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ashe
American Society of Health Economists

Newsletter of the
American Society of Health Economists

View from the Program Office

by Mike Hagan

I'm an economist and Federal program officer in the Agency for Healthcare Research and Quality (AHRQ) where I've served as a project officer on grants and contracts at the Agency and its predecessor, the Agency for Health Care Policy and Research (AHCPR) since 1991. I also was previously employed in the mid-1980s at the predecessor of those two Agencies, the National Center for Health Services Research (NCHSR). Over these years, I've witnessed an evolution in the extent, breadth, processes, emphases, and distribution of funding for what ASHE members would call health economics research. This evolution has current implications for the development and support of externally generated grant-funded projects.

Drawing on my experience and current observations of the research funding landscape, I can offer a few comments from a program officer's point-of-view, reflecting the questions I'm frequently asked these days by potential applicants for

continued on pg 3

Interview with Board Member Gloria Bazolli

Q *One of the characteristics of your work that stands out is the close tie between the theory and empirical work. Is there something about hospital markets that makes this combination work so well together?*

A What is interesting when you study hospitals is the ability to match reasonably well theory and available data. In particular, we have quite a bit of relevant theory that has developed over time. We have the work of Joe Newhouse on the behavior of nonprofit hospitals and complementary work that extended this model by Tom Hoerger. And then, of course, you have the standard economic model of for-profit behavior, which certainly applies to a segment of the

continued on pg 5

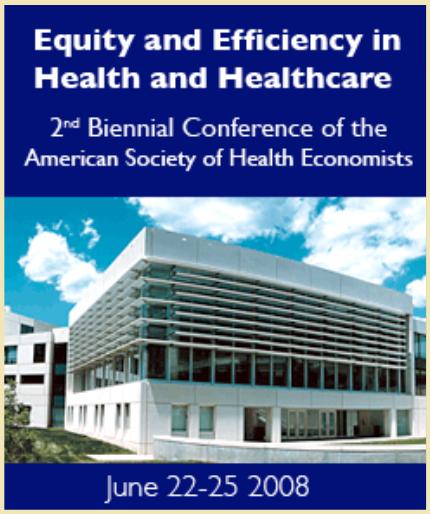
Gloria Bazzoli is a founding Board Member of ASHE and the Bon Secours Professor of Health Administration in the Department of Health Administration at Virginia Commonwealth University.
Photo: VCU Creative Services

Interview with Board Member John Mullahy

Q *How did you become a health economist?*

A I had a big interest in environmental economics when I started graduate school. About halfway through, I had the opportunity to go to work for Resources for the Future half-time as a research assistant and half-time on my dissertation. When I got there, I met Paul Portney who was a senior researcher there, and we began working on a project involving air pollution

continued on pg 3



More Inside this Issue

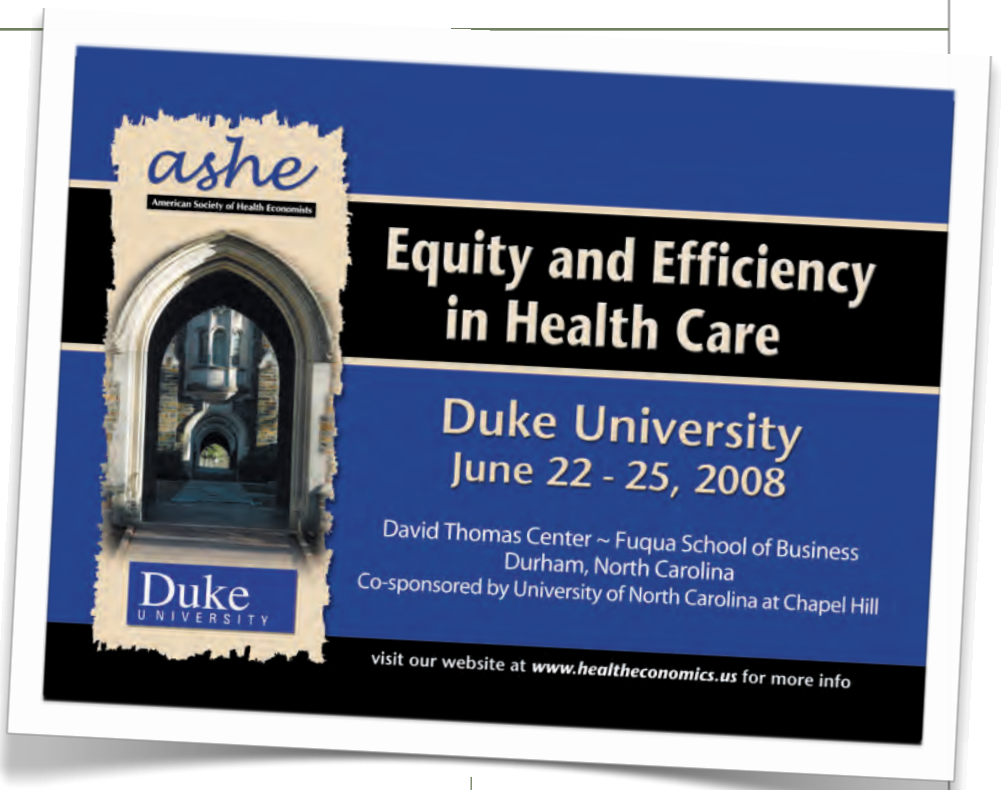
Mission Statement

The mission of the newsletter will be to develop the social capital of the health economics profession by providing a forum for community building and networking among health economics faculty, researchers, and students. This newsletter will be published thrice yearly and is not intended to engage in advocacy or to provide information already available in other newsletters.

The President's Column

Our biennial conference is all-important for achieving ASHE's mission. The Planning Committee is intent on having a first-rate academic conference at Duke University June 22-25. While working on the conference, I have been musing over what makes a conference so important, particularly in the digital age of ready access to research and instant communication over the Internet.

Part of the value of a conference, in my view, comes from creating a stimulating environment and developing a community of scholars. This value extends beyond the days of the conference. However, it needs to be fostered and rekindled, from time to time. A thought-provoking environment gets the creative juices flowing and inspires ideas. Interactions with researchers from different specialties who are similarly committed to developing rigorous research on topics of importance to society are worthwhile for all.



It is a rare opportunity to get a room full of researchers focusing on your own work and providing constructive feedback. Too often, those who you would most like to comment on your work are also those who are too busy to do so. A conference offers a time when experts present, prepare formal discussion, and engage in animated exchange. Putting yourself on the spot a bit by presenting new ideas can be stimulating, even if it also, at times, adds some anxiety.

The ability to renew old friendships, meet new people, and network are important as well. Conversation is a source of inspiration.

The ASHE conference is designed to maximize the benefits of a conference. We have two spectacular plenary speakers: 1992 Nobel Laureate, Gary Becker, and Mark McClellan, former head of the FDA and CMS. Mark will start the formal part of the conference on Sunday night with a reception following the plenary. The training sessions will precede the plenary on Sunday. Further, we invited some prominent health economists to organize sessions, ensuring coverage of key topics. The call-for-papers allows you to put together a session of topics that interest you and researchers who you would like to meet. We intentionally set aside time and provide food for lunch, receptions,

continued on pg 4

News From Executive Director Richard Arnould

Dear ASHE Members and Friends:

Most of my comments in the first newsletter involved discussing the past, namely, the great success of the Inaugural Conference in Madison. This time I want to talk about many things that are happening now and others that will be happening in the near future.

Second Biennial Conference at Duke

Planning is well under way for the Second Biennial Conference at Duke University and co hosted by UNC-Chapel Hill. The David Thomas Center and Fuqua Business School will provide a fantastic venue for this meeting. Keep your eyes on the ASHE website for details.

By the time you read this you should already have received at invitation to nominate yourself to serve on the Scientific Committee as well as a call for the submission of sessions and individual abstracts to be reviewed by the Scientific Committee. The most important thing ASHE provides to its members is the biennial conference. Members who responded to the questionnaire following the Madison meeting let us know that they expect to have high quality papers presented and to be able to network with other health economist. The Conference Planning Committee (CPC) that consists of Jody Sindelar, President; Mike Grossman, President Elect; Frank Sloan, Chair of the Local Planning Committee; and Edward Norton, Local Planning Committee; operates with these two goals being foremost in every aspect of the plan.

The quality of papers is dependent upon each of our members responding to the call with an organized session, abstract, and willingness to serve as a session chair and discussant. We are continuing with three papers per one and one half hour session to permit ample time for presentation and discussion led by the discussant but also open to the audience. So, we look forward to your response to the call to serve on the Scientific Committee and to the call for organized sessions and individual abstracts.

continued on pg 6

Interview with Board Member John Mullahy

continued from pg 1

and health. The data also had information on smoking and that is where I got started. You might say I came into health economics through the backdoor of environmental economics. As I finished my Ph.D. I realized I knew almost nothing about the broader field of health economics and I decided to do a post doc with Jody Sindelar when she was an assistant professor at Yale, in 1986-1988. That was also my first opportunity to teach health economics.

Q *Have you ever thought about returning to your environmental economics roots?*

A Not really. A lot of the interesting questions in health economics I confront involve the big "E" environment. It encompasses a lot, including the natural environment but also the built environment, for example, whether there are jogging trails, whether it is a bike-friendly community or not, and things along those lines. This is a big issue and is becoming an increasingly studied issue as the data catch up to the interest.

Q *Within health economics, what motivated you to spend a lot of time thinking about methods?*

John Mullahy is a founding Board Member of ASHE and professor in the Department of Population Health Sciences at the University of Wisconsin.

A Here's another area where I've come in through the back door. I didn't have a particularly strong interest in econometrics during my graduate work. Part of the air pollution and health study at RFF looked at restrictions of activities. The data measured the number of restricted activities days or the number of days of missed work due to restricted activity. During the analysis, Scott Zeger from Johns Hopkins was brought in as an outside evaluator by the EPA who was funding the work. Scott suggested that we should look at count data methods for some of these models due to the nature of the data, so we went back and began looking into this literature. At the time, there was very little work on this topic in econometrics. The very first paper where we applied this is published in the *Journal of Urban Economics*, and my 1986 *Journal of Econometrics* paper on related methodology is still probably my most cited paper. This is where my interest in methods really began, and my interest grew much deeper during my postdoctoral fellowship at Yale, participating in the Labor and Population Workshop with Jody, Paul Schultz, John Strauss, Duncan Thomas, and others.

There two additional stories about how I my interest in methods developed. First, I was never totally satisfied with the econometrics analysis in my dissertation even after it had been accepted. Just as I was preparing to submit the first paper from my dissertation to the *Journal of Political Economy*, I received an unsolicited letter from Gary Becker. He explained that Michael Grossman was kind enough to send him a copy of my dissertation since Mike knew Becker had interests in the topic. Specifically, Becker's letter informed me that Kevin Murphy and he were working on models of rational addiction that were clearly richer than

continued on pg 9

View from the Program Office

continued from pg 1

grant funding, by those engaged in the application process, by current grantees, by users of health economics research, and by leadership in the Agency and Department. My intention is not to be exhaustive of the issues but rather to hit some high points that might be useful to those in the field of health economics seeking financial support for their research – and to stimulate a conversation.

1. **Know your funder and its mission.** Health services research (HSR) and health economics overlap – but not completely. Health economics focuses on health, health care, and healthcare financing. Health services research naturally focuses on health services but in more non-economic dimensions – especially in non-economic clinical and other technical dimensions involved in the provision of health services. AHRQ's mission concerns health services research. Health economics is a part of that mission.

Historically, NCHSR, AHCPR, and AHRQ were the major funders of HSR, with health economics garnering a large chunk of that funding. That is no longer the case. NIH has increased its own support for health services research in recent years. At the same time AHRQ has emphasized more clinical issues (e.g., clinical effectiveness, patient safety), technical issues (e.g., health information technology), the development of measures and tools, and the implementation of these tools. This has been associated with a decline – at least in a relative sense – of funding for research itself and, in particular, for research on business, economics, and health system issues. Yet, funding does continue. I personally have 25 currently active research grant projects and there are several other program officers in AHRQ with similarly active projects.

continued on pg 4

View from the Program Office

continued from pg 3

2. **Health services research is interdisciplinary and multi disciplinary.** Not all of my projects are pure health economics. However, most of my projects have a team member with health economics skills who is intimately involved in the project. Usually there is an 'economic' dimension to the research objectives of the project. Having health economists on such projects is seen as a strength by most study sections reviewing proposals. From my program officer point-of-view, the presence of a health economist on the project is almost always a strength.

3. **Know your study section.** AHRQ has four active study sections, each with a different emphasis. NIH now has two main study sections reviewing investigator-initiated proposals. Much research on health economics issue would easily fit with the mandate for those NIH study sections. However, a review of the rosters for any study section is very, very revealing. An examination of study section rosters should be an important part of conceiving, developing, and submitting a grant application for support of a health economics research project. Inquiring as to what projects have been recently funded from targeted study sections is also critical to project development.

4. **Contact with program staff early in the process of project development is a good practice.** Interpretation of mission, budgets, study sections, program announcements, and processes can change rapidly. Contact with program officers can provide current information that is useful and points toward success. An ounce of prevention . . . . It may be useful to think that a critical part of program officers' agenda – developing high quality grant applications – is very much aligned with the objective of applicants seeking funding.

5. **Does this stuff make a difference?** In September 2006, AHRQ awarded Mathematica Policy Research Inc. a contract to describe the extent, nature and effectiveness of AHRQ's grants-supported research on business, economic, and related health system issues. The intent is to focus on AHRQ-sponsored grant research that addressed the topics of healthcare costs, productivity, organization, and market forces. The evaluation considers 150 projects funded since 1998 under the rubric "cost, productivity, organization, market forces" – the precise language of AHRQ's Congressional authorization. The intent of the procurement is to support a systematic review of the research AHRQ has funded in this area, how it has been disseminated and used, and how the work complements other research in this area.

The four research questions of interest to the study are: 1) Since the late 1990s, what grant research has AHRQ funded that relates to health care costs, productivity, organization, and market forces? 2) How are the research findings disseminated to public and private decision makers and what are the factors that contribute to their use? 3) What is AHRQ's role in supporting research in this area and how does its role compare to that of others, such as the NIH or private funders? 4) What actions, if any, could enhance AHRQ's efforts to track, disseminate, and encourage use of these research findings?

Aside from the focus of the study, these questions obviously point towards a programmatic concern with relevance of supported research – and an environment within the Federal government of increased accountability. The implications of such an effort for those seeking funding for research are: a) that policy relevance is important, b) that dissemination efforts are important programmatic concerns, and c) that the Federal government is seeking ways to understand the impact of funded research, to facilitate such impact, and to document it.

Projects of high technical merit with other inherent programmatic characteristics (e.g., policy relevant questions and a team with a track record in providing information to policymakers) are good projects from the point-of-view of a program officer seeking to achieve the mission of AHRQ as articulated in the Agency's authorization: to support health services research on healthcare "cost, productivity, organization, market forces," on efficiency, on health care financing and – the word of the day – on "value" in health care. These concepts are the stuff of which economics has been made for a quarter-millennium. Health economics is an increasingly important part of the field of economics. Health economics is an important part of the mission of AHRQ.

Michael Hagan
Senior Economist, Extramural Program Officer
Center for Delivery, Organization, and Markets (CDOM)
Agency for Healthcare Research and Quality (AHRQ)
(301) 427-1409, fax (301) 427-1430
Michael.Hagan@AHRQ.HHS.gov

The President's Column

continued from pg 3

and coffee breaks on-site. This promotes mingling and enhances the ability to talk with people you might not otherwise meet. Over 500 people attended the Madison conference and we are expecting more at Duke. The Duke campus is a great setting for the conference.

I hope you will participate in these activities. Consider organizing a session or submitting an abstract for a paper. With your help, the conference will offer an abundance of expertise and diversity of views. I look forward to seeing you at the ASHE luncheon in January. Please sign up in advance to secure a spot.

Jody Sindelar, President

Interview with
Board Member Gloria Bazolli

continued from pg 1

hospital industry. We also have theories focused on how firms make decisions about the quality of their products, as well as their decisions about producing multiple outputs simultaneously, all of which certainly apply to hospitals when you think about the nature of their outputs. So you have this great pool of theory to draw upon and you've got some pretty good data – of course, certainly not perfect. In particular, there are annual data from the American Hospital Association that examine basic structural and operational characteristics. You've got financial data from the Center for Medicare and Medicaid Services. You've got a number of inpatient discharge databases with detailed patient data, and in some states, some outpatient and emergency room data. This gives researchers many opportunities to match theory with available data to conduct research on hospitals. In other health care sectors, that's just not the case. Physician organizations and markets really stand out as places where one would like to test certain theories and hypotheses but the data don't exist.

Q *In your early work you focused on physicians rather than hospitals. Did you start that work with your dissertation?*

A I was trained in labor economics back in the late 70's and early 80's at Cornell University. And what happened to labor economics when I was entering the job market? Unfortunately, the Reagan administration was in place and there was no money at all to support research on labor issues. When there's no available research support, there are very few positions available for PhDs in a field. When I entered the job market, I found there was quite a bit of interest in workforce issues related to physicians. There was a lot of concern about the effect of medical school debt on physician specialty choices and related career decisions. There was also interest in physician retirement decisions given stresses in the market, especially the malpractice situation, and also the effects of malpractice on physician decisions to relocate their practices geographically. So, there were all these labor issues manifesting themselves in the physician workforce that required an economic framework to analyze. That was my transition initially into health care. I went to work for the American Medical Association and I was a labor economist studying physician work force issues.

Q *So what was the focus of your dissertation?*

A My dissertation was on the retirement decisions of older men. I was using the Health and Retirement Survey and was simply looking at why some men were retiring before the age of 65, which is typically considered normal retirement age. At the time, many felt – believe it or not – that people retiring before age 65 must have health or other disability reasons that explain their discontinuation of work. Now it's funny to even imagine this as a burning issue because we realize that most people retire primarily when they have the financial means to do so. But back then this was a big issue and my dissertation attempted to provide new insights on the relative impact of social security benefits, pension income, and health on retirement decisions.

Q *How did you transition from that to your work with hospitals and the safety net? Once you started, you really never looked back.*

A When I was at the AMA, there were some really great people there. Also there was available data plus unique opportunities to design and conduct physician surveys. Over time, the pressures on professional associations like the AMA grew and this meant that our ability to do rigorous research and novel data collection was declining. I left the AMA and ultimately ended up at the American Hospital Association's Health Research and Educational Trust, and that's when my work transitioned from looking at physicians to looking at hospitals.

Q *It seems like there are a completely different set of skills than you would have used in your dissertation and in your work with the AMA, much more industrial organization than labor. How did you make that transition?*

continued on pg 7

Join ASHE in 08

2008 Memberships

In 2008, we are introducing lower-cost ASHE memberships for members interested in only becoming a member of ASHE.

Individual ASHE $50
Student ASHE $35

You can become a iHEA individual member when you purchase a Joint ASHE/iHEA membership. This joint membership has all the benefits of iHEA's Individual Membership, including all discounts (including journal subscriptions) and special rates.

Individual ASHE/iHEA $115
Student ASHE/iHEA $60

Duke Conference Registration

2008 Early Bird Member Registration $465

Non-Member Registration $865

SPECIAL: Presenters, Chairs, Discussants and Organizers who are 2008 ASHE Members qualify for the

2008 Early Bird Participant Registration $415

Dear ASHEly

The following letter might have been written by a junior health economist embarking on his or her new academic career. This "letter" has been sent to several senior economists who have generously shared their anonymous advice.

Dear ASHEly,

My new job has lots of opportunities to become involved in interdisciplinary research. The projects look interesting but I'm not sure about working in group with such varied backgrounds. Can you give me some advice on the challenges and opportunities of working on an interdisciplinary project?

Sincerely,

Not Yet Ready to Commit

Dear NYRTC:

If you are joining an interdisciplinary team that has proven success in taking research ideas and turning them into useful analysis, you stand to gain from such a collaborative effort. You'll learn how people from different disciplines approach research questions and you'll end up learning more about our, well, interdisciplinary field. Interdisciplinary groups are a natural and widespread way to address questions that lie at the intersection of economics, medicine, law, epidemiology, and management.

A word of caution: if you are newly employed in an economics department, the challenges of working on an interdisciplinary project early in your career probably aren't worth it. You first need to establish yourself as an economist by honing your understanding of economics and deciding where your contributions to the discipline will be.

Also to do interdisciplinary work well, you need a "Rosetta stone" to translate your understanding of economics to non-economists and also, equally important, to understand what the non-economist is saying to you. Time spent learning a new language is not productive in the short-run and would be inadvisable if you have yet to establish a publication record. So first concentrate on building up that portfolio of research while you start learning someone else's language. That learning process also benefits from experience; the more you really understand your discipline, the better you can explain it to someone else. If you are not in an economics department, you'll be thrown right into interdisciplinary work anyway, and you need to have an understanding with your department chair about the need to spend some time building new skill sets.

Another risk of interdisciplinary work is that economists can come off as arrogant and extremely intolerant of methods of other disciplines that seem less rigorous. Once you understand economics more deeply, you'll see the holes in what we do and you won't be so self-righteous. That is something that takes some seasoning to achieve. You need to be conscious about being humble and not appear to be aggressive or attacking.

To summarize, the keys to success of interdisciplinary collaborative efforts are leadership, collegiality, effective division of labor, and experience in overcoming language barriers. If you can, give yourself time to develop these skills while your main focus is on establishing your reputation in economics.

-ASHEly

News From Executive Director Richard Arnould

continued from pg 2

A brief note about philosophy behind the conference registration fees is in order. We make every effort to keep fees as low as is feasible to run the conference and the association. The fees must cover the conference expenses as well as the ongoing operation of ASHE. We also are responsive to the need to provide extensive opportunities for all attending the conference to network with other health economists. Your board is particularly concerned about students and young health economists who may be relatively new to the field. For that reason, your board and the CPC fully endorse a fee that is inclusive of all activities. The registration fee covers conference attendance and most of the meals for those in attendance (if one wishes to consider break food as an adequate breakfast and reception food as a dinner). And after the fact, most who attended the Madison conference were happy with all they received for the expenditure.

So, we hope to provide a great venue for the meeting but are relying on you to provide the quality papers and discussions.

ASHE Membership

ASHE is scheduled to become an independent organization by 2010. Certainly there will be high levels of interaction with iHEA after that time, but ASHE needs to develop its own legal status. Moves are underway now in preparation for that to happen. This is the first year that a separate ASHE membership is being offered to our members. Joint membership with iHEA will continue to be available at a discount for those who continue to want to join both organizations.

If your university or organization is an organization member, we hope you will continue with either an ASHE or joint ASHE/iHEA org membership. If not, you are encouraged to do so. Org memberships provide needed operating funds to ASHE and many benefits to the health economists, and especially students, in your organization. Please check to ASHE website for detailed information.

Elections

The first election of members to the ASHE Board of Directors was held this fall. ASHE by-laws call for the election of 3 regular members of the board each year. Those who were up for election were chosen randomly. You probably have seen the results on the website. We are happy to welcome Gloria Bazzoli and Marty Gayner back to the board and we provide a special welcome to new board member Dana Goldman.

In closing I once again invite you to let us know your comments on the newsletter and other aspects of the activities of ASHE.

Richard J. Arnould
Executive Director

Interview with
Board Member Gloria Bazolli

continued from pg 1

A When I went to the AHA, I needed to move from basic theories of labor economics and develop my understanding of IO models. That's something I tell my Ph.D. students here at VCU: you've got to be a life-long learner once you receive your Ph.D. In my case, I had to re-tool myself in terms of the theories used in my research. Not only did I spend time learning IO theory, I also started working with a people whose primary focus was medical sociology, especially Organizational Behavior theories. In particular, I worked with Steve Shortell, Jeff Alexander, and Lawton Burns. I was intrigued by the linking of economic and sociological perspectives when studying hospital behavior. So my theoretical frame began to expand beyond just economics.

Q *A lot of health economics is economics plus some other area, for example health economics + labor economics or health economics + IO. That's something you've really taken seriously and might make a good headline for your biography …*

A Many of us who work in health care realize that we have to be multi-disciplinary. You have got to expand your horizons, especially theoretically, because health care organizations are quite complex. I've expanded in a variety of different ways: I've gone from labor to health care, from physicians to hospitals and then expanding my theoretical base from strictly economics theories to a broader set of organizational theories.

Q *Some of my colleagues in the economics department are turned off by health economics because it is such a complex market but is it that complexity that interests you?*

A That's what is fascinating about health care, from my perspective, namely that the industry is complex and keeps changing. The other thing about health care is that it is awash with exogenous shocks. Researchers in other fields frequently are unable to identify exogenous shocks to study, and we have them happening all the time in health care: the federal government changes Medicare payment policy; states implement insurance mandates or change Certificate of Need requirements. So there are all sorts of things that can be studied, but again, the complexity and changing environment in health care is what keeps me intrigued with the industry.

Q *You've recently won a big new grant continuing your work on the safety net. Can you tell me a little bit about that?*

A A number of years ago, I had an RWJF grant through their Health Care Financing and Organization program to look at safety net issues particularly the effect of financial pressures and market pressures on safety net institutions. Our current grant from the National Institutes of Health allows us to examine how those financial pressures are affecting people, particularly those people who depend on the safety net. There continues to be growing financial pressure on the safety net, and of course, growing numbers of uninsured individuals. We are examining how these institutions are faring and what happens to people and the care they receive when these organizations are highly stressed? The new grant is the next logical step given the research we've already done.

Q *What is the current state of the safety net?*

A It is certainly fraying in a number of places, and in some communities, it is near collapse. This is especially true for particular types of patients, such as uninsured individuals with psychiatric emergencies. In other areas of the country, the safety net is intact but uncompensated care is becoming increasingly concentrated in a small number of institutions and providers. It is sad in several respects. Ideally, we'd have a health system that recognizes that there are public goods that need to be publicly supported and there are private goods that should be privately supported. But that's just not the kind of system we have. We put the burden on hospitals and other providers to figure out how to use a mixture of private funding – namely profits generated from paying patients – plus special subsidies and monies that otherwise would be paid in taxes to provide a public good. As an economist, this implicit funding system doesn't make sense to me. I would rather see an explicit system for measuring and supporting the public good. This would improve accountability from my perspective.

Q *Have you thought about advising a political campaign about proposals for reforming the system? Have you thought about playing a more direct role in policy making?*

A I've not been asked, and if asked, would make the decision based on the philosophy and thinking of the candidate. I'm not a big fan of politics. I always tell my students: there's politics and then there's policy and these are completely different. Economists and health services researchers can certainly play an important role in providing useful insight on policy, including better definitions of problems and assessment of policy effects and needs. Certainly, we have a lot to offer and many times our research has influenced policy. However, I've always found the political process and politicking quite frustrating, and for that reason, I would be very hesitant to advise a political campaign.

Q *How about your work specifically? Is there one particular area you look at and think there's where I really made a difference?*

continued on pg 8

Interview with
Board Member Gloria Bazolli

continued on pg 7

A For the most part, I would characterize my research as laying the groundwork for my own subsequent work and that of other researchers in the field. Frequently, that is the primary contribution we make as researchers. Also, our research tends to contribute to a body of evidence that in turn influences policy. It's hard for me to identify one of my studies that really made a difference. Probably the one that stands out the most is my work with Steve Shortell to characterize the strategies and structures of multi-hospital systems and networks. At the time we were doing the work, many people were saying that it was impossible to compare System A to System B because systems were all unique. We developed a taxonomy of health systems and networks in 1999 that has been cited in about 60 different published studies at this point. I'm quite pleased when I hear people, even today, using the terms we developed to describe the primary structures and strategies of these organizations, namely they talk about the degree to which they are differentiated in services offered, centralized in service structure, and have implemented specific integration strategies. And I hear this not only from researchers but also practitioners and hospital executives. That certainly pleases me.

Q *What is it that made you want to get involved in the American Society of Health Economists? Why did you want to give your scarce time to help ASHE become established?*

A Certainly, health economists need forums to present their work and to obtain good feedback on it. As we've discussed, health care is very complex, and because of this complexity, these kinds of forums are essential. There was nothing comparable to ASHE before it was created for US health economists. IHEA is a great organization, and I have really enjoyed being a part of it. But it only has meetings every two years and it is difficult for some people in the US to attend given the expense. We needed something more and we have been fortunate that ASHE has developed to connect us on a more regular basis. Also, I wanted to be involved with ASHE because I thought it was important for someone like me who was very applied to provide input to the organization. I didn't want to see it weighed too heavily toward theorists or towards econometricians. You need to have a balance between solid theorists, methodologists, and applied researchers. Diversity and good representation is critical so that educational and other programs are developed that cover all the bases.

I'm amazed when I go to a meeting like ASHE's Madison conference to see how many people are involved in the field…

Where do you see ASHE going forward?

Q *Did you seem some particularly good things at Madison you'd like to see continued or some things we weren't yet in a position to do but might be able to accomplish in future conferences?*

A What ASHE did extraordinarily well was bring a diversity of people together and provide a very large number of opportunities for people to discuss and obtain feedback on their research. It will be worthwhile for ASHE to continue to expand its activities, including developing intensive theory and methods workshops. Some of that has already occurred but there may be other opportunities out there, such as web-based educational programs. That way, there could be continuous learning rather than one shot deals at the conferences.

Q *The focus of the newsletter is on health economics as a profession and I'd like to get your perspective on where the profession is headed. You've worked in a variety of settings from the AMA to the government to a university setting. What do you see on the horizon for the profession?*

A There is good news and bad news when it comes to the health care system and the role of economists in studying it. The good news is that there certainly are lots of issues for us to study. There seems to be a continuous stream of economic concerns in health care and thus continuing demand for the talents of a health economist. However, one has to ask how sustainable our current health care system is, given the increased number of uninsured individuals and ever escalating costs. But from a purely research perspective there are a variety of things to study and fortunately good data in some areas. So there are many good opportunities for health economists.

Q *Do you see any important new trends in the profession of health economics?*

A I'm amazed when I go to a meeting like ASHE's Madison conference to see how many people are involved in the field and also the diversity of these individuals. It's great to see so many people involved with the field of health economics. It means we have a strong future.

Interview with Board Member John Mullahy

continued from pg 3

what I had developed in the dissertation. It was a very nice letter, but the bottom line was that I'd been scooped plus one by Gary Becker! Because of that and my dissatisfaction with the econometrics I never submitted that paper. When I finally worked out a different way to do the econometrics, I took the data from my dissertation and re-analyzed it for a paper that was published in the *Review of Economics and Statistics* in 1993. There I finally found a more-or-less conceptually defensible way to analyze the data and bring the whole thing to closure (at least in my mind!).

The second story is that after I finished my post-doc at Yale, I took a position at Trinity College just up the road from Yale. It worked out great and we loved living there. At that time – the late 1980's- I got to meet Will Manning. I remember exactly where I was the first time I spoke with Will. If you know Will, you know that a phone conversation with him is rarely brief, but always substantive and rewarding. At the time, Will was working on the cost of poor health habits, and we connected in our first chat over our interests in the analysis of the costs of smoking and drinking. Will has an infectious interest in econometric methodology. I've been blessed with great mentors over the years, and while I think of will Will as a colleague now, in my early days as a new assistant professor, I really though of him as a mentor.

Q *What kinds of things did you learn from Will Manning?*

A One of the main tenets of Will's approach to data analysis is that the simpler or more direct path to an answer is not always the inferior one. The tools that are more user-friendly can often times be the superior to those that are more complex so long as one keeps focus on the question at hand. This is really just good science. Our 2001 *Journal of Health Economics* paper is one of my favorites and a good example of this. The idea of the paper is to look at alternative ways to answer particular questions rather than merely deploying the estimation technology. .

Q *There have been a lot of changes in the field of health economics since you first started studying the effects of smoking. What have been the most striking changes to you?*

A What's been most amazing is the growth in the field during this time. The *Journal of Health Economics* has just celebrated its 25th anniversary, and it has gone from a slim three issue per year publication, to a really robust journal. Other health economics periodicals have also blossomed; in fact, I sit on editorial boards of four journals that would be considered health economics journals. In the 1980s, if someone was called a health economist by an economist working in a different specialization, it was often almost a mark of second class citizenship. Now the discipline has a sense of maturity, and is just as respectable as other applied microeconomics fields such as Industrial Organization or Labor. The fact that the core problem on which we work -- human health -- is so enormous is surely part of what motivates this.

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Q *What kind of students do you work with and has that changed over time?*

A Even though I work in a medical school, the doctoral students with whom I work come from Economics, the Business School, the Agriculture and Applied Economics, the School of Pharmacy, Sociology, and my own Population Health program. Last year, I was chairing or sitting on 17 doctoral committees. It scared me a bit after I added it up for my annual review! One thing this signifies is that interest in topic related to health economics is broadening. At this time of year, there are many different job markets that my students and I must pay attention to: schools of public health, medicine, public policy, and pharmacy, in addition to economics. One feature of our field is there are also many opportunities outside of academia in government, private research, industry and consulting. While it is nice that there are so many different venues in which health economists can practice their trade, it does make students and their advisors work harder searching across different margins.

In terms of my day-to-day teaching life, health economists in medical schools typically spend less time in classroom teaching than those in economics departments. But I spend a lot of time with our doctoral students and love spending that one-on-one time.

Q *Have you thought about becoming more directly involved in policy-making?*

A If there were counterfactually a 25th hour in the day, I might do more, but as it is, I don't see how to carve out more time. I do think about policy a lot though, perhaps in large measure because my students typically are quite interested in policy. Being in a medical school, some of my colleagues and I take a broad view of what constitutes "policy". For instance, the impact our work might have on the conduct of clinical practice is a form of policy involvement. When the information one provides moves the decisions that move resources, then I'd say one is engaged in policy work.

Q *What made you want to get involved in ASHE?*

A There was an obvious void for US health economists to rally regularly around research, and we are quite proud that the 2006 ASHE conference at Wisconsin was in an important sense the birth of ASHE. It was a lot of work putting the conference together, but it was also enormously rewarding. What's more, the first conference showed that we are onto something here. Providing a forum like this clearly has a lot of value for the US health economics profession, and the initial evidence shows that ASHE will fill that gap.

Letter from the Editor

The first newsletter appears to have been a success and appreciate the feedback both positive and negative. As this is a new publication, we are still making decisions about what works and what doesn't, so now is a great time to get your two cents in.

In this issue, we have two Board member profiles that provides a great cross section of the leadership in the field: John Mullahy's research has provided the econometric backbone for applied health economics research while Gloria Bazzoli's work shows how theory and econometrics can successfully marry together to provide the best insights into complicated health care markets. I was also fascinated to see how a little bit of encouragement in the form of grants and research assistantships can play such a big role in recruiting talented people to our field and shaping their research agendas.

Because grants are such an important factor for health economics research, I asked Mike Hagan, Senior Economist at AHRQ, write a column giving his insider's perspective on the environment for funded research at AHRQ. I'm hoping I can persuade Agnes Rupp of NIMH to contribute a column for the next newsletter and will gladly take suggestions on other program officers I can recruit.

The "Dear ASHEly" column is back with advice on success in interdisciplinary work, and we also have letters from our President Jody Sindelar and Executive Director Richard Arnould giving us updates about the next conference and other important ASHE news. I hope you got your abstracts submitted on time! The letters from Jody and Dick, through no fault of their own, may be a bit dated. We have had some production delays in the newsletter that worked against those contributors who got their columns in on time. I am eager to find more individuals who would like to contribute to the newsletter but, a word of warning, am going to be VERY FIRM about deadlines. Perhaps Dear ASHEly can write a column about the perils of procrastination! Maybe I'll ask her about it tomorrow . . .

Melayne Morgan McInnes, Editor
University of South Carolina

AEA/ASSA Schedule for ASHE/iHEA

Event	Date	Time	Location
ASHE Board Meeting	**Friday, January 4, 2008**	**8:00 AM**	**Sheraton Southdown**
ASHE/iHEA Reception	**Friday, January 4, 2008**	**6:00 PM**	**Sheraton Grand Chenier**
Session 1: Topics in Health Economics	**Friday, January 4, 2008**	**2:30 PM**	
Presiding: RICHARD ARNOULD, University of Illinois	**MARK DUGGAN**, University of Maryland--The Effect of Medicate Part D on Dual Eligibles: Evidence from California-s Medicaid Program **AMY FINKELSTEIN**, Massachusetts Institute of Technology--The Effects of Universal Coverage: Evidence from the Introduction of Medicare **DOUGLAS STAIGER and JONATHAN SKINNER**, Dartmouth College--Diffusion and Productivity in Health Care **DAVID BECKER**, University of Alabama-Birmingham, **KENNETH CHAY**, University of California-Berkeley and Brown University, **and SHAILENDER SWAMINATHAN,** University of Alabama-Birmingham--Mortality and the Baseball Hall of Fame: An Investigation into the Role of Status in Life Expectancy		**Discussants:** **MICHAEL ANDERSON**, University of California-Berkeley **CARLOS DOBKIN**, University of California-Santa Cruz **JUSTIN MCCRARY**, University of Michigan **JAY BHATTACHARYA**, Stanford University
Session 2: Health Insurance and Incentives	**Sunday, January 6, 2008**	**8:00 PM**	
Presiding: RANDALL P. ELLIS, Boston University	**M. KATE BUNDORF and JONATHAN LEVIN**, Stanford University--Pricing Health Insurance: The Efficiency Implications of Heterogeneous Risks and Preferences **GEIR GODAGER, TOR IVERSEN**, University of Oslo, and **CHING-TO ALBERT** MA, Boston University--Service Motives and Profit Incentives among Physicians **RANDALL P. ELLIS**, Boston University, and **WILLARD G. MANNING**, University of Chicago--Optimal Health Insurance for Prevention and Treatment		**Discussants:** **AMY FINKELSTEIN**, Massachusetts Institute of Technology **DANA GOLDMAN**, Rand Corporation **W. DAVID BRADFORD**, Medical University of South Carolina