

1. Burnham G, Lafta R, Doocy S, Roberts L. Mortality after the 2003 invasion in Iraq: a cross-sectional cluster sample survey. *Lancet* 2006;368:1421-8.

THE AUTHORS REPLY: Our estimate of violent deaths in Iraq from March 2003 to June 2006 was based on the 2006–2007 IFHS, a cross-sectional, nationally representative survey of 9345 households. We reported only the analysis of violence-related mortality, not our analysis of deaths due to other causes.

Substantial underreporting of deaths is common in household surveys because of recall bias, the effects of migration, and missing households. The security risks in Iraq add to the reporting problems. The geographic heterogeneity of violence-related death rates may have further affected reported deaths, even though 971 clusters were sampled.

The preinvasion crude mortality rate of 3.17 (95% CI, 2.70 to 3.75) in the IFHS report is lower than the rate of 5.5 (95% CI, 4.3 to 7.1) reported by Burnham et al. Because the level of underreporting is almost certainly higher for deaths in earlier time periods, we did not attempt to estimate excess deaths. The excess deaths reported by Burnham et al. included only 8.2% of deaths from nonviolent causes, so inclusion of these deaths will not increase the agreement between the estimates from the IFHS and Burnham et al.

We imputed data for missing clusters in the Anbar province among the HMGs, and we included uncertainty in this imputation; it cannot account for the 10-fold difference between our rates and those reported in other HMGs. Burnham et al. selected only a few clusters in each of the HMGs,

which may not be representative of those governorates. We estimated that 45% of violence-related deaths were in HMGs after the adjustment, as compared with 36% of the Iraqi population. This may even be an overestimate if the reports collected by the Iraq Body Count project concentrate on high-impact events closer to main cities.

Although the estimated number of violence-related deaths in the IFHS is approximately three times higher than those reported by the Iraq Body Count project, the results are consistent with the Iraq Body Count trends and distribution, based on collations of press reports for civilian casualties. As indicated in Table 4 of our report, the IFHS and the Iraq Body Count both showed a drop and a subsequent increase in violence-related deaths, but not a doubling and then more than a fourfold increase for the same time periods as reported by Burnham et al.

To reach the 2005–2006 death rate of more than 900 per day, estimated by Burnham et al., the IFHS would have had to miss nearly 90% of violence-related deaths. It is unlikely that a small survey with only 47 clusters has provided a more accurate estimate of violence-related mortality than a much larger survey sampling of 971 clusters. We may never know with any accuracy the effect of the conflict in Iraq on mortality, but all the evidence points to a high level of deaths due to violence.

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Slowing the Growth of Health Care Costs

TO THE EDITOR: The limitation of the article by Mongan et al. (April 3 issue)¹ on options for slowing the growth of health care costs is the acceptance only of reforms that will not irritate powerful, entrenched corporate and labor interests. Our system is costing us perhaps twice as much as it should. We need to target the fattest cats and slim them down. Hospitals currently seek consolidation rather than efficiencies, charge a fortune for routine services, and pay higher wages rather than taking strikes. Insurance companies

add so little at so high a charge. Pharmaceutical companies advertise, develop frivolously repetitive drugs, and charge without restraint. Medical specialists in some areas operate and serve dying patients with little restraint.

The interventions suggested in the article are popguns against a profit-bound army. Restraint in our mixed system needs to come from government, not voluntary acts by corporations.² Schlesinger³ has identified a cycle of government activism at 30 years, the last peak being 40

years ago. It is possible, then, that suggestions that are more challenging to entrenched interests should be entertained.

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1. Mongan JJ, Ferris TG, Lee TH. Options for slowing the growth of health care costs. *N Engl J Med* 2008;358:1509-14.
2. Reich RB. *Supercapitalism: the transformation of business, democracy, and everyday life*. New York: Borzoi Books, 2007.
3. Schlesinger AM Jr. *The cycles in American history*. New York: Houghton Mifflin, 1986.

TO THE EDITOR: Mongan et al. list 12 options for reducing health care spending. I would like to point out two options that they seem to have overlooked. The first option is to increase the ratio of primary care physicians to specialists. Numerous studies have shown that as the ratio increases, costs decline.¹ The second option is to eliminate the ever-growing administrative restrictions in managed care that markedly reduce the efficiency of primary care practices — especially including prior authorization for referrals, medications, and imaging procedures. These needless restrictions waste the time of physicians and their staffs, considerably increase overhead, and lower morale. Primary care physicians have every desire to practice cost-effective, evidence-based medicine and are well trained to do so. A high degree of self-regulation must be restored in order to promote and maintain professionalism. Otherwise, the first option listed above cannot be achieved.

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1. Kravet SJ, Shore AD, Miller R, Green GB, Kolodner K, Wright SM. Health care utilization and the proportion of primary care physicians. *Am J Med* 2008;121:142-8.

TO THE EDITOR: Mongan et al. discuss many options for slowing the growth of health care costs. However, the authors do not bring up the taboo subject that we physicians are a significant cause of high health care costs. The greatest cost-saving option, in my opinion, is changing the outlook and ordering habits of physicians. We need to be reasonable about our treatments and expectations. We should not be like sheep, writing prescriptions for the latest recommendation from the drug-company representative or paid speaker; instead, we need to look critically at new information and seek the most economical treatment for our patients' problems.

The entities that own the gold (government and insurance companies) can obviously make the rules, but the entities spending the gold (us) can have the greatest impact on how fast and where it is spent. I realize that many of our habits result from rules made by the paying entities, but still, our physician community needs a period of serious self-examination.

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Shortage of Chemotherapeutic Agents in Iraq and Outcome of Childhood Acute Lymphocytic Leukemia, 1990–2002

TO THE EDITOR: The United Nations (UN) imposed economic sanctions against Iraq in 1990, after the invasion of Kuwait, which remained in effect until 2003. During the sanctions, there was a widespread shortage of medications, including antibiotics and chemotherapeutic agents, and basic services.^{1,2} We sought to determine the effect of the shortage of chemotherapeutic agents on the outcome of acute lymphocytic leukemia (ALL) in Iraqi children during the period of UN sanctions.

A total of 651 children with ALL who were

treated at the Children's Welfare Teaching Hospital in Baghdad and who had complete medical records were included in this analysis. There were 408 patients with standard-risk disease, with a median age of 4.9 years (range, 1.1 to 9.8) and a median white-cell count at presentation of 9050 per cubic millimeter (range, 400 to 47,000). The remaining 243 patients were at high risk and had a median age of 8 years (range, 1.3 to 15.0) and a median white-cell count at presentation of 78,600 per cubic millimeter (range, 800 to 600,000). All children were treated according to