We will try to publish authors' responses in the same edition with readers' comments. Time constraints might prevent this in some cases. The problem is compounded in a bimonthly journal where continuity of comment and redress are difficult to achieve. When the redress appears 2 months after the comment, 4 months will have passed since the original article was published. Therefore, we would suggest to our readers that their correspondence about published papers be submitted as soon as possible after the article appears.

Future of Health Care Reform

To the Editor: In his fine article entitled "Health Policy and the Future of Health Care Reform," Dr. Howard Rabinowitz[1] opines that strong pressure for federal health care spending reductions will continue for years; and despite Congressional deliberations and effects of presidential politics, major downsizing of several years' duration will come to pass regarding federal health care financing.

At first blush, this prognostication might appear to augur ill as far as the problem of lack of access to health care is concerned: with less money overall in the pot, it would be tempting to assume that the extant problem of inequity plaguing the health system will, if anything, worsen. But it is not necessarily true that a decrease in federal health care spending must inevitably result in an increase in the ranks of persons uninsured or underinsured for health care. Family physicians, and providers in general, need to take a hard look at changes that can be made in the health care system which might enable the country to secure adequate health coverage for more Americans with less money.

One area that should be examined closely involves administrative-related costs. Because of factors including enormous insurance-related overhead, as well as marketing and billing expenses, administrative costs devour enormous amounts of health care dollars in the United States. In 1987, for example, administrative costs consumed more than 20 percent of health care costs. The seemingly inexorable evolution toward a managed-care model of health care does not appear to offer any real promise of respite from extremely high administrative costs. One multimillion member, managed-care entity, for instance, spends only about 74 percent of its revenues on medical care.[2]

There is no intrinsic reason why health care administrative costs in America must remain at such an extraordinarily high level. In Canada, for example, administrative costs represent about 10 percent of the country's health costs.[3] Particularly during an era of downsizing in federal health care spending, ways can, and must, be found to substantially reduce administrative costs.

Although not mentioned often in the debates about health reform that have raged in the United States in recent years, fraud, abuse, and waste are major problems plaguing the country's health system, which, if corrected, will leave more money available for needed medical services. The degree of the fraud problem cannot be quantified precisely, but it is estimated that as much as $100 billion is lost each year to fraud (WS Cohen, United States Senate, Washington, DC: personal communication).

Fraud is extant throughout the health care system, with far-flung tentacles reaching to the distant corners of the system. Congressional investigators have conjectured that, as the health system evolves ever-closer toward a managed-care model, chances for fraud may grow further, particularly in the absence of embellished antifraud efforts. A two-step process was recommended as a tourniquet to stop the bleeding of health dollars to waste, fraud, and abuse, namely, the immediate strengthening of pertinent criminal laws and enforcement tools, and the constructing of tough antifraud provisions as part of any health reform plan enacted by Congress.

Action of a substantive nature clearly must be pursued. Issues relevant to health care fraud, moreover, must be debated robustly in public and professional forums. If fraudulent practices remain substantially detached from exacting scrutiny, then the largely neglected, albeit quite nefarious, problem of fraud in America's health system might well worsen in the future.

In sum, it is plain that even with less money the country can do a much better job of providing health care to more of its people. Physicians must understand this and do their best with the resources they have to work with.

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References

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2. Woolhandler S, Himmelstein DU. Extreme risk—the new corporate proposition for physicians. N Engl J Med 1995;333:1706-7.
3. Angell M. How much will health care reform cost? N Engl J Med 1993;328:1778-9.

Residency Training and Rural Practice

To the Editor: The survey study of rural physicians perceptions of the adequacy of their residency training by Norris et al (Norris TE, Coombs JB, Carline J. An educational needs assessment of rural family physicians. J Am Board Fam Pract 1996;9:86-93) aims to define content areas where training could be augmented to better prepare residents for rural practice. The responders rather uniformly felt adequately trained in the core content areas of family practice. To me these