

LETTERS

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Value-Based Drug Rationing

J.D. Kleinke (Jan/Feb 04) provides a healthy dose of balance and clarity to the increasingly shrill debates over how to best manage America's pharmaceutical revolution. Prescription drug policy is problematic because it involves a for-profit industry within the field of medicine, where profits seem inappropriate. The industry's economic structure—with high fixed costs, low marginal costs, and gross profit margins of 75–80 percent—creates complicated payment games between drug manufacturers and purchasers.¹ Consequently, medical progress is not explicitly rationed according to need, as the author shows, but implicitly rationed “one sick patient and one medical claim at a time.”

Kleinke's antidote is to ditch our current price-based insurance system in which patients pay less for “preferred,” often generic drugs and more for costly new drugs. In its place he argues for a value-based system that requires no copayment for a life-saving drug (for example, insulin), a low copayment for a productivity-enhancing drug (Prozac), a moderate copayment for a life-prolonging drug (Lipitor), and a high copayment for a life-enhancing drug (Viagra). Individual drugs and classes of drugs would be assigned to each tier by an independent, publicly funded “pharmacoeconomic research institute.” Others have made similar suggestions, but their vision has been to use this type of research to change physicians', not patients', behavior.² Moreover, it is not clear how a new layer of review, be-

yond the Food and Drug Administration's (FDA's) already demanding clinical trial process, could be enacted over the intense political opposition of the Pharmaceutical Research and Manufacturers of America (PhRMA). Few industries are as politically powerful and successful at warding off regulation. Nevertheless, would we be better off as a country under this type of value-based rationing? Absolutely.

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NOTES

1. R.G. Frank, “Government Commitment and Regulation of Prescription Drugs,” *Health Affairs* (May/June 2003): 46–48.
2. S.H. Altman and C.P. Thomas, “Controlling Spending for Prescription Drugs,” *New England Journal of Medicine* 346, no. 11 (2002): 855–856.

Baby Boomers And Medicare

Uwe E. Reinhardt (Nov/Dec 03) argues that we need not accept that future per capita health spending will increase for the elderly. Reliance on per capita data, however, masks the true impact of the aging population on health care demand. If health care is left as it is today, the sheer numbers of baby boomers will drive increased use and, therefore, spending. In the 2000 census the Medicare-eligible U.S. population totaled 35.1 million. By 2030 that same population is projected to grow to 69.7 million, and by 2050 to 81.9 million.¹ Medicare Part A spending totaled \$107.8 billion in 1999.² Using Reinhardt's worst-case scenarios for per capita spending, Medicare's annual acute care costs would rise to \$259.8 billion in 2030 and to \$287.5 billion in 2050. By their vastly increased numbers alone, the elderly will be consuming ever-increasing health resources over the next half-century. The issues of improved health and longevity are further changing the

equation. In the final decade of life, Medicare costs rise dramatically. The high costs associated with acute care and morbidity will simply be postponed to later in life.³ Reinhardt does not address what this will mean for nonacute Medicare spending. Not only are there more Medicare beneficiaries flowing into the system in successive years, but they will be living longer. Thus, there will be more elderly using nonacute Medicare services for longer periods. The United States has yet to confront this impending reality from a policy or financing perspective. Until we do, we won't be able to assure baby boomers that high-quality health care will be there when they need it. Nor will we be able to assure the generation paying for this care that we won't bankrupt it in the process.

LOUIS J. GANIM
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NOTES

1. U.S. Census Bureau, Population Division, "Projections of the Total Population by Five-Year Age Groups and Sex with Special Age Categories: Middle Series, 1999-2100" (Washington: U.S. Census Bureau, January 2000).
2. Centers for Medicare and Medicaid Services, *Health Care Financing Review: Medicare and Medicaid Statistical Supplement, 2001* (April 2003).
3. T. Miller, "Increasing Longevity and Medicare Expenditures" (Unpublished paper, University of California, Berkeley, Center for the Economics and Demography of Aging, November 2000).

The author responds:

Louis Ganim appears to have missed the thrust of my paper. I do not deny that if the growth trends of health spending on all age groups during the past thirty years persist for another thirty years, our health system will absorb somewhere close to 30 percent of gross domestic product (GDP) by 2030. It is so because Americans seem to prefer a health system in which a highly fragmented and consequently weak demand side can be made to use and pay for whatever new technology and treatment intensity the supply side chooses to proffer. My only point was that the aging of the population per se does not drive these growth trends very much through the demand

side. If we could freeze the fraction of our population age sixty-five and older at current levels, it would not give us much relief in health spending. In 2030 we would still spend a lot more on the elderly than we do now, and, of course, on all other age groups as well. The focus of our health policy debate should be on the extra benefits we gain by letting health spending grow as rapidly as it does for all age groups, not simply on the growing number of elderly people in our midst.

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Future Of Hospitals Uncertain

David Shactman and colleagues (Nov/Dec 03) paint a picture of hospitals returning to their past boom years. But they overlook two key issues that will affect what hospitals will look like in the next five to ten years. First, they do not mention the influence of specialty facilities and "boutique" outpatient services. These have become a growing trend in many communities, ours included, where a group of cardiologists is proposing a freestanding \$50 million cardiac facility to compete with eight hospital-based units. Such facilities will be designed as both ambulatory and short-stay centers with the capacity to keep a patient up to forty-eight hours after a procedure. This will entirely change how we look at an "admission" and will accelerate movement of care out of the traditional hospital setting.

Second, consumerism will increasingly exert itself in shaping what services are demanded, where they are provided, and how they are reimbursed. The authors rightly note the higher incomes of the baby boomers and their propensity to consume. But they underestimate these consumers' propensity to demand. Baby boomers are far less likely than the current older generation to tolerate poor service, incomplete information, or inefficiency. And they are willing to pay to avoid them. This is a direct threat to many hospitals, built as they are on a physician-centric rather than consumer-centric model. Ambulatory services that offer speed, convenience, superior service,

and comparable if not better outcomes will quickly capture the baby-boomer market and put hospitals at a competitive and financial disadvantage. This may leave established hospitals as “public goods” to be supported by tax funds in order to provide the unprofitable services that a community requires.

DEREK VAN AMERONGEN
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The authors respond:

The growth of consumerism and the demands of the baby-boom generation cited by Derek van Amerongen strengthen rather than weaken our argument that hospital spending will increase. Indeed, we identified an important change in which baby boomers had a higher growth rate for hospital spending than the elderly did. The demand for an additional 136,000–211,000 beds that we predicted may indeed occur in some “boutique” settings, but we did not attempt to distinguish between general and specialty hospitals. Nevertheless, we agree that specialty facilities could have a major impact on general hospitals. However, many of these boutique services are provided by community hospitals. The U.S. General Accounting Office reports that about one-third of specialty hospitals are at least partially owned and operated by local general hospitals.¹ Yet many stand-alone specialty centers focus only on high-margin patients and drain revenue from community hospitals that is needed to subsidize unprofitable and charitable services. The problem is exacerbated by federal regulations that permit physicians to invest in, and refer patients to, specialty hospitals.

Van Amerongen is likely correct about the demand for superior services from some baby boomers, but neither the capital to build new facilities nor the means to access them may be widely available. Given the budgetary outlook, public payers (about half the market) are likely to restrict future payments, particularly for high-margin services. This could reduce the capital available to meet the demand for additional beds in general and specialty facilities. On the private side, with increased cost sharing, rising uninsurance, and restricted choice

of providers, many nonaffluent people could be forced to a second tier of medicine that is decidedly not more superior in service and amenities.

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NOTE

1. U.S. General Accounting Office, “Specialty Hospitals,” Pub. no. GAO-04-167 (Washington: GAO, October 2003).

Competition And Medical Care

William Sage’s interview of Timothy Muris (Nov/Dec 03) offers readers a chance to reflect on the role of competition policy in medical care. Two different ways of framing the issue reflect different assumptions. The first approach asks how best to protect the principles of competition and consumerism in medical care; it presumes that competitive markets are themselves a desirable policy goal. The second approach asks what role competitive markets should play in allocating medical goods and services in modern industrial democracies. This has become salient in the European Union (EU), where transnational policies intended to integrate markets have run headlong into diverse national policies regarding financing and regulating medical care. The first perspective dominates U.S. policy debate, as reflected in Muris’s assertion that “markets benefit consumers” and in his hope that the Federal Trade Commission (FTC) will be viewed as a friend trying to make life “better for consumers.” In this view, the appropriate role for the FTC is to discourage price fixing and fraudulent claims, but not to directly question if price competition, antitrust practices, or consumer information are reliable ways to address medical care issues. This philosophy creates a form of policy provincialism that inhibits Americans from learning from the EU experience.

In pharmaceuticals, for example, Muris extols the benefits of policies that encourage advertising and generic drugs, while ignoring the European experience with price regulation.

The consequences of this narrow purview are evident in the huge costs of Medicare drug reforms and the higher prices Americans pay for drugs. For physicians, an aversion to monopolistic markets leads Muris to reject structured bargaining between consolidated physician groups and organized payers, although this model has been successfully followed in most industrial democracies.

The restrictive nature of these policy presumptions is best illustrated in Muris's claims about Medicare. He asserts that "we would be much better off if Medicare followed a more competitive model," believing that "more emphasis on...rewards for quality couldn't help but be beneficial." Medicare's own history belies these claims. Although beneficiaries valued the expansion of private health plans in Medicare+Choice, these efforts to make Medicare "more competitive" also destabilized insurance arrangements for the millions of beneficiaries whose plans withdrew from the program, exacerbated the consequences of Medicare's regional spending disparities, and disrupted physician-patient relationships for scores of elders. The net benefits are hardly self-evident.

Finally, Muris is an advocate of competition. Yet even the most devout neoclassical economists recognize that making any good or service marginally more marketlike offers no guarantees of greater economic efficiency or better outcomes. Whether more competitive markets lead to a better balance among cost, quality, and access in medical care is a matter for careful scrutiny, not blanket assertion.

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Ineffective Approach

"Pay for performance" (Nov/Dec 03) is the kind of seductive focus group-tested catch phrase that has come to dominate much of health policy discourse but is largely devoid of real content. And it is hardly "a bedrock principle in most industries," as the signatories of the statement claim. Indeed, few of the compa-

nies led by the statement's signatories derive much income from transactions that could be described as performance-based.

Rhetoric aside, however, the authors are clear about their agenda. "Systematic change" in quality "will not come forth quickly enough unless strong financial incentives are offered to get the attention of managers and governing boards." It's hard to argue with the idea that we should do everything we can to improve quality as quickly as possible. Some of the steps in that process, particularly in information technologies, indeed will require a considerable investment. But apart from those propositions, the letter's arguments are almost entirely rhetorical and make little sense.

First, at least in Medicare, quality in some areas is already improving in the absence of explicit financial incentives. Programs begun in the 1990s have produced measurable improvements in outcomes, including reduced mortality.¹ Of course, there are very few longitudinal data about quality, and both the standards and technologies of measurement are evolving rapidly—which, in itself, calls into question the practicality of reimbursement-related incentives. But the expectation that complex, decentralized social change should happen instantaneously is mere political posturing. The real question is whether adding financial incentives to the other forces now promoting quality improvement will accelerate or retard the rate of change. As policymakers make that judgment, providers' assertions that they can't move any faster unless they are paid more should be evaluated in the context that providers always claim they can't do anything different unless they are paid more.

Second, Medicare's and most other payers' track record in changing providers' behavior through explicit reimbursement incentives is decidedly mixed. Introducing case-based prospective payment for hospitals in 1983 led to reduced lengths-of-stay, as expected, although the extent to which Medicare length-of-stay fell below existing secular trends can be debated, especially since length-of-stay fell faster for the privately insured whose care was not being paid for per case. But it also led to re-

duced admissions, contrary to the system's incentives. In a very different case, the transition to the Medicare physician fee schedule has shifted considerable dollars from procedural to cognitive services, but not enough to increase the availability of primary care or dampen the trend toward proceduralism. Each layer of refinement added to payment systems—on top of geographical, teaching, rural, and risk adjustments—is incrementally less comprehensible to providers whose behavior it is supposed to affect and more likely to be drowned out by other adjustments.

Providers' behavior is complex and influenced by a variable set of factors, which payment incentives don't always counterbalance. Those who run payment programs are used to wrestling with problems of suboptimization, upcoding, managing to the measure, horizontal and vertical equity, and administrative complexity. But such problems are likely to be particularly consequential when quality, and thus human lives, are at stake.

If we could measure quality well enough, it's not clear that a public program like Medicare should pay anything at all to providers who don't meet minimum standards. That is already Medicare policy, but the current standards are too low. Raising them directly through accreditation or selective contracting immediately leads to real or claimed problems of access, particularly in smaller communities. Given Medicare's size, if it only paid providers in the top half of the quality distribution, some beneficiaries would have trouble getting served. Yet if Medicare paid a bonus to those in the top half while permitting the bottom half to remain in the program, it would legitimize the notion that some beneficiaries are entitled to higher-quality services, and would redistribute money in the opposite direction from current policy trends.

The current infatuation with "pay for performance" represents another step in payers' efforts to extend their sphere of control over providers. As one who initiated efforts (meeting only limited success) to transform Medicare from passive bill payer to aggressive purchaser, I can hardly criticize the general trend.

But I think it's appropriate to raise the question: Is the increasing commodification of health care, especially as embodied in "pay for performance" schemes, consistent with a thoughtful, long-term strategy to maximize quality? A comprehensive quality improvement strategy needs to focus on reinforcing the norms and values of professional responsibility, rather than on undermining them through the exercise of economic muscle. Unless we can continue to assume that most providers and administrators want to do the right thing for most patients most of the time, we are all sunk, and no amount of economic incentives can salvage the situation.

We do need to help hospitals, physicians, and other providers finance quality-related information technologies. There are lots of ways to do that, but "paying for performance" is an obtuse—and likely ineffective—approach.

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NOTE

1. See, for example, S.F. Jencks, E.D. Huff, and T. Cuerdon, "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001," *Journal of the American Medical Association* 289, no. 3 (2003): 305–312; and A.R. Sehgal, "Impact of Quality Improvement Efforts on Race and Sex Disparities in Hemodialysis," *Journal of the American Medical Association* 289, no. 8 (2003): 996–1000.

Should Medicare Lead?

The Open Letter, "Paying for Performance: Medicare Should Lead," makes a strong case for rewarding hospitals for clinical quality. But to suggest that Medicare lead ignores the serious flaws in its payment system. Medicare is underfunded, paying hospitals about ninety-eight cents on the dollar for care. In the aggregate, hospitals lose money caring for Medicare patients. Medicare payments have been fiscal yo-yos, responding to budget crises and lack of political will to be candid about what high-quality health care actually costs. Should we now add "rewards" to a system that has consistently been and will be the source of budget

“savings” that often have robbed communities of needed services?

U.S. hospitals are committed to improving safety and quality. Paying for performance could help achieve that, if we have accurate quality measures and the will and wallet to put sizable resources into Medicare to adequately pay for care and to reward documented quality improvement. Paying for performance also will require a new level of trust between government and the health care community. Hospitals support public-private partnerships such as the Quality Initiative—more than 2,500 hospitals now are part of this voluntary effort by the American Hospital Association and others. Rather than go it alone, Medicare should be part of a public-private partnership to design quality, safety, and efficiency incentives that will benefit all Americans.

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Private Sector Slow To Act

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 gives the government the chance to continue its important work in tying payments to the performance of physicians, hospitals, and other providers. In the past twelve months the Centers for Medicare and Medicaid Services (CMS) has demonstrated impressive leadership in pushing the market for greater disclosure and tying performance improvement to payments, despite sizable regulatory constraints. Some payers and purchasers are asking for more, yet they fail to follow the example already shown. The private sector does not have Medicare’s regulatory constraints in modifying payment and benefit designs and could therefore bring about fundamental market change much faster. Some large self-insured employers, through the Leapfrog Group and Bridges to Excellence, have demonstrated leadership in adopting performance measures and reward programs.¹ But most employers rely on health plans to move the market.

If the five largest health plans—Aetna, An-

them, CIGNA, Humana, and United—were to adopt for their entire populations the pay-for-performance efforts of Leapfrog, Bridges, and the CMS, the market would move. Paying for performance is part of the solution to our health care problems. We call on fellow employers and health plans to not just worry about cost and quality, but to act—now.

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NOTE

1. A. Milstein et al., “Improving the Safety of Health Care: The Leapfrog Initiative,” *Effective Clinical Practice* 3, no. 6 (2000): 313–316; and “Bridges to Excellence: Bringing Quality Health Care to Life,” Case no. N9-604-030 (Cambridge, Mass.: Harvard Business School Publishing, 15 September 2003).

Complex Tasks Ahead

Paying for performance is an overdue reimbursement model for the health care industry. Before it can succeed, however, two critical issues must be addressed. First, we must develop valid, comprehensive, and reliable performance measures. This is an extremely complex task, as we have learned in recent years from many well-intentioned but flawed attempts to measure quality. To get beyond process-of-care measures to truly comparative quality measures requires collecting comprehensive and detailed data, the standards for which should be developed by the CMS as part of a major national initiative.

Second, the authors correctly note that a major contributor to quality problems is the lack of systems, especially information systems, which are key to measuring performance and reducing variability and errors. Hospitals lack these systems for one reason: their extraordinary costs. The CMS, through Medicare, should support cost-based reimbursement for hospital investment in information systems that link directly to national data repositories. Commercial insurers should support specific hospital initiatives to install these systems. Drug and device makers should work

directly with hospitals to make the products they sell to hospitals and their delivery systems error-resistant or even error-proof.

Hospital leaders must take responsibility and accept accountability for the medical quality in our institutions. But achieving safe, high-quality hospital care is a responsibility that is shared with every player in the health care system.

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The Will To Change

The petition for Medicare to lead the nascent pay-for-performance movement strikes a chord with those of us who have long championed health care quality and patient safety. This is an opportunity to eliminate disincentives to pursue safety and quality improvement goals and to encourage desired behavior by provider organizations and practitioners. Indeed, it is time for Medicare and its multiple imitators to begin to manage this country's mammoth investment in health care.

That said, we must not underestimate the magnitude of the challenges that lie ahead. The cornerstone of this new direction will be the ability to measure the right things well. Performance measurement will truly count now, and there is much to be done if the rapidly escalating expectations for this movement are to be met. For example, there is not yet any grand strategy for wide implementation of electronic medical records (EMRs) as well as getting providers and practitioners to buy into their use. Performance measurement will be a sham until data are collected as by-products of care delivery, a capability that only the EMR can provide.

Nor is our repository of performance measures remotely adequate. Good measurement requires evidence-based measure sets that provide meaningful portrayals of care and agreed-upon processes for updating measures as the science of medicine evolves. Today we have a few of the former and none of the latter. Indeed, this country has no identified national

quality goals, nor even an entity or individual authorized to make such a pronouncement.

Finally, the design of pay-for-performance frameworks must rise above a zero-based budgeting mentality. Rewarding good performers and their salutary behavior is desirable, but taking away from bad performers may simply make them worse. An investment and improvement strategy will be needed to truly raise the standard of care across the delivery system. These strategies can be achieved if we have the will to see them through, coupled with a work plan to guide this public/private-sector effort and provide a benchmark against which actual progress can be measured. Such a plan must balance the legitimate need for "experimentation and testing of models" against the urgency for real solutions and improvements. The building is burning.

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Errata

In "Retail Prescription Drug Spending in the National Health Accounts," Jan/Feb 04, Exhibit 2, the legend labels are incorrect. The segments labeled "Drug prices" should have been labeled "Use and intensity," and vice versa. A corrected version is available at content.healthaffairs.org/cgi/content/full/23/1/160.

In "Are the Young Becoming More Disabled?" Jan/Feb 04, page 172, the sentence reading "The problem is even more serious than this factor alone would suggest, though, because rates of disability have also been growing more rapidly among the disabled than among the nondisabled" contains two errors. The word "disabled" should be "obese," and the word "nondisabled" should be "nonobese." Also, in Exhibit 1, the column heading for the rightmost pair of columns should be 60–69, and in Exhibits 1 and 2, the percent signs for the rows labeled "Change" should be omitted.