

## TO THE EDITORS

I just read the commentary by McMahon et al.<sup>1</sup> I very much support their arguments and would like to share a 30-year-old anecdote.

In the early 1970s, as a graduate student at Carnegie-Mellon University, I was involved in a project that applied cost-effectiveness analysis to medical screening tests in use at that time, one of which was Pap smears. The faculty concluded that cervical cancer screening was not cost effective, based on a mathematical model that used the low overall incidence of cervical cancer, among many other inputs. I and another student independently re-did the analysis, separating the data by ethnicity and age. We found that screening guidelines should vary by both the woman's ethnicity and age.

Thirty years on, this concept of targeting screening or treatment to those for whom it would most benefit and not providing it to those for whom it would least benefit is still not accepted. Some may say this is rationing—if so, it is rationing based on clinical and epidemiologic information. In a society with limited resources for government programs such as Medicare and Medicaid, and with 48 million people without health insurance coverage, rationing based on clinical and epidemiologic information is preferable to rationing based on economic criteria.

Bradford Kirkman-Liff, DrPH  
W. P. Carey School of Business  
Tempe, AZ

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## REFERENCE

1. McMahon LF, Hayward R, Saint S, Chernew ME, Fendrick AM. Univariate solutions in a multivariate world: Can we afford to practice as in "the good old days"? *Am J Manag Care*. 2005;11:473-476.

## Correction Statement

On page S167 of the August 2005 supplement to *The American Journal of Managed Care* (Blonde L. The road ahead in diabetes management. *Am J Manag Care*. 2005;11(5 suppl):S167-S169), the CDC estimate of national costs of diabetes was stated as "\$192 million." The correct cost is "\$192 billion."

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