to a combination of longer episodes and greater intensity; among the persons who were disabled, they were due primarily to longer episodes. Some evidence was also found of higher satisfaction with care among the disabled individuals treated in the specialty sector. However, evidence of differences in psychiatric hospitalization rates was weaker. CONCLUSIONS: Mental health care provided to Medicare beneficiaries in the general medical sector does not appear to substitute perfectly for care provided in the specialty sector. Our study suggests that the treatment patterns in the specialty sector may be preferred by some patients; further, earlier findings indicate geographic barriers to obtaining specialty care. Thus, the matching of service use to clinical need among this vulnerable population may be inappropriate. The need for further research on outcomes is indicated.

PMID: 10445900 [PubMed - indexed for MEDLINE]
OBJECTIVE: This study assessed the extent to which patients treated with electroconvulsive therapy (ECT) had diagnoses for which ECT is an efficacious treatment according to evidence-based standards. METHODS: ECT use among all beneficiaries of a large New England insurance company in 1994 and 1995 was examined using a retrospective cohort design. Associations between provider characteristics and ECT use for diagnoses outside the standards were determined using logistic regression analysis. RESULTS: A total of 996 individuals among approximately 1.2 million beneficiaries were treated with ECT. They received a total of 1,532 ECT courses. For 86.5 percent of the courses, the diagnosis was within evidence-based indications; for 13.5 percent, the diagnosis was outside the indications. In more than half of the 13.5 percent of cases, conditions were depressive disorders for which no studies have been conducted or disorders that likely had associated depressive symptoms. Patients receiving ECT for diagnoses outside evidence-based indications were more likely to have been treated by psychiatrists who graduated from medical school between 1940 and 1960 and between 1961 and 1980 than by those who graduated between 1981 and 1990. These patients were also less likely to have been treated by psychiatrists who received their medical education outside the U.S. CONCLUSIONS: Diagnoses of patients treated with ECT were mostly within evidence-based indications. The results provide reassurance to those concerned that ECT may be used indiscriminately. If confirmed by further research, the finding that psychiatrists trained in earlier eras were more likely to use ECT for diagnoses outside evidence-based indications may offer an opportunity for targeted quality improvement.

PMID: 10445655 [PubMed - indexed for MEDLINE]
BACKGROUND: Implicit in "any willing provider" and "freedom of choice" legislation is the assumption that ongoing provider relationships lead to better patient outcomes on average. Although previous studies have identified associations of usual source of care with medical utilization, its relationship to patient lifestyle has not been examined. OBJECTIVE: To determine the effect of having a usual physician on health behaviors.

METHODS: Data on 3,140 adults from the 1995 Mid-Life in the US study were used to estimate logistic regressions of the effect of having a usual physician on exercise, obesity, vitamin-taking, smoking quits, substance abuse behaviors, preventive medical visits, and respondent assessments of the ability to affect one's own health and risk of heart attacks and cancer.

RESULTS: Respondents with a usual physician were 3 times as likely to have had a preventive medical visit during the past year. Among lower-income respondents, those with usual physicians were one-half as likely to report substance abuse behaviors. Instrumenting reduced the magnitude of the former but not latter effect. No other significant differences were found.

CONCLUSIONS: Strategies designed to foster regular patient-provider relationships may affect certain health behaviors, such as preventive care visits and substance abuse. Yet in the absence of interventions to improve the effectiveness of these relationships, they are unlikely to be a powerful policy instrument for achieving widespread improvements in patient lifestyle choices.

PMID: 10386567 [PubMed - indexed for MEDLINE]


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OBJECTIVE: To determine the relative growth of types of chronic health conditions among children and adolescents receiving Supplemental Security Income (SSI) benefits before and after major SSI program changes, including changes in definitions of childhood disability and outreach to identify eligible children. DESIGN: Retrospective analysis of Medicaid claims from California, Georgia, Michigan, and Tennessee.

PARTICIPANTS: All children (aged < or = 21 years) newly enrolled in SSI programs in these states from July 1989 (n=21 222) to June 1992 (n=38 789). METHODS: Medicaid data indicate eligibility status and diagnoses for services rendered. For children newly enrolled before (time 1, July 1989 to June 1990), during (time 2, July 1990 to June 1991), and after (time 3, July 1991 to June 1992) the program changes, we used claims for the first 6
months of enrollment to determine rates of chronic conditions in general and rates of asthma, attention-deficit/hyperactivity disorder (ADHD), and mental retardation specifically. We also followed up time 1 enrollees during the study period to determine the likelihood of a chronic condition claim at any time. MAIN OUTCOME MEASURE: Presence of claims for chronic conditions. RESULTS: New SSI enrollees almost doubled during the study period. Increasing numbers of new enrollees had chronic condition claims in their first 6 months (from 29% to 36%); 58% of time 1 enrollees had such claims during any study month. Rates of chronic physical conditions other than asthma increased 14% (time 1 to time 3); asthma rates increased 73%. Rates of mental health conditions other than mental retardation and ADHD increased 63%; rates of mental retardation decreased 29%, while rates of ADHD increased almost 3-fold. CONCLUSIONS: The number of children with chronic conditions receiving SSI benefits experienced rapid growth from 1989 to 1992. Growth was particularly marked for children with diagnoses of asthma and ADHD.

PMID: 9895004 [PubMed - indexed for MEDLINE]


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CONTEXT: A prior national survey documented the high prevalence and costs of alternative medicine use in the United States in 1990. OBJECTIVE: To document trends in alternative medicine use in the United States between 1990 and 1997. DESIGN: Nationally representative random household telephone surveys using comparable key questions were conducted in 1991 and 1997 measuring utilization in 1990 and 1997, respectively. PARTICIPANTS: A total of 1539 adults in 1991 and 2055 in 1997. MAIN OUTCOMES MEASURES: Prevalence, estimated costs, and disclosure of alternative therapies to physicians. RESULTS: Use of at least 1 of 16 alternative therapies during the previous year increased from 33.8% in 1990 to 42.1% in 1997 (P < or = .001). The therapies increasing the most included herbal medicine, massage, megavitamins, self-help groups, folk remedies, energy healing, and homeopathy. The probability of users visiting an
alternative medicine practitioner increased from 36.3% to 46.3% (P = .002). In both surveys alternative therapies were used most frequently for chronic conditions, including back problems, anxiety, depression, and headaches. There was no significant change in disclosure rates between the 2 survey years; 39.8% of alternative therapies were disclosed to physicians in 1990 vs 38.5% in 1997. The percentage of users paying entirely out-of-pocket for services provided by alternative medicine practitioners did not change significantly between 1990 (64.0%) and 1997 (58.3%) (P=.36). Extrapolations to the US population suggest a 47.3% increase in total visits to alternative medicine practitioners, from 427 million in 1990 to 629 million in 1997, thereby exceeding total visits to all US primary care physicians. An estimated 15 million adults in 1997 took prescription medications concurrently with herbal remedies and/or high-dose vitamins (18.4% of all prescription users). Estimated expenditures for alternative medicine professional services increased 45.2% between 1990 and 1997 and were conservatively estimated at $21.2 billion in 1997, with at least $12.2 billion paid out-of-pocket. This exceeds the 1997 out-of-pocket expenditures for all US hospitalizations. Total 1997 out-of-pocket expenditures relating to alternative therapies were conservatively estimated at $27.0 billion, which is comparable with the projected 1997 out-of-pocket expenditures for all US physician services. CONCLUSIONS: Alternative medicine use and expenditures increased substantially between 1990 and 1997, attributable primarily to an increase in the proportion of the population seeking alternative therapies, rather than increased visits per patient.

PMID: 9820257 [PubMed - indexed for MEDLINE]

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High-expenditure children with Supplemental Security Income.

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OBJECTIVE: To examine the clinical characteristics and health service use of children with high Medicaid expenditures. METHODOLOGY: We examined 1992 Medicaid claims and eligibility files from four states (California, Georgia, Michigan, Tennessee) for children with at least $10000 billed to Medicaid who obtained Medicaid through the Supplemental Security Income (SSI) Program and a comparison group (matched by age group and gender) of children receiving Medicaid for other reasons. We compared mean expenditures, examined expenses by category, and examined diagnoses associated with at least $10000 in expenses. RESULTS: In 1992, Medicaid paid on average approximately $1000 for children with non-SSI Medicaid enrollment. Expenditures for children with SSI were 2.9 to 9.4 times higher, but once the approximately 10% of
children with high expenditures were excluded, SSI average expenditures were only 1.5 to 2.7 times higher than the non-SSI average. Children with high expenditures are likely to use hospitals and long-term care, and these services account for more than half of the average expenditures. Children with high expenditures and SSI are more likely to have chronic medical conditions than are their peers enrolled in Medicaid but not through SSI.

CONCLUSIONS: A small proportion of children, even on SSI, account for very large proportions of Medicaid expenditures. Most children with SSI, despite having relatively severe mental health, physical, or developmental disabilities, have relatively modest Medicaid expenditures.

PMID: 9738184 [PubMed - indexed for MEDLINE]

□ 21: Milbank Q 1998;76(3):403-48, 305

Contribution of psychosocial factors to socioeconomic differences in health.

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The National Survey of Mid-life Developments in the United States (MIDUS) is one of several studies that demonstrate socioeconomic gradients in mortality during midlife. When MIDUS findings on self-reported health, waist to hip ratio, and psychological well-being were analyzed for their possible roles in generating socioeconomic differences in health, they revealed clear educational gradients for women and men (i.e., higher education predicted better health). Certain potential mediating variables, like household income, parents' education, smoking behavior, and social relations contributed to an explanation of the socioeconomic gradient. In addition, two census-based measures, combined into an area poverty index, independently predicted ill health. The results suggest that a set of both early and current life circumstances cumulatively contribute toward explaining why people of lower socioeconomic status have worse health and lower psychological well-being.

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□ 22: Psychiatr Serv 1998 Sep;49(9):1173-9

Inpatient psychiatric treatment of elderly Medicare beneficiaries.
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OBJECTIVE: The clinical characteristics and treatment patterns of elderly Medicare beneficiaries hospitalized for psychiatric disorders were examined. METHODS: Administrative data on all elderly Medicare beneficiaries in the United States hospitalized in a nonfederal hospital for a primary psychiatric disorder in 1990-1991 were used to calculate descriptive statistics on case-mix by age group, hospital type (psychiatric hospital, general hospital psychiatric unit, or general hospital nonpsychiatric unit), and primary diagnosis. Length of stay, costs, and discharge destination by hospital type and primary diagnosis were also determined. RESULTS: A total of .6 percent of elderly Medicare beneficiaries were hospitalized for a psychiatric disorder in 1990, accounting for more than 240,000 admissions and $1 billion in Medicare payments. The most common reasons for hospitalization were major depressive disorder (28.1 percent), dementia and other organic disorders (26.8 percent), and substance-related disorders (12.6 percent). Organic disorders were particularly prevalent among the oldest old, accounting for more than half of psychiatric admissions among those 85 and older. A total of 43 percent of the psychiatric admissions were to general hospital nonpsychiatric units, 38 percent to general hospital psychiatric units, and only 19 percent to psychiatric hospitals. Within each diagnostic category, patients admitted to general hospital nonpsychiatric units had the shortest average lengths of stay and the lowest average costs. Among beneficiaries with organic, affective, and psychotic disorders other than schizophrenia, those admitted to general hospitals had shorter lengths of stay, higher rates of discharge to nursing homes, and lower rates of discharge to self-care than those treated in psychiatric hospitals. CONCLUSIONS: Case-mix-adjusted treatment patterns varied substantially across hospital types, due to differences in either illness severity or treatment styles.

PMID: 9735958 [PubMed - indexed for MEDLINE]

Risk adjustment of mental health and substance abuse payments.

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This study used 1992 and 1993 data from private employers to compare the
performance of various risk adjustment methods in predicting the mental health and substance abuse expenditures of a nonelderly insured population. The methods considered included a basic demographic model, Ambulatory Care Groups, modified Ambulatory Diagnostic Groups and Hierarchical Coexisting Conditions (a modification of Diagnostic Cost Groups), as well as a model developed in this paper to tailor risk adjustment to the unique characteristics of psychiatric disorders (the "comorbidity" model). Our primary concern was the amount of unexplained systematic risk and its relationship to the likelihood of a health plan experiencing extraordinary profits or losses stemming from enrollee selection. We used a two-part model to estimate mental health and substance abuse spending. We examined the R2 and mean absolute prediction error associated with each risk adjustment system. We also examined the profits and losses that would be incurred by the health plans serving two of the employers in our database, based on the naturally occurring selection of enrollees into these plans. The modified Ambulatory Diagnostic Groups and comorbidity model performed somewhat better than the others, but none of the models achieved R2 values above .10. Furthermore, simulations based on actual plan choices suggested that none of the risk adjustment methods reallocated payments across plans sufficiently to compensate for systematic selection.

PMID: 9719789 [PubMed - indexed for MEDLINE]
characteristics significantly influence whether a psychiatrist uses ECT. Opposing trends in the U.S. psychiatric workforce could affect the availability of the procedure. Expanding training opportunities for ECT and making education, training, and testing more consistent nationwide could improve clinicians' consensus about ECT and narrow variation in its use.

PMID: 9659852 [PubMed - indexed for MEDLINE]


State variations in supplemental security income enrollment for children and adolescents.

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OBJECTIVES: The purpose of this study was to determine the effects of poverty, program generosity, and health on state variations in enrollment of children and adolescents in the Supplemental Security Income (SSI) program during recent program expansions. METHODS: The relationship of state SSI rates for 1989 and 1992 to child poverty, health, and program generosity were determined by multiple regression. RESULTS: The mean percentage of children enrolled grew from 0.36% (1989) to 0.75% (1992). Poverty rates accounted for 78% of the variance among states in 1989 and 53% in 1992. Other indicators accounted for little variance. CONCLUSIONS: Differences in state poverty levels explained almost all variation in SSI enrollment.

PMID: 9618622 [PubMed - indexed for MEDLINE]

26: Med Care 1998 May;36(5):720-7

The influence of psychiatric disorders on patients' ratings of satisfaction with health care.

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OBJECTIVES: Patient ratings of satisfaction with health care have been
used by patients, insurers, and employers seeking data to compare the quality of health plans and systems of care. Concerns with these ratings include their subjective nature and potential for being influenced by patient characteristics unrelated to the quality of their care. The authors examined the influence of an active psychiatric disorder on patient satisfaction with health care, hypothesizing that patients with psychiatric disorders would be less satisfied with their health care, due to the adverse effects of these conditions on mood and cognition. METHODS: The authors used linked claims and survey data from the 1991 Medicare Current Beneficiary Survey. Using logistic regressions that controlled for patient sociodemographic and clinical characteristics, the authors examined the influence of an active psychiatric disorder on satisfaction with overall quality of health care and with specific dimensions of quality. The authors also examined the effects of specific types of psychiatric disorders. RESULTS: Aged and disabled beneficiaries with psychiatric disorders were significantly less likely than those without disorders to be satisfied with the overall quality of health care, follow-up care, and the physician's concern for their overall health. Disabled beneficiaries were also less likely to be satisfied with the health information provided. Further variation was found by type of psychiatric disorder. CONCLUSIONS: One interpretation of these findings is that Medicare beneficiaries with psychiatric disorders receive lower quality care, a possibility that warrants further investigation. Alternatively, patients with psychiatric disorders may report lower satisfaction despite receiving comparable health care; this interpretation points toward the need for casemix adjustment when comparing satisfaction ratings across health plans and the development of quality measures less susceptible to subjective biases.

PMID: 9596062 [PubMed - indexed for MEDLINE]

Performance of Massachusetts HMOs in providing Pap smear and sexually transmitted disease screening to adolescent females.

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PURPOSE: To describe the extent to which health maintenance organizations (HMOs) provide preventative health services to female adolescent enrollees. METHODS: All Massachusetts HMOs were asked to provide 1992 Papanicolaou (Pap) smear, gonorrhea, chlamydia, syphilis, and human immunodeficiency virus test rates for adolescents from medical records and claims data. The rates were compared with criterion standards and national utilization data from the National Survey of Family Growth.
Seven of 14 Massachusetts HMOs agreed to provide data for female members aged 15-21 years on the Pap smear rate (n = 34,415) and sexually transmitted disease (STD) test rate (n = 33,701). RESULTS: Papanicolaou smear rates for females in the HMOs ranged from 5% of 15-year-olds to 45% of 21-year-olds during 1992. Test rates for chlamydia and gonorrhea ranged from 2% and 3%, respectively, for 15-year-olds to 9% and 10% for 21-year-olds. Among 15-19-year-old females, only 18% received a Pap smear, and only 11% received an STD test through their HMO during 1992, despite professional guidelines recommending that all of the estimated 53% of sexually active females age 15-19 years should receive both Pap smears and STD tests. Among 18-21-year-old females, only 37% had had a Pap smear through their HMO during 1992, despite professional guidelines recommending Pap smears for all women age 18 years and over.

CONCLUSIONS: Efforts are needed within HMOs to ensure that STD screening, Pap smears, and other health screening services are provided for sexually active adolescent enrollees.

PMID: 9502004 [PubMed - indexed for MEDLINE]

How low birthweight and gestational age contribute to increased inpatient costs for multiple births.

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The dramatic rise in the number of multiple gestation births has led to concerns about heavy resource use by these newborns and the design of cost-effective interventions. This study uses medical records data to compare single and multiple births in terms of hospital charges by cost center, length of stay, neonatal intensive care unit (NICU) days, and discharge status. Potential mediators examined were gestational age and birthweight. These factors, respectively, accounted for 50% and 40% of the increase in total charges due to multiple gestation. The remaining "direct effect" was due primarily to longer hospital stays among twins and higher daily charges among higher-order multiples. Room and board charges were higher for multiples, while charges in other categories were actually lower, after controlling for birthweight and gestational age. Birthweight and gestational age accounted fully for the increased use of NICU services among multiples. These results show that while prevention of multiple gestation, where possible, is of paramount importance, strategies that decrease preterm delivery and/or increase birthweight should attenuate the adverse economic impact of multiple gestation pregnancies.

PMID: 9472231 [PubMed - indexed for MEDLINE]
29: Harv Rev Psychiatry 1997 Jan-Feb;4(5):283-6

Mental health services under Medicare: the influence of economic incentives.

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PMID: 9385005 [PubMed - indexed for MEDLINE]


Provider specialty choice among Medicare beneficiaries treated for psychiatric disorders.

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This study estimates the probability of mental health specialist use among elderly and disabled Medicare beneficiaries treated for a primary psychiatric diagnosis, based on the 1991 Medicare Current Beneficiary Survey (MCBS) and physician claims. Beneficiaries with psychotic and affective disorders or multiple psychiatric diagnoses had a higher probability of specialty use, as did beneficiaries in counties with greater psychiatrist density. Elderly in counties with greater general practitioner density and disabled in counties with greater psychologist density were less likely to see a specialist, suggesting possible provider substitution. Government programs to recruit and retain mental health professionals in underserved areas may change provider specialty choices among Medicare beneficiaries treated for psychiatric disorders.

PMID: 10173123 [PubMed - indexed for MEDLINE]


Medicaid participation among the eligible elderly.

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This study uses data from the Survey of Income and Program Participation to address three issues: (1) what were the 1987 rates of Medicaid participation and private insurance coverage among elderly predicted to be categorically eligible and medically needy?; (2) how did these rates change between 1987 and 1992?; and (3) which factors influence insurance choices among persons who are categorically eligible for Medicaid? The 1987 Medicaid participation rates were 64 percent for the categorically eligible, but only 11 percent among the medically needy. Participation among the categorically eligible declined to 59 percent by 1992, but the difference was insignificant. In both years, about 23 percent of all categorically eligible persons had private insurance, but among those who do not participate in Medicaid, the rate rises to 48 percent.

PMID: 10169692 [PubMed - indexed for MEDLINE]

□ 32: J Health Econ 1997 Oct;16(5):543-62
Adverse selection and the purchase of Medigap insurance by the elderly.

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This study uses data on 8561 elderly respondents from the 1991 Medicare Current Beneficiary Survey to examine adverse selection in the supplemental private insurance market. Logit models of supplemental insurance choices provided modest but mixed evidence of self-selection on the basis of observable health status. Wealth had a strong influence on coverage. Two part models of Medicare utilization and expenditures showed that beneficiaries with individually purchased policies had higher total, part B and physician expenditures than those with employer-provided policies, even after controlling for observable differences, suggesting adverse selection. Results were similar for basic and more comprehensive policies.

PMID: 10175630 [PubMed - indexed for MEDLINE]

How well do ambulatory care groups predict expenditures on mental health and substance abuse patients?

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This paper evaluates the ability of Ambulatory Care Groups (ACGs) to prospectively predict mental health and substance abuse expenditures and total health care expenditures of persons enrolled in the New Hampshire Medicaid Program during fiscal years 1993 and 1994. A series of multi-part models is estimated separately for adults and children and a synthetic R-squared and the mean absolute predictive error are calculated. The results show that with the exception of predicting total expenditures for children, ACGs do not perform as well as simple models containing various demographic and prior mental health/substance abuse utilization measures.

PMID: 9217332 [PubMed - indexed for MEDLINE]

Measuring the human cost of a weak economy: does unemployment lead to alcohol abuse?

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This paper uses two-stage instrumental variables methods to examine whether unemployment affects alcohol use and symptoms of dependence, and if so, in which direction. Data were obtained from the 1988 National Health Interview Survey. The outcomes examined were average daily consumption during the previous two weeks and a summary measure of the number of symptoms related to alcohol dependence during the previous year. After eliminating potential bias due to reverse causality, evidence was found that non-employment significantly reduces both alcohol consumption and dependence symptoms, probably due to an income effect. Involuntary unemployment had a mixed effect-job loss increased the consumption of alcohol in the overall sample but reduced dependence symptoms among single respondents. Studies of the impact of alcohol use on economic outcomes should take potential reverse causality into account.

PMID: 9015877 [PubMed - indexed for MEDLINE]

Comment in:

The timing of preventive services for women and children: the
effect of having a usual source of care.

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OBJECTIVES: This study investigated the causal effect of having a usual
source of medical care on the timing of preventive services by women and
children. METHODS: Data on 17,110 children and 23,488 women from the
1988 and 1990 National Health Interview Surveys were used to estimate
ordered probit models of the effect of having a usual source of medical care
on the time since the last receipt of each preventive service (routine
checkups for children; blood pressure checks, Pap smears, and breast exams
for adult women; mammograms for older women). Two-stage instrumental
variables methods were used to eliminate simultaneity bias. RESULTS: The
existence of a usual source of medical care was strongly correlated with the
earlier receipt of preventive services, and the relationship appears to be
causal for Pap smears, breast exams, and mammograms. However, there
was little evidence that having a regular provider caused an increased rate of
routine checkups for children or blood pressure checks for adult women.
CONCLUSIONS: Delivery systems that encourage the development of
long-term relationships with medical providers may increase cancer
screening rates among women.

PMID: 9003132 [PubMed - indexed for MEDLINE]

New evidence on the relationship between income and health.

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Using data from the National Survey of Families and Households, the
Survey of Income and Program Participation, and the National Health
Interview Survey, I estimate the structural impact of income on the
following measures of health: self-assessed health status, work and
functional limitations, bed days, average daily consumption of alcohol, and
scales of depressive symptoms and alcoholic behavior. Both ordinary and IV
estimates indicate that increases in income significantly improve mental and
physical health but increase the prevalence of alcohol consumption. Cost-
benefit analyses of government policies that may reduce disposable income
should take into account potential effects on morbidity.

PMID: 10157429 [PubMed - indexed for MEDLINE]

The impact of "parent care" on female labor supply decisions.

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Data from the 1986-1988 Survey of Income and Program Participation panels were used to analyze how informal caregiving of disabled elderly parents affected female labor supply. Instrumental variables analyses suggested that coresidence with a disabled parent leads to a large, significant reduction in work hours, due primarily to withdrawal from the labor force. Although the impact of nonhousehold member caregiving was insignificant, evidence of an effect was stronger when commitment of caregiving time was greater. Projections of female labor force participation rates should account for potential increases in caregiving demand due to the aging of the U.S. population.

PMID: 7774731 [PubMed - indexed for MEDLINE]

The economic impact of multiple-gestation pregnancies and the contribution of assisted-reproduction techniques to their incidence.

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BACKGROUND. Although the medical complications associated with multiple-gestation pregnancies have been well documented, little is known about the effects of such pregnancies on the use of health care resources and the associated costs. This is an important issue because of the increasing use
of assisted-reproduction techniques, which commonly result in multiple-gestation pregnancies. METHODS. We determined hospital charges and the use of assisted-reproduction techniques (such as induction of ovulation, in vitro fertilization, and gamete intrafallopian transfer) for 13,206 pregnant women (11,986 with singleton pregnancies, 1135 with twin pregnancies, and 85 with more than two fetuses) who were admitted for delivery to Brigham and Women's Hospital, Boston, in 1986 through 1991 and their 14,033 neonates (11,671 singletons, 2144 twins, and 218 resulting from higher-order multiple gestations). RESULTS. After we controlled for variables known to affect hospital charges, the predicted total charges to the family in 1991 for a singleton delivery were $9,845, as compared with $37,947 for twins ($18,974 per baby) and $109,765 for triplets ($36,588 per baby). Assisted-reproduction techniques were used in 2 percent of singleton, 35 percent of twin, and 77 percent of higher-order multiple-gestation pregnancies; such procedures were approximately equally divided between induction of ovulation alone and in vitro fertilization or gamete intrafallopian transfer. CONCLUSIONS. Multiple-gestation pregnancies, a high proportion of which result from the use of assisted-reproduction techniques, dramatically increase hospital charges. If all the multiple gestations resulting from assisted-reproduction techniques, dramatically increase hospital charges. If all the multiple gestations resulting from assisted-reproduction techniques had been singleton pregnancies, the predicted savings to the health care delivery system in the study hospital alone would have been over $3 million per year. Although assisted reproduction provides tremendous benefits to families with infertility, the increased medical risks entailed by multiple-gestation pregnancies and the associated costs cannot be ignored. We suggest that more attention be paid to approaches to infertility that reduce the likelihood of multiple gestation.

PMID: 8015572 [PubMed - indexed for MEDLINE]
(unpaid) caregivers to coordinate efforts. Data from interviews with a sample of 231 persons with AIDS in the Boston area were used to compare the use of formal and informal home care between the two largest risk groups, homosexual men and i.v. drug users. Multivariate regression analysis was also employed to adjust estimates and to determine the significance of population characteristics in explaining utilization differences. IV drug users received about twice as much formal and informal home care as homosexual men. Controlling for functional status, income and assets, insurance and potential caregiver supply, i.v. drug users obtained significantly fewer formal home care services, but more informal care. Overall, i.v. drug users received a greater number of adjusted home care hours. These findings cast doubt upon the previous assumptions of the literature and suggest that members of both risk groups are appropriate candidates for formal home care services.

PMID: 8182974 [PubMed - indexed for MEDLINE]

Do elderly Medicaid patients experience reduced access to nursing home care?

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This paper uses data from the National Long-Term Care Survey and the Area Resources File to analyze the problem of diminished access to nursing home care for elderly Medicaid patients. Using a proxy for the length of time on a waiting list before nursing home entry as my measure of access, I find evidence suggesting that nursing home operators in some areas preferentially admit private patients. Waitlisting of Medicaid patients appears to be a problem mainly in counties in which a high proportion of potential nursing home patients are private and counties in which bed supply is low.

PMID: 10171727 [PubMed - indexed for MEDLINE]