# Paying for the Uninsured

I am a lifetime member of the Wisconsin Medical Society and am a retired orthopaedic surgeon. I had a very active general orthopaedic practice in Sheboygan, Wisconsin, for 42 years.

When I started, we did not have emergency department physicians or hospitalists, so we essentially took care of everything from beginning to end. Of course, in those days we had patients who did not pay their bills, but I can honestly say I never was sure which was which and I never refused patients orthopedic care based on their ability to pay.

Times have changed, and it is time that we make some changes to help pay for those who are uninsured. There always are innovative ways of doing things, and I have 2 suggestions. The first is entirely my idea, and I have run this by senators and other public officials only to get the response, "that's interesting."

First, I would give physicians tax credit for providing uncompensated care. We have the mechanism for doing this. We have a code for every procedure we perform, and practices have elaborate fee collection services. We also have the IRS, so it would be no more difficult to take a tax deduction on unpaid care as easily as we deduct other professional expenses.

Second is something that, unfortunately, I heard only at the end of a discussion on the radio. Apparently it has been instituted in at least 1 state and I am sorry I cannot name the state. Essentially, what they did was use free care and broke it down into block units and used the money that was saved from that to pay the physicians' malpractice insurance. As I understand it, they would pay a portion or all of the premium. If this were a state-run program and enough physicians were involved, plaintiffs and their lawyers would be in the position of essentially suing the state, which is a much more formidable task than suing an individual.

Obviously, there are a lot of details that could be worked out, but that is why we have all those MBAs that have invaded the medical profession. It is about time we came up with some innovative ideas on how to deal with uncompensated care. The Affordable Care Act notwithstanding, these people are still going to be around and need to be helped. I hope readers will consider my suggestions into consideration and we can get some action at the level of the state medical society.

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# Clarification on Use of High-dose Influenza Vaccine in the Elderly

I write in response to the commentary on my letter that was published in the April 2013 issue of the *WMJ*.[1,2] One statement in Dr Temte's commentary might benefit from some amplification. He wrote that the FDA licensed the high-dose vaccine on the basis of "non-inferiority of the resulting antibody concentrations." I believe he was referring to the phase 3 trial outlined by Falsey, et al.[3]

The Falsey paper concluded in the abstract: "There was a statistically significant increase in the level of antibody response induced by HD [high-dose] influenza vaccine, compared with that induced by SD [standard dose] vaccine." This was based on results noted in the paper: "The HAI [hemagglutinin inhibition antibody] GMT [geometric mean titer] ratios were 1.7 (95% CI, 1.6–1.8) for [influenza strain] A/H1N1, 1.8 (95% CI, 1.7–2.0) for [influenza strain] A/H3N2, and 1.3 (95% CI, 1.2–1.4) for strain B." They went on to say: "HD vaccine met superiority criteria for the 2 A strains and showed non-inferiority for the B strain; it demonstrated overall superiority in accordance with predefined criteria." Prespecified criteria for superiority of proportions of patients achieving seroconversion also were met for the A strains, and seroconversion was noninferior for the B strain.[3] (Figure)

Dr Temte's statement, therefore, is correct in noting that the high-dose vaccine induced noninferior antibody responses for influenza B. However, this is not the whole story, since antibody concentrations were superior (not just noninferior) for the A strains and superior overall. This is important, since superior antibody response was the basis for our routine use of the high-dose vaccine in the Nebraska-Western Iowa system.

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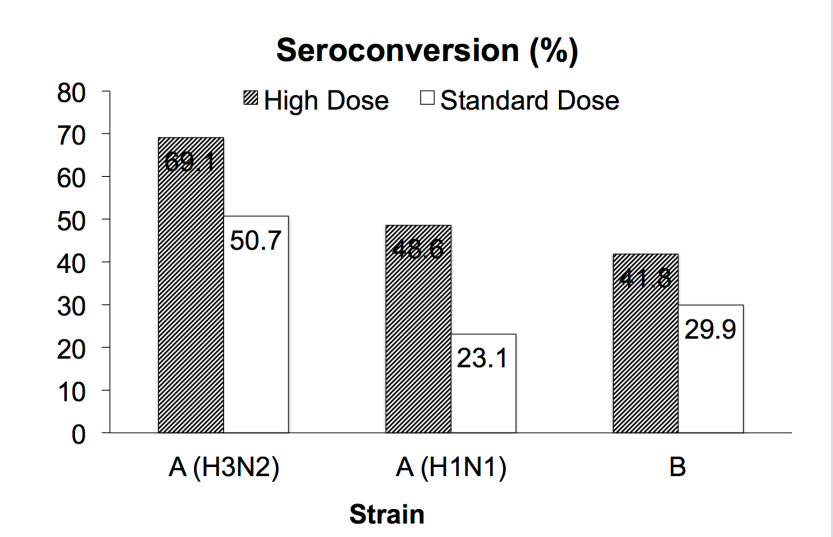
## References

**1.** Bittner MJ, Gorby GL, Parks CC. Absence of laboratory-confirmed failures of high-dose influenza vaccine in the elderly. *WMJ.* 2013;112(2):45.

**2.** Temte JL. Commentary: Solid evidence is lacking, but signs are hopeful. *WMJ.* 2013;112(2):45.

**3.** Falsey AR, Treanor JJ, Tornieporth N, Capellan J, Gorse GJ. Randomized, double-blind controlled phase 3 trial comparing the immunogenicity of high-dose and standard-dose influenza vaccine in adults 65 years of age and older. *J Infect Dis.* 2009;200(2):172-180.

**Figure.** Increased Antibody Response Induced by High-dose Influenza Vaccine.



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