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Rochester Health Care: An Epilogue

To the Editor:

In their paper, “Cost-Effective Health Care: The Rochester Experience” (Health Affairs, Spring 1993), William J. Hall and Paul F. Griner offer an insightful analysis of how Rochester achieved the level of health system performance that has generated such intense national interest. Rochester’s success in providing broad access to high-quality, affordable health care has been well documented and offers valuable lessons.

I agree with the authors’ assessment that the major determinants of Rochester’s history of success include a strong commitment to community-rated health insurance and a focus on managing hospital capacity through regional health care planning, cooperation, and innovation. It is important to recognize, however, that for decades health care has been operating in a paradigm in which inpatient facilities serve as the foundation of health care delivery. Within this paradigm, Rochester has achieved a remarkable record through certificate-of-need (CON) processes and innovative, cooperative initiatives such as the Hospital Experimental Payment Program (HEPP).

In today’s rapidly changing health care environment, however, we are moving toward another model—one in which the delivery of health care shifts from inpatient hospital facilities to outpatient, community-based settings. Today, advances in technology are challenging the affordability of medical care and redefining the roles and relationships of health care providers. In recognition of this, I offer a brief epilogue to “The Rochester Experience” outlined in Hall and Griner’s analysis.

Building on a legacy of strong regional planning and successful regulation of hospital service capacity, Rochester is today embarking on a new venture to manage the growth of nonhospital-based capacity. The need for this effort is clear. One of the keys to maintaining an affordable health care system is fitting capacity to need. Also, technology is rapidly shifting capacity from traditional inpatient settings to nontraditional outpatient facilities.

While these new and emerging technologies hold the promise of achieving near-miracle treatments and cures, they also present difficult decisions. For example, at what point do new technologies and procedures stop being experimental? When should they be paid for through a community’s insurance premiums? How can local residents be assured access to the latest and most effective medical technologies without overburdening the community with the cost of unneeded or underused capacity?

To address these issues, Rochester has drawn from its experience, recognizing that the key to successfully answering these questions lies in its ability to share decisions and to work together to meet the community’s long-term needs. It was with this in mind that the Community Technology Assessment Advisory Board (CTAAB) was created in March 1993.

This community-based mechanism provides an impartial process to determine what technologies should be acquired and disseminated in the community. Unlike state
CON regulations, which apply only to hospitals, CTAAB will address technology and capacity issues regardless of site or ownership. Created jointly by Blue Cross and Blue Shield of the Rochester Area and the Rochester Community Individual Practice Association (the largest PA-model health maintenance organization panel in Rochester), CTAAB includes representatives of hospitals, physicians, the business community, and local consumers. This board will be asked to evaluate proposals for new technologies and new applications of existing technologies, as well as proposals to acquire new capital-intensive service capacity. Importantly, CTAAB will receive substantial input from medical professionals, health planners, and others to ensure that its decisions are based on complete, current data.

CTAAB's recommendations, while advisory in nature, will be used by Blue Cross and Blue Shield and other payers to determine coverage and payment levels. Through these payment incentives, the community decisions made through the CTAAB process can contribute to Rochester's continued success in fitting health care capacity to community need. With CTAAB, Rochester is positioning itself to move from the old health care paradigm to the new frontier of health care delivery.

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Cooperative Decision Making In Rochester

To the Editor:

The Community Technology Assessment Advisory Board described above by Howard Berman may be another example of the Rochester health care system's ability to adapt to change and reach community consensus on important issues of technological deployment. I suggest an additional element to consider regarding the Rochester experience and appropriate use of technology.

Any change in the deployment of technology ultimately involves decisions at the level of the individual physician/patient relationship-the final common pathway for most decision making in health care delivery. Somewhat overlooked in the midst of the current national debate regarding needed alteration in the nation's health care system is the clear and almost frightening sense of disaffection of both the public and providers with the current system of health care delivery, especially in the area of technology. The reasons for these attitudes are complex. Contemporary biomedical-based medical care does not always provide the level of solutions patients expect to complex medical problems. This lack of success is often viewed as a failure of the physician or the medical care system, not as a symptom of the inherent limits of our technology. The ever-increasing specter of malpractice may be more reflective of these misplaced expectations and inadequate communication skills than of incompetence.

Similarly, physicians may share in this sense of personal inadequacy and disaffection, leading them to use excessive amounts of medical technology and even to turn away from the primary care specialties. In this context, physicians and patients often are drawn into adversarial relationships, rather than partnerships, and any opportunity for physicians to develop and exercise the interpersonal skills they need to promote new attitudes and changes in clinical behavior are abandoned. The cycle is repeated, often resulting in even more use of marginally useful technology.

At the same time, as Berman points out (and as we pointed out in our paper), all existing components of the health care system are calling for new levels of "vertical" integration, aimed at cost containment, to be sure, but also striving for clinical integration-a "wellness" model to replace the current "illness" model. The characteristics of this new model call for new physician skills in health status prediction and case management, based on the physician's ability to facilitate change and forge meaningful collaborative relationships with other health care providers. These systems mandate
provider/patient partnerships, as well as a complex new network of institutional and group partnerships. Cost, technology, chronic illness, information management, and quality improvement must be addressed in a communitywide context.

There is, therefore, a need for leaders who have both observational/analytical skills (whether for assessing the effectiveness of a new treatment or the performance of a practitioner) and the interpersonal/management skills needed to promote new attitudes and appropriate changes in clinical behavior. To date, traditional health services research training has focused on the more quantitative techniques necessary for the macroanalysis of health policy and care systems. Yet there is an emerging body of knowledge regarding a scientific approach to the more qualitative aspects of the medical care system as reflected in the personal encounters of physicians with their patients. These approaches are a logical maturation of the ideas generally embraced under the rubric of biopsychosocial system theory, a concept that originated in Rochester with the seminal work of George Engel. This model describes an integrated approach to clinical reasoning and patient care, provides techniques suitable to analyze physician/patient encounters, and provides a framework to study group dynamics and their impact on the outcomes of health policy. These concepts have been developed in Rochester over the past three decades and have been the major philosophical foundation of medical education and health services research here for several generations. It is possible that one of the factors that facilitates physician participation in broad technological assessment in Rochester as described by Berman is this long-standing research emphasis on the qualitative aspects of medical decision making and the educational emphasis that touches virtually all Rochester physicians. If this is the case, it suggests a key challenge for our nation’s medical schools in the exciting health care revolution ahead.

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Developing A Lexicon For Reform

To the Editor:

By identifying the need for each health insurance purchasing cooperative (HIPC) to ensure that a free-choice-of-provider plan is offered, Paul Starr and Walter Zelman may have saved managed competition (“A Bridge to Compromise: Competition under a Budget,” Health Affairs, Supplement 1993). To state what everyone knows, a large segment of Americans find a “systems approach” to their personal health care needs unacceptable; freedom of choice is perceived as uniquely important, particularly in the case of serious illness. In fact, the insurance market is a continuum that will resolve itself naturally into three segments: freedom of choice at one end, vertically integrated (Kaiser-type) plans at the other, and, in the middle, the traditional market for managed care in which providers and insurers remain economic adversaries.

Because vertically integrated entities combine insurance and delivery functions, the market for this kind of care contains certain natural checks and balances. However, concepts contained in the following statement by Starr and Zelman may hold the key to stabilizing the far more volatile free-choice-of-provider and middle markets: “For any given enrollee, the purchasing cooperative would pay no more than it pays for the benchmark plan—that is, the plan providing the uniform package at the lowest price and a satisfactory standard of care.”

Three strategies. Plans can use three basic strategies to achieve this objective: First, competition can occur through “positive” contributions, including improvements to quality of care (which often reduce cost) or through legitimate economic contributions such as cuts to insurance overhead or improved efficiency in the delivery system. Such strategies should be encouraged.

In contrast, plans can appear to meet the same objective through a second strategy: “risk selection.” By targeting healthy working families and by avoiding the poor, the elderly, and the sick, plans can reduce their own costs of providing care. Open enrollment, community rating, and mandatory...
marketing through the HIPCs begin to get at the problem. But in the end, “risk adjustment” is the critical correction needed to make the insurance market function properly; that is, plans that attract “high-risk subscribers” must have their payments adjusted upward and their premiums adjusted downward, through a redistribution or subsidy. Risk adjustment is also critical to plans that demonstrate exemplary quality of care; such plans will naturally attract a more difficult case-mix. As outcomes information becomes more widely available, plans that demonstrate good outcomes for expensive types of patients will as a result of open enrollment he faced with an influx of these patients. Without an adequate risk adjustment methodology, these plans will be financially punished for their good outcomes performance. The combination of outcomes information and open enrollment makes an accurate capitated risk adjustment methodology indispensable for the functioning of the system proposed by Starr and Zelman.

The problem is that neither the technology nor the data for doing adequate risk adjustment to capitated payment are currently available. For example, Medicare uses average adjusted per capita cost (AAPCC) to risk adjust capitated payments to HMOs. With an R2 of only .01 to .03, the AAPCC has little power to predict future health care expenditures. Even when detailed physiologic and patient history data (such as smoking history or blood pressure) are available, the R2 only improves to .1. By comparison, diagnosis-related groups (DRGs) produce an R2 for per case payments of .3 to .5, depending on the version of the DRGs used. Using currently available capitated risk adjusters is roughly equivalent to establishing a per case payment system without DRGs.

Plans also may use a third strategy, a “pricing strategy,” to reduce costs. The problems with this strategy hide in the authors’ words: “Consumers who want to enroll in a free-choice-of-provider option should be able to do so, so long as they pay the true difference in cost.” Middle-market insurers can reduce their costs by selecting efficient providers or by selecting different providers for different purposes. So far, so good. But, what if insurers demand discounts for agreeing not to remove patients? What if certain insurers with “some leverage” extract financial concessions disproportionate to the amount to which they might be entitled based on any realistic appraisal of economic or social contribution?

Proponents of managed competition sometimes leave the impression that reforming the relationship between insurers and consumers will automatically produce desirable results in the relationship between insurers and providers. The problem is that in treating the latter like any other market and thereby leaving plans to act purely in their own economic self-interest when dealing with providers, certain plans may be tempted to overuse their leverage. Using leverage in this way turns a so-called volume discount into a market share discount. The short-term result is the infamous cost shift: Freedom-of-choice patients and members of smaller plans end up paying vastly higher amounts for the same service from the same provider. Ironically, this is precisely the problem that caused various states, beginning with Maryland, to legislate all-payer systems in the early 1980s. The long-term result may be an unwanted level of consolidation with unexpected and unintended impact on access and quality, as well as price.

Finding the right labels. So where do we begin? Starr and Zelman were on the right track when they observed that labels hold a great potential to misinform this debate. For example, some people refer to rate setting as price controls. A failed attempt under the Nixon administration, price controls essentially freeze the status quo. Because any inequities in the pricing relationships among businesses were preserved, administrative agencies were set up to hear complaints. Because there was little or no science with which to evaluate these claims and make judgments, price controls were justifiably criticized as an inefficient and inaccurate substitute for the market mechanism.

Rate setting was a response to the inadequacies of price controls. In contrast to price freezes, rate setting establishes a fair price that rewards efficient providers, penalizes inefficient providers, and provides incen-
tives for all providers to become more efficient. More than twenty years have been spent defining the “product” of the health care industry—the patient. Empowered by a language, purchasers and sellers are now able to “fix in advance” a price. (Here again, prospective payment is a concept with no economic ideology; it is, in fact, the way capitalism generally functions.) As Starr and Zelman state, terms such as competition and regulation should be scrapped. Instead, we must begin with the basics—a language. Then we can develop an approach to cost containment built on the strengths of those elements of various systems that have shown success: prospective payment with respect to “price,” and managed care with respect to utilization or “volume” of services. Price times volume equals total cost. All-payer rate setting should be established to avoid cost shifting and to allow fair premiums to be established for those consumers who prefer the freedom-of-choice or middle-market options. Health care reform should create an environment in which the full range of options are available to consumers, and in which none of the options are economically disadvantaged by the reform plan’s design.

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NOTES


A Cautionary Note On HIPCs

To the Editor:

No one who read the Health Affairs Supplement 1993 could fail to be impressed with the quality of the papers and the sophistication of the alternative approaches to health care reform that they explored. Authors and editors are to be complimented on a job well done. As a skeptic on the sidelines who was a participant observer in both the New Deal and the Great Society reforms, I wish to raise a number of cautions aimed at reminding reformers that the US. political process makes it difficult, if not impossible, to alter radically (at least in the short run) the ways in which corporate and nonprofit institutions, the market, and government interact.

Paul Starr sees no reason that health insurance purchasing cooperatives (HIPCs)—now called health alliances—should not be operational in eighteen months, recalling for the reader that President Johnson got Head Start going within twelve weeks. What Starr failed to add is that a quarter-century later Head Start covers no more than 20 percent of youngsters in need, and many of these are enrolled in poor-quality programs. If it is agreed that two overriding challenges face U.S. health care in the spring of 1993—universal coverage and cost containment—why should so much attention be directed to getting HIPCs up and running? Clearly, they will not be able to respond in the short term, or even in the middle term, to these two priorities.

A related question is, What models do we have to guide us in establishing HIPCs in all or most large metropolitan centers? The conventional answer points to the Federal Employees Health Benefit Program (FEHBP) and the California Public Employees Retirement System (CalPERS). We know, however, that the FEHBP has been unable to control adequately the movement of employees into and out of higher-priced plans as they reassess their needs for more or less comprehensive services. And we know that the favorable CalPERS track record is both very brief and very recent.

One of the major gains asserted for HIPCs is the assurance of health care coverage for employees in small enterprises at a reasonable cost. However, it is far from clear, given the different health care needs of low-income urban populations and suburban residents, that competing HIPCs in the large
est metropolitan centers will not pursue risk-avoiding marketing strategies.

Another caution: The proponents of HIPCs emphasize that a major basis for their cost containment potential will be their ability to assess, through much-improved data analysis, the cost and quality of services of different provider groups. That may prove possible sometime in the future, but it is unlikely that such systematic funding determination will be feasible soon.

After about thirty years of experience with Medicaid, we should be forewarned that there is nothing easy about delivering mainstream medical care to the poor, even when a federal/state system finally provides universal insurance coverage. Just how the states will provide not only insurance coverage but access to services for all of the poor as well as for the medically needy remains a formidable challenge. Specifically, where will the HIPCs find physicians who are willing and able to take on the task of providing essential services to large concentrations of low-income persons in inner cities? We know that the ratio of private practitioners to population in the affluent suburbs and in the inner city often varies by a factor of thirty or forty; our recent book (E. Ginzberg, H.S. Berliner, and M. Ostow, Changing U.S. Health Care: A Study of Four Metropolitan Areas, Westview Press, 1993) speaks to this issue. Enrolling poor people in insurance plans is a necessary but not sufficient condition to ensure their access to essential care.

If the concept of the HIPC is worth pursuing, then it deserves to be treated seriously, which means that time, innovation, and feedback are essential for its successful implementation. In the meantime, we had better get on with slowing our rate of total health expenditures, extending insurance coverage to the entire population, and assuring that this coverage translates into effective services.

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The Somers Plan: An Early Managed Competition Proposal

To the Editor:

Your 1993 Supplement on managed competition is impressive—as is usual for Health Affairs. I wish to add to the history of managed competition as outlined by Alain Enthoven in “The History and Principles of Managed Competition.” In his narrative he neglected to mention the original “Somers plan.” First presented to a Sun Valley Forum on National Health, June 1971, it was published in the Milbank Memorial Fund Quarterly the following year (H.M. and A.R. Somers, “Major Issues in National Health Insurance,” April 1972, 177-210). We proposed expanding the basic principles of the original Federal Employees Health Benefit Program (FEHBP) to national health insurance. We called the result regulated competition. This proposal was discussed in detail with Scott Fleming and other officers of the Kaiser Permanente Medical Care Program.

Admittedly, we did not push the idea aggressively. As interest in national health insurance declined through the 1970s, I shifted my primary attention to prevention and health education and, after Red Somers’s stroke and disability, to long-term care. However, the Somers plan remains clearly on record, not only in the Milbank paper, but also in a slightly abbreviated version in our anthology, Health and Health Care: Policies in Perspective (Aspen, 1977) and in my Health Care in Transition: Directions for the Future (Health Research and Educational Trust, 1971). In the latter I use the term controlled competition.

Aside from the historical accuracy, this has some practical relevance. In 1992, after Red Somers’s death, I undertook to update our 1971 program in conjunction with the New Jersey Conference on National Health Reform. As in the original, the revision included the concepts of “controlled competition” and “supervised consumer choice” under national budgetary limits (a combination now hailed as a great new compromise) but added much greater emphasis on prevention—including research and consumer education—and some long-term care in the
basic benefit package.

It is appropriate for new generations to carry the torch for national health reform today. But the Somers plan and the nine criteria for effective national health insurance we set forth in 1971 remain, in my view, as relevant today as they were twenty-two years ago.

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Original Intent Of Blues Plans

To the Editor:

In his history of the noncompetitive health system we have today, Alain C. Enthoven (“The History and Principles of Managed Competition,” Health Affairs, Supplement 1993) seems unaware that the initial Blue Cross and Blue Shield program was designed with the poor in mind. He states: “Blue Cross and Blue Shield were created, respectively, by hospital associations and medical societies as chosen instruments to apply the guild principles to health care financing.” Rather, it was an outgrowth of the impact on the medical profession and hospitals of the final report (1932) by the Committee on Costs of Medical Care. The program’s benefits were substantial, but the premiums were initially token amounts, as were the payments to physicians and hospitals. The hospitals granted Blue Cross significant discounts because of the program’s charitable structure. It was a most commendable project to provide access to needed medical care for the poor, initiated and supported by the medical profession (fearful of state medicine) and the hospitals.

It was my personal experience to treat the poor with Blues insurance in the Chicago area. I had no knowledge of the Blues activity in other states. But, according to C.D. Weller, Enthoven’s source of information, Blue Cross/Blue Shield programs were enacted with variable frameworks and not necessarily by physicians and hospitals. For example, Cleveland Blue Shield was organized and controlled by business, and Hawaii Blue Shield, by business and labor.

When commercial health insurance became popular in the late 1960s, the structural framework of the Blues began to change. One major change was the removal of physicians from its board of directors. To be sure, some confusion and misunderstanding of the program took place. The discrepancy between surgeons’ charges for care of Blue Shield patients and Medicare beneficiaries did not escape Sen. John J. Williams of Delaware, who in the Chicago Tribune, 26 May 1969, correctly noted: “Medicare’s average payments for common surgical procedures are running two to four times those allowed by Blue Shield.” Wrongly accusing the Medicare surgeons of profiteering, he was unaware of the purpose of Blue Cross/Blue Shield insurance (for “low-income earners”) and its token premiums and token payments to providers.

I offer these historical perspectives as a way to clarify Enthoven’s recounting of the initial structuring of the Blues.

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NOTE


Clarification On Nurses’ Association

To the Editor:

In “Political Contributions from Health and Insurance Industries” (Health Affairs, Winter 1992), Larry Makinson comments that the American Nurses Association (ANA) is a “labor organization” and that its spending patterns are “typical of labor unions.” Makinson clearly is unaware of the organization and its objectives.

The ANA represents nurses nationwide and is the largest and most influential nursing organization in the United States. The ANA has over a quarter of a million members, and through the organization, each
nurse has a voice. It is the advocate for nurses, nursing, and the patients in the health care system. Standards are set for the nursing profession through the ANA, and we most certainly are involved in influencing health care legislation. The ANA is a respected authority on health care issues and is regularly consulted by regulatory bodies, state and national media, and other health care organizations. The association safeguards and promotes nursing licensure, credentialing, and the right of the profession to regulate its practice. Continuing education offerings foster our professional development. And, yes, collective bargaining is a function of the organization, just as all of the above are. The ANA is a professional organization, not a trade union.

In reference to the comment that more ANA contributions go to Democratic candidates, that too has nothing to do with our collective bargaining issues. The ANA supports any candidate who supports the issues we are interested in as health care providers: equal access to care, increased access to nurse providers of care (nurse practitioners, nurse midwives, and nurse anesthetists), comprehensive health care coverage for all Americans, and increased access to care for our most vulnerable populations, such as children, the homeless, victims of abuse or crime, and the chronically ill. We are not a partisan organization; we will support those who agree with our beliefs and values as health care professionals.

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Discourse On GAO Drug Price Comparisons

To the Editor:

Despite the fact that prescription drugs constitute a relatively modest portion of U.S. health care spending, drug prices have become a major issue in the past few years. Congress, health care authorities, and the public are all monitoring drug prices with great interest and increasingly question whether U.S. consumers are paying too much for their drugs. To answer this question, the U.S. General Accounting Office (GAO) has undertaken two international price comparisons. The first of these, Prescription Drug Charges in the U.S. and Canada (1992), found that manufacturer prices for the top 200 drugs in the United States were on average about 32 percent higher than the prices of those drugs in Canada. These results have been used by policymakers as evidence that policies are needed to contain U.S. drug prices. This example illustrates how policymakers have used international drug pricing studies without serious consideration of the large methodological problems inherent in this area of research.

It is important to make clear that there is no generally accepted methodology on how to conduct drug price comparisons, and many methodological issues remain unsolved. The results of most studies are, therefore, affected by more or less serious methodological flaws, which are never properly addressed. The GAO study is no exception to this problem. In it, the GAO considerably overstated the U.S./Canadian drug price difference. The 200 most frequently prescribed drugs used in the GAO comparison represent 54 percent of all prescriptions dispensed in U.S. drugstores during 1990. Among these top 200 drugs, researchers found 121 direct matches—drugs that were sold by the same manufacturer, had the same dosage strength, and took the same dosage form in both countries. The GAO did not report total volume of the matched drugs relative to the U.S. market, but a plausible range would be 30-35 percent. For these 121 drugs, the U.S. factory prices in 1991 were on average 32 percent higher. The median price differential was 43 percent; 81 percent of the drugs were more expensive in the United States.

The GAO obtained U.S. manufacturer prices from the Wholesale Acquisition Cost (WAC), collected from a company specializing in pharmaceutical information (Medi-Span). WAC reflects the factory prices of drugs bought in retail pharmacies in the United States. For Canada, the GAO obtained manufacturer prices for 101 of the 121 drugs from the Best Available Price.
(BAP) listed in the Ontario Drug Benefit (ODB) formulary. The GAO claimed that the ODB formulary generally is representative of factory prices throughout Canada. For the twenty drugs not listed in the ODB formulary, the GAO obtained factory prices directly from the manufacturer or from a major Canadian wholesaler.

I seriously question the GAO’s claims of representative U.S. and Canadian prices, because the study does not compare like with like. The study overlooks discounts and the buying power of large institutional buyers. U.S. prices are based on ex-manufacturers’ prices to small noninstitutional buyers. It is expected that because such purchasers have limited buying power, discounts offered to them are lower or nonexistent, and thus prices are higher. Canadian prices are based on the prices to a large institutional buyer (the province of Ontario), which exerts concentrated buying power and therefore is expected to obtain generally lower prices from the manufacturers. Each of the twelve Canadian provinces or territories has its own drug benefit program. In nine of the provinces or territories (including Ontario) the drug programs pay only for drugs used by the elderly and low-income persons. Each product on the ODB formulary is listed with its own maximum price at which the pharmacist is reimbursed. The drug programs will only reimburse the lowest price offered in Canada, thus placing strong pressure on manufacturers to decrease their prices to get access to the 40 percent of the Ontario prescription market now covered by the ODB formulary (about 15 percent of the total Canadian market).

The effect of the GAO’s methodological flaw can be seen if the sample is divided into two subsets. For the twenty drugs not listed on the ODB formulary (those with free pricing, as in the United States), the U.S. prices are only 10 percent higher (median value). For drugs listed on the ODB formulary, the GAO found a median price differential of 49 percent. It is evident that by grouping all 121 drugs into one sample, the GAO study has strongly exaggerated the price difference between the United States and Canada. The appropriate way to compare drug prices would have been to do the comparison along two lines: (1) to compare prices for drugs on the Canadian ODB formulary with prices for an equally large institutional U.S. buyer (such as Medicaid, Medicare, the Department of Veterans Affairs, or a large health maintenance organization); and (2) to compare prices for drugs not on the Canadian ODB list with prices for drugs dispensed through U.S. drugstores (the particular sector of the U.S. drug market that the GAO did focus on).

The end result is that the GAO study is strongly biased upward for the U.S. prices, by not including large institutional buyers in the price comparison. Furthermore, by concentrating on a large institutional buyer in Canada, the study does not take into account the fact that these prices are biased downward, mainly because of the large buying power of the ODB formulary. Together, these two sources of bias may explain a relatively large share of the proposed difference between U.S. and Canadian drug prices. This mistake raises serious doubts concerning the findings of the GAO study. Methodologically sound studies are urgently needed before drug pricing studies can be fully put to use as a basis for important policy decisions in the U.S. health care arena.

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NOTE
1. F. Anderson and P. McMenamin International Text
Price Comparisons of Pharmaceuticals—A review of Text