ashe
American Society of Health Economists

Newsletter of the
American Society of Health Economists

Welcome from the Editor

The Inaugural ASHE conference in Madison, Wisconsin, provided a great venue for presenting and learning about research, meeting new colleagues and catching up with old friends. For those of you who'd like to keep the conversation going between conferences, we are launching the ASHE Newsletter. Our first issue features an interview with President Jody Sindelar. We are introducing a "Hot Topics" column that will bring up-to-date information on a current area of research or methodology. In the first column, below, David Bradford of MUSC gives us the state of the art in Direct to Consumer Advertising research. Look for upcoming columns on behavioral health economics, pay-for-performance and non-linear instrumental variable techniques. Tim McBride has graciously

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Hot Topics: Direct to Consumer Advertising for Prescription Drugs: A Very Brief Survey

By W. David Bradford

Historically, pharmaceutical marketing was largely directed towards physicians in the form of: detailing—promotion from the manufacturer to the physician through visits by sales representatives; sampling—promotion through free samples distributed by sales representatives; and professional journal advertising. In August of 1997 the Food and Drug Administration (FDA) relaxed rules governing broadcast media advertis-

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Interview with ASHE President Jody Sindelar

Q: *You are one of the founders of ASHE. What made you want to get involved from the beginning?*

President and Founding Member of ASHE, Jody Sindelar is the Head of the Division of Health Policy and Administration at the Yale School of Public Health.

Jody: I have a strong sense that in the past health economics has been undervalued field in economics. My best example of this is when I was at the University of Chicago Business School, someone from their press contacted me saying he'd love to hear about my research and that his readers would be very interested. It turns out he had gotten me mixed up with another woman professor whose area was oil and gas. The minute he found out that I studied health economics, he disappeared. I was astounded that oil and gas were hot and he walked away the minute he heard "health economics". Of course, it didn't say much for women either: with 100 men and only 4 women, they couldn't tell the women apart!

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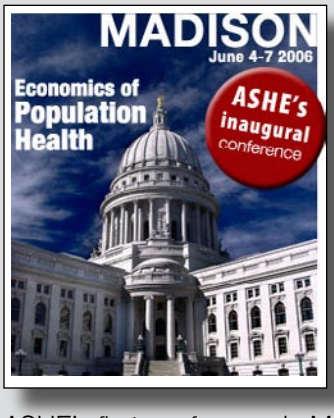

ASHE's first conference in Madison was a tremendous success. See Dick Arnould's letter on page 2 for more on the conference.

In This Issue

ASHE Newsletter 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.

Dear ASHEly: Advice on the Profession of Health Economics

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,

I've been given lots of advice about what I should be trying to accomplish as I embark on my new career as a health economist, but was wondering about the pitfalls. What should I be on the lookout for? Where do health economists go wrong?

-About to be Newly-minted

Dear Newly,

First, congratulations on successfully finishing your career as a student and welcome to the wonderful world of academia. Now to the pitfalls in your new career ...

I think the number one pitfall of new health economists is spreading themselves too thin and saying "yes" to too many things. You've got to keep your eye-on-the-prize when you start out and that typically means getting publications from your dissertation and working on getting funding. I've seen a number of young faculties create difficulties for themselves by trying to link up with other faculty in their department to do new research when they haven't yet capitalized on their dissertation research. I've seen them say "yes" to too many department and school requests for time, only to get hit for not having a record of solid publications and grant money when they come close to tenure. Maintaining focus is critical for new faculty so that they can work on their new class preparation and get some feathers in their caps in terms of publications and grants. In short, finish your papers and focus on your research agenda. It is better to have 10 published papers than 20 in the pipeline.

This brings up a related pitfall: some junior faculty fail to consider how they will be evaluated come tenure time. Health economists are unusual in that we are found in a variety of settings, each with quite differ-

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Letter from the Executive Director

Dear ASHE members and Friends:

I am very happy to be writing to you in the first issue of the ASHE Newsletter. Professor Melayne Morgan McInnes, Department of Economics at the University of South Carolina, has graciously agreed to serve as the first editor. The Newsletter Committee consisting of David Bradford, Gloria Bazzoli, Susan Ettner, Deborah Haas-Wilson,and Tim McBride have agreed to serve as the Editorial Board. I fully endorse Melayne in this position. She brings to it a generous amount of enthusiasm, knowledge of the field, ideas and a strong commitment to facilitating a successful ASHE in all of its endeavors. The intent is to walk into this venture being careful not to promise more than we can deliver. Thus, it will come out three times a year. Regular features will include information from the Executive Director, an interview with a prominent health economist, notes from the Editor, announcements and news items. Melayne will explain these features and other items we hope to include below. Our overall goal is to provide valuable and interesting information but not duplicate other sources of similar information. So, please respond to any calls for information that she issues in this and upcoming issues of the newsletter.

Inaugural Conference Report

I would like to bring your attention to the Madison Conference Report. The full report can be found on the ASHE website at <http://healtheconomics.us/conference>. Scroll down to Past Conferences and click on Conference Report. I believe it is safe to say that the Inaugural Conference was a smashing success. Over 330 papers were presented in 107 sessions and 85 posters were on display. Over 80% of the respondents to the survey rated the papers high or very high in quality. Presenters and attendees were particularly happy with the three paper sessions, which provided ample time for serious discussion in most cases. The Presidential Address by Joseph Newhouse, the John D. MacArthur Professor of Health Policy and Management, Harvard, along with the plenary speeches by David Cutler, Otto Eckstein Professor of Applied Economics, Harvard, and B. Douglas Bernheim, Lewis and Virginia Eaton Profess of Economics, Stanford, were given high marks by all in attendance. The ASHE Medal winners were David Cutler and Jonathan Gruber, MIT, clearly setting a

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Of course, that was a long time ago and right now this story seems antiquated because thing have changed so much. Still, I am a big proponent of how important health economics issues are, and ASHE is a vehicle for making sure things keep changing in the right direction. Also, the conference offers a wonderful opportunity to get a large number of experts together to discuss research and policy issues and to see lots of friends and meet new people.

Q: *What does ASHE bring to the health economics community that IHEA does not?*

Jody: ASHE provides an opportunity to bring together a community of scholars who share an in-depth interest in a similar set of topics. I think you get a better sense of affinity and community with people who share a common set of issues and facts. Some of these issues that are so important to people in the United States are not of interest to people in the international community. IHEA is not interested in some of these topics because they are not as broadly appealing to people in other countries. Health economists from other countries don't feel a need to learn all about Medicaid or SCHPs, HMOs, PSOs, and other institutions and policies that are specific to the United States.

Q: *How did you go from labor economics to health economics?*

Jody: I think that I was the first person to use the Rand Health Insurance experiment data. I was at Stanford and decided I wanted to learn more about policy-oriented ideas so I went to Washington D.C. to write my dissertation (although I finished at University of Chicago Economics Department as a post-doc). I went to Health Education and Welfare in DC to work on welfare reform but instead was assigned to oversee the Rand Health Insurance Study. Through this I met Joe Newhouse and Will Manning and others. I think that was one of the first to get to use the baseline data from that study, and this drew me into the area of health. My interest had been human capital and education, so it was a really easy transition to focus on health as a component of human capital. Once I started, I could see that health economics was an important and untapped area and labor economic approaches seemed quite applicable.

Q: *When you went out on the market were you billed as a health economist or labor economist?*

Jody: I went out as a health economist with a labor background. My dissertation was on why women use more medical care than men. The paradox that I found interesting is that women lived longer but they reported themselves to be in worse health and they used more medical care. I examined factors such as the role of women in providing health for the whole family (e.g. she would use medical care and apply this to the family), competing risks of death being higher for men thus reducing the expected long term gains to prevention and other factors.

Q: *You said earlier that health economics has really changed since you began your career. Would you talk a little bit more about that?*

Jody: Over the past 20 years, I have witnessed an enormous change in the area of health economics. When I was at Stanford, Victor Fuchs was one of the first well-known economists to study health care issues. Now it is a vibrant field with an abundance of health economists, diversity of topics studies, a multitude of journals, and even textbooks. Even since I've been at Yale, this place has really developed and changed. The whole profile of health services research and health economics has increased. It is much more in demand across the university. Students have recently asked for an undergraduate concentration in public health and there is a huge demand for a health economics course.

Q: *As you started your career, did you ever have any qualms about doing something untraditional like health economics?*

Jody: I didn't have a strategy but I just knew I was very interested in economics and human capital, particularly personal health, and knew it was a good investment. One result of my experience in graduate school is that I am a good mentor. I know what a difference a good mentor can make.

Q: *Are mentors particularly important in health economics and is this something ASHE can help develop?*

Jody: I think mentors are really important in health economics, because it is good to have a personal strategy of where you want to go and how you want to get there. Getting external advice on how to develop a long-term strategy can be very helpful. There are also some choices to make along the line, and you have to be opportunistic as well. ASHE's role on this will have to start off small. If there is an individual or group who wants to help to organize a session or

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pre-session for mentoring at the ASHE meetings, that could be really effective. The main way we are going to get something done is for members to take the initiative.

Q: *What new activities do you envision for ASHE?*

Jody: One of the things I'm working on is an ASHE web page. Susan Ettner has volunteered to take the initiative on this. A really informative webpage will be a great benefit to ASHE members and students. If someone is going to teach a new course in health economics or health care finance or a newly minted Ph.D student wants some help getting started, they can have access to syllabi, some problem sets, and other teaching materials. There can also be links to other material available on the web. Susan is particularly interested in providing material that will be helpful to PhD students relating to research. Some of this material is already out there, but having it together on one central site can be a real benefit to members of ASHE. The newsletter is also important too, because in addition to being informative, we need a sense of community and purpose in the profession.

Q: *Sounds like you are looking for volunteers.*

Jody: If members have ideas about what they think is important, particularly if they are willing to put some effort into it, that would be really appreciated. ASHE simply doesn't have the money to hire professional organizers for additional activities. The main way we can get something done in ASHE is to have individuals who have strong interests and who are willing to take on an activity. Thanks to you Melayne for taking the initiative as Editor.

Q: *Your research has focused on the economic bads of smoking, drinking and drug use. What drew you to those areas?*

Jody: I started off looking at mental health as a problem and addictive disorders was one dimension of that problem. It seemed like addiction was an area where an economist could add the most because of the public policy issues. Take alcohol as an example. There's drunk driving legislation. There's taxes. What attracted me to these issues was the possibility of intervening in policy-making where economists have a lot to say. The tax on cigarettes is a great example of where economists have had a real impact. Medical professionals focus on treating individuals who smoke or use drugs. The power of a tax is that you affect a lot of people at the same time, and it has a big effect. A tax on cigarettes can reduce the harm of addiction and of course there's revenue to be gained as well.

Q: *You've talked about how taxes can alter incentives for bad behavior but some of your more recent research has focused on rewarding people for healthy behavior.*

Jody: I am very interested in how providing economic incentives can affect behavior. Taxes provide a disincentive for negative behavior, but we can also look at providing economic rewards for good behavior. For example, we have looked at paying people on an escalating basis not to use drugs, so that the price of using drugs each time becomes higher and higher.

One thing about using economics incentives to reward good behavior is that it doesn't have to be as paternalistic bans or other restrictions. Instead, this might help people do something they really want to do like quit smoking. Providing economic incentives can help people pre-commit to something they want to do or help them to realize what the consequences of continuing are. Lotteries have been developed to encourage smokers to quit. Currently I am trying to develop an intervention based on this work for an innovative setting aimed at smokers.

Q: *Are you exploring any new areas in your research?*

Jody: A new line of research (supported by a NIA grant) analyzes a potential determinant of health that has received relatively little attention compared to other factors. Occupation deserves further inquiry as a social determinant of health and as an 'initial condition' in life that affects later health. I am studying the dynamic nature of the interplay of occupation and health over the life cycle, specifically regarding whether occupational choice early in life affects health in older ages. There are several reasons why occupation could affect health, these include systematic differences by occupation in income, education, peer influence on health habits (e.g. smoking), job conditions (such as stress and job control, heat, noise etc) and the relative social position of occupations. I am aiming to address the potential endogeneity of occupational choice.

Hot Topics: Direct to Consumer Advertising for Prescription Drugs: A Very Brief Survey

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ing of prescription pharmaceutical products. Before that time, broadcast ads were permitted only to mention either the name of a drug, or a disease against which a drug was effective, but not both. After August of 1997, pharmaceutical ads were allowed to mention both the disease and drug brand name. As a consequence, direct to consumer advertising (DTCA), which had been steadily rising since the early- to mid-1990s, shifted significantly toward the broadcast media and the growth in (particularly) television ad spending accelerated. Spending on DTCA for prescription drugs went from $596 million in 1995 to an around $3.8 billion by 2004. Ten years on there continues to be a great deal of concern among policy makers about the impact of this practice, with both the U.S. House and Senate currently sponsoring bills that could curtail DTCA significantly (e.g., S.484 -- the proposed "Enhancing Drug Safety and Innovation Act of 2007"[1]).

There are a variety of economic arguments supporting and opposing DTCA. The beginnings of the current policy debate on DTCA may date to Masson and Rubin[2] which made two main points about the merits of consumer advertising for pharmaceuticals. First, advertising can help consumers to realize that they suffer from an undiagnosed medical condition. Second, drug advertising may also provide information about new treatments to consumers who suffer from diagnosed medical conditions. These effects are probably the two most-cited benefits of DTCA by supporters of drug advertising. (See also Rubin[3] and Keith[4].) On the other side of the argument, one of the recurring themes among critics of DTCA is the concern that the practice could intrude on the agency relationship between physicians and patients (e.g., Weissman et al.[5]) Industry observers (often, non-economists) ask: if patients hire physicians with superior medical knowledge to make decisions regarding diagnoses and treatment, then what new information can be added by DTCA? Theoretical problems with DTCA along these lines are discussed in Brekke and Kuhn[6] who suggest that DTCA can raise prices to patients if it is a complement input to detailing, or that it may cause over-consumption if pharmaceuticals have low insurance copayments. Given the lack of consensus from economic research, it is not surprising that t he medical community is divided over the value of DTCA. (A measure of the deep ambivalence toward DTCA in the medical community can be found in Holton's work[7].)

With the theoretical effects of DTCA uncertain, it is natural to turn to empirical work on the subject. Berndt and colleagues[8] studied aggregate data on the anti-ulcer drug class to determine how DTCA affected the elasticity of demand when detailing and clinical journal advertising were also taken into account. While in

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Welcome from the Editor

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agreed to write a regular column describing some recent ways in which health economics has been portrayed in the news and will even give some suggested discussion questions for those of you who want to bring the news into your teaching. Look for this in our next issue.

While aimed more at junior colleagues and graduate students, I found I could learn a lot from our first "Dear ASHEly" column. Those of you who can forgive our "cute" name will find tips from experienced, successful, and anonymous colleagues on how to avoid the pitfalls that can sidetrack a junior health economist. Finally, our Executive Director Richard Arnold gives the stats that reveal the great success of the Madison conference and also has some words about what's coming up for ASHE. I invite you all to enjoy the newsletter and solicit your suggestions for how we can improve. I invite suggestions for future "Hot Topics" columns and questions for our advice column. To give you something interesting to look forward to, our next issue will feature a "View from the Program Officer" column. The first column will be written by Mike Hagan, Senior Economist at AHRQ. Mike will give his unique insider's perspective on the environment for funded research at AHRQ. We hope his column will inspire his counterparts at other funding agencies to follow suit . Finally, I want to thank the newsletter board for its above-and-beyond-the-call-of-duty assistance in designing and launching the newsletter. The mission statement we have adopted is given below. We look forward to your feedback and hope you enjoy this, our first, newsletter.

Melayne Morgan McInnes, Editor
University of South Carolina

Dear ASHEly: Advice on the Profession of Health Economics

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ent criteria for promotion. Given the opportunity cost of one's time, these criteria are often conflicting. It is true that in the ideal world, one would publish many high-quality single-authored and co-authored articles in economics, medical and health services journals; bring in lots of grant funding; be a great teacher; give lots of presentations at academic conferences and be active on the policy front. But the reality is that nobody can do everything and still have a life. So the key is to "know thy audience." For example, you can get tenure in an econ department with six articles and no grants, but those six articles better be in economics journals (and darn good ones, too). In a medical or public health school environment, you might need twenty articles, but they don't have to be in economics journals and many of them can be co-authored (which in turn means something different than it does in an economics department). Bringing in grants in an economics department might not count for much beyond buying out class time, whereas in a medical school, being a consistent source of funding can make up for an otherwise weak publication record and is sometimes considered essential to getting promoted. In a public health school, being active in the policy world (e.g., testifying regularly before the legislature and so forth) will be valued more than in some other settings. In an economics department, having a CV without a single co-authored article will be interpreted to mean that you are an independent thinker and don't need anybody else to be productive; in a medical or public health school environment, it might be interpreted to mean that you are a poor collaborator. "Senior authorship" counts for a lot in most medical schools, not much in public health schools and is an unknown concept in economics departments. Order of authorship is something you want to think about and negotiate up front. So in summary, you need to understand exactly what gets valued in the environment in which you ultimately hope to work and how the promotions committees will be interpreting your CV, then focus on the essential tasks first.

Of course, as you focus your research agenda and tenure criteria, you still need to keep in touch with the broader field and new methods. So start making plans for the next ASHE conference!

– ASHEly

Letter from the Executive Director

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high standard for future choices. The student paper award was presented to Grant Miller, Stanford, for his paper titled "Contraception as Development? New Evidence from Family Planning in Colombia." The conference provided an opportunity for the 535 registered attendees to present and hear cutting edge papers dealing with almost every aspect of health economics. Also, it was very clear that the venue for the meetings and the organized social activities provided for ample networking with fellow health economists from academe, government and industry. Over 87% gave the conference a high or very high overall rating. The conference promoted excellence in health economics research and provided a forum for emerging ideas and empirical results of health economics research, the major mission of ASHE. Clearly, this conference set very high standards for future ASHE conferences. Finally, it should be noted that there is no way a conference of this magnitude could have been pulled off without the tremendous support received from iHEA.

Second Biennial ASHE Conference-June 22-25, 2008

Plans are well under way to have the Second Biennial ASHE Conference at the Fuqua School at Duke University. We believe this facility will provide a venue much like the Pyle Center at the University of Wisconsin. Registration, pre-conference sessions, concurrent sessions, lunches and breaks, and exhibitors will be contained one facility to provide convenience and ample opportunities for networking.

Third Biennial ASHE Conference, 2010

We have committed to have the Third Biennial ASHE Conference at Cornell University, Ithaca, NY. Stay tuned for more details.

In closing let me assure you that we look for your comments and suggestions about how to make this newsletter useful to each of you. Please send these comments and suggestions to Melayne, any member of the Editorial Board or me.

Richard J Arnould, Executive Director

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general they found each type of marketing to have an effect on aggregate prescribing, DTCA had the smallest effect -- though 1997 was the last year of their data. Several studies from the immediate post-1997 period relied upon aggregated data on pharmaceutical DTCA marketing and sales. As one example, Calfee, Winston and Stempski[9] examined whether the August 1997 FDA policy change increased the demand for the statin class of drugs using national aggregate drug sales by class. They were unable to find any significant short run direct effects. These authors suggest that the best way to examine this question may be to look at patient-level data.

In recent years, a growing number of DTCA studies have used micro data. A study by Zachary et al.[10] used the National Ambulatory Medical Care Survey (NAMCS), along with national frequencies of advertising for a number of drug classes to examine frequencies of monthly prescribing for 1992–1997. While that study found some significant relationships, the measured impacts of DTCA were not consistent across drug classes. Iizuka and Jin[11] also utilized the NAMCS and found that DTCA tends to prompt relatively large increases in the number of physician visits and modest changes to the nature of the physician/patient interaction (through longer visits), but did not prompt significant changes to actual physician prescribing. Wosinska[12], used a four-year panel data set from Blue-Shield of California, and found that while patient adherence to prescribed statin therapy did rise, the effect was small in magnitude and not sufficient in and of itself to yield a positive return on investment for the pharmaceutical manufacturers. Like much of the other literature, she also found class effects (spending on one brand of drug has effects on all other brands in the class) in DTCA spending. Donohue et al.[13] explored an administrative database that included actual prescriptions filled at the patient level—though there was limited patient-specific clinical information—and focused on the use of anti-depressants. They found that DTCA for antidepressants led to higher rates of diagnosis of depression and prescribing, but much smaller increases in appropriate adherence to therapy.

More recently, I and several colleagues have published work focusing on Cox-2 inhibitors and statins which uses data from an electronic medical record system with very detailed clinical data on several 100,000 patients from over 30 states. Bradford et al.[14] examined the rate of Celebrex® and Vioxx® prescribing to osteoarthritis patients at the physician-practice level to test whether physician visits and prescribing respond to national and local television DTCA. We found that increases in DTCA led to increases in the flow of patient visits to the practice, consistent with the patient selection hypothesis of Rubin and Masson, and that DTCA has class-level effects on prescribing. With regard to statin drugs, Bradford et al.[15] examined the role that high levels of DTCA plays in improving the likelihood that patients who begin treatment with statin therapy for high cholesterol are able to meet their LDL cholesterol goals within 6 months. We found that patients who began statin therapy during months of high exposure to DTCA were about 3% to 7% more likely to be at their LDL goal within 6 months than people who began therapy during moderate or low DTCA broadcast months.

In addition to the work extant in the published literature, recent ASSA conferences and the 1st ASHE conference witnessed even more work on the issue nearing completion. Bradford et al.[16] examines the duration of delay between osteoarthritis diagnoses and the adoption of daily Cox-2 inhibitor use. Interestingly, the results of this work strongly indicated that higher exposure to DTCA was effective at encouraging adoption among patients with favorable indications for Cox-2 inhibitor use and discouraging adoption among patients with contraindications. Wosinska and Bradford[17] examined the joint role of DTCA and media coverage for the Cox-2 inhibitors using the clinical data that supported the published studies discussed above. We categorized each story for whether it had a positive or mixed message about the drugs' attributes and modeled changes to the flow of patient visits and prescribing. The results indicates that—after controlling for clinical characteristics, trends in detailing and samples, journal publications and time—both DTCA and media coverage have important effects on clinical interactions. Avery and colleagues[18] have presented evidence that DTCA for smoking cessation products can assist public health efforts at tobacco control by combining a survey of smokers with a rich database on print DTC ads which has been created as part of a series of on-going projects at Cornel University. DTCA research has been presented at other forums as well: by Ginger Jin on the role of DTCA in patient learning; by Bill Encinosa on how DTCA can affect the dispersion of pharmaceutical prices; and by Jayani Jayawardhana on structural modeling of physician prescribing and the impact of DTCA in that context.

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This brief survey of the most recent published and presented research on DTCA is, at best, cursory. Space does not permit a complete presentation of the research conducted over the past 15 years on the subject, nor a comprehensive mention of the research currently underway by the authors mentioned in this review and others. Among the issues which have yet to be addressed—either fully or in part—are questions about: how DTCA affects pricing of pharmaceuticals; whether DTCA is an effective response for pharmaceutical manufacturers to formulary restrictions; how DTCA interacts with detailing and sampling behavior; whether DTCA has spillover effects on other segments of the health care industry; how the information inherent in DTCA is used by patients and physicians; and, ultimately, what the net welfare effects of DTCA are, both in a static and dynamic sense, on the pharmaceutical industry from the drug development to the drug utilization stage. Given that this industry is one of the few arenas in the health care sector where advertising directly to consumers is permitted—and thus can provide a laboratory for the impact of this behavior on health care use—much research remains yet to be done.

Contributed by W. David Bradford, Director, Center for Health Economics and Policy Studies, Medical University of South Carolina, E-mail: bradfowd@musc.edu.

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