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Letters

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The Coming Physician Shortage

To the Editor:

Of the seven perspectives published with our recent paper (Jan/Feb 02), noteworthy was the one by leaders of the Association of American Medical Colleges (AAMC), who believe that we offer convincing evidence of emerging physician shortages. Mary Mundinger concurred, although she favored an even greater role for advance practice nurses than we had modeled. These thoughtful reflections from leaders in medical and nursing education signal a sea change: no more giant surpluses; shortages are the issue. Other commentators raised interesting questions and concerns, but none offered any conceptual or quantitative alternatives to our projections. Our central conclusion about increasing physician shortages remains. The dialogue must begin now.

Several commentators raised concerns about “the market” being a determinant of physician supply, since patient-initiated purchasing decisions at the time of service are imperfect. Unlike the market for most other goods and services, health care spending depends not only on decisions at the time of service, but also on decisions made in advance, such as employees’ decisions to accept health benefits in lieu of wages, political decisions to expand Medicare, and community decisions to build health care facilities. Each decision is made cognizant of what is “affordable,” and what is affordable relates back to some measure or perception of wealth such as per capita income or gross domestic product (GDP). In 1967 Rashi Fein concluded that 85 percent of the growth in physician utilization could be accounted for by the direct and indirect effects of per capita income. Like GDP, per capita income both underlies and serves as a proxy for the varied inputs. Therefore, there is value in using it to aggregate demand. No other indicator of comparable value exists.

Similarly, there is value in aggregating physicians as a head count rather than as full-time-equivalents (FTEs) engaged in particular tasks. Most planning exercises in the past sought absolutes, measured as FTEs, and all failed. Why? Quantifying physicians in this manner is difficult, and doing so means that demand must be similarly projected, which has proved to be impossible. Jonathan Weiner comments that “the track record of U.S. workforce policy has not been stellar,” echoing earlier sentiments. On the other hand, approaches that relied on trends, as ours did, have done well. Earlier failures should not be taken as a mark against subsequent designs.

The brevity of our paper did not allow for much detail about the path connecting changes in GDP and physician supply, raising questions for some commentators. That path is spelled out more fully in previous and pending publications and flows as follows. As GDP (and per capita income) expand, a newfound sense of wealth enhances desire and creates a perception of possibility at various levels (individual, group, employer, community, political). Demand slowly increases and health care spending rises. The existing labor force responds, but over time more workers are trained and more international medical graduates (IMGs) migrate in. If pressure continues, medical schools expand. The lag between changes in GDP and changes in the number of physicians averages about ten years.

Some commentators suggested that changes in physician supply occurred not be-
cause of some “natural law” of economics, but because graduate medical education (GME) support attracted more IMGs to the United States and because incorrect population projections led Canada to add medical school places. In both countries, growth in physician supply fed a demand created by the economy. Had there not been an influx of IMGs in the United States or had population growth not slowed in Canada, current physician shortages would be even more severe.

Morris Barer was critical of our use of the term _demand_ because when an economy deteriorates and its GDP declines (as happened in Russia), “need” doesn’t fall, it rises. The observation is correct, but there is no inconsistency. Need (a medical term) does rise, but demand (an economic term) falls, because resources are insufficient. Similarly, “need” is great in sub-Saharan Africa, but “demand” is low because fiscal resources are sparse. What about the current U.S. recession? If it continues long enough, demand for medical services will certainly fall, despite increasing needs due to aging and poverty. However, if the recession is brief, it will simply be averaged in with other short-term oscillations. Such economic fluctuations are common, which is why the trends that we examined span several decades.

Several commentators suggested that it’s not the economy but physicians who determine spending—the old concept of “physician-induced demand.” After thirty years of debating its merits, most economists have concluded that physician-induced demand is not of sufficient magnitude to warrant serious consideration in formulating policy. Nonetheless, it continues to influence analysts and, coupled with a belief that health care spending is bad for the economy, has spawned a policy of constraining physician supply to decrease health care costs. This logic, which originated in Canada in the 1970s, drifted south and became embedded in U.S. workforce policy. Unfortunately, it ignores the reality that health care spending is not propelled by physicians but by a combination of human aspiration and economic potential. The health care sector is among the economy’s most vibrant. If the U.S. is ever to have a rational physician workforce policy, planners must move beyond the myth that demand is caused by physicians and that health care spending in proportion to GDP growth is detrimental to society.

A further obstacle to formulating rational policy is a lack of appreciation among some planners for what it is that specialists do. Various commentators assert, for example, that half of specialty care is inappropriate; that even when it is, it isn’t as good or as cheap as that provided by primary care physicians; that it’s an unnecessary luxury—“another gas-guzzling SUV” (per Kevin Grumbach) that, says Fitzhugh Mullan, specialists provide because they “follow the money.” Some commentators also lament that additional specialists won’t decrease the ranks of uninsured nor improve health outcomes in the U.S., so why do we need so many anyway? Perpetuating the primary care–specialist schism and looking to specialists or physicians generally to solve systemic problems are not useful.

Do the trends that we have observed mean that “social planners are presumptuous” or that “the inevitability of the market belittles their efforts?” Not necessarily. But they do suggest that planners must be more mindful of societal dynamics, that the public’s perception of need should not be discounted. Yet, even as the California Medical Society warns of a “coming physician supply problem,” Grumbach and colleagues proclaim that there are “more than enough.” And even as the major Canadian medical organizations lobby for relief from “the stresses of physician shortages,” Barer and Robert Evans cling to physician-induced demand and pursue tangential theories that divert attention from the reality that Canada’s workforce policies have failed.

In sum, we believe that the AAMC’s leadership hit the nail on the head. The time for petty rhetoric and tired dogma has passed. The facts are upon us, and they are rather simple. Health care is an increasing portion of growing economies, and the demand for physicians bears a direct relationship to that
process. If, as seems likely, the U.S. economy continues to grow, there will be an inescapable need for more physicians, principally specialists. Although Uwe Reinhardt is correct in cautioning against fixing on any “right” number, Ralph Snyderman and his AAMC colleagues squarely framed the alternatives: Oversupply is undesirable, but undersupply could have far more serious ramifications. Either additional physicians will have to be trained, or the spectrum of services that physicians now provide will have to be entrusted to others.

Richard A. Cooper
Medical College of Wisconsin
Milwaukee, Wisconsin

Thomas E. Getzen
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Philadelphia, Pennsylvania

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Evans, “Supplier-Induced Demand”; M.L. Barer, Untold True Story,” Health Affairs 5–21; M. V. Pauly, “U.S. Health Care Costs: The Competitiveness,” Health Affairs Reinhardt, “Health Care Spending and American may not be detrimental to the economy, see U.E. tion of Clinical Care: A Canadian Perspective,” in Wade, “Investment for Health and the Contribu-


nomic reasoning to formulate restrictive physi-
cian workforce policy, see R.A. Cooper and L.H. Aiken, “Human Inputs: The Health Care Work-

force and Medical Markets,” Journal of Health Poli-


**The Hospital Crisis Is Here**

To the Editor:

We agree with many of the points raised by Mark Harrison and Cecelia Montalvo (Jan/Feb 02). California hospitals are in financial trouble. The paper sets a good founda-

tion, but we would like to expand upon its basic tenets.

The financial erosion already has affected hospitals’ ability to provide care. The issue is not wait times for staff to answer a patient’s call light. It is about reputable, high-quality hospitals’ not having enough staff for their emergency departments (EDs) and physicians’ being unwilling to take emergency calls. Lack of staffing forces many good EDs to spend much of their time on “closed status” to critical patients, with four-to six-hour wait times common for routine care. Social status or preferred insurance coverage is irrelevant in a world where the hospital cannot afford to hire, train, and pay for adequate staff. This, obviously, limits access for patients.

Also, being labeled a “have” hospital often bears no correlation to providing high-quality patient care. For many reasons, financial health and good patient care are not always synonymous. Compounding the issue is the government’s one-size-fits-all approach. A classic mistake, with respect to SB 1953 (the retrofit bill responding to the 1994 Northridge, California, earthquake), was the government’s offering no-interest financing for hospitals without considering market fac-

tors such as overcapacity, scope of services, and community access. If this broad approach continues, we may all be doomed to remain in weak financial health.

In addition, government and other regulatory bodies issue prescriptions or methods to solve complex patient care problems rather than defining the problems and monitoring outcomes. This approach squelches creativity, increases costs, and produces ambiguous re-

sults. Also, regulators have not been able to
establish fundamental industry standards such as a single methodology for payment or a common billing form. Such standards would instantly eliminate billions of dollars in administrative costs. Hence, government has not played a constructive role in creating a more efficient health industry and has not led in bringing change.

Health care is an industry far more complex than most. Its financial realities are continually pitted against social wants and ethical needs. We consider health care a fundamental right yet accept that so many underprivileged lack access to immunizations, prenatal care, or respectable long-term care. Perhaps the hospital crisis will produce leadership, vision, and a results-oriented focus to set our health care industry on solid footing.

William B. Caswell and Timothy J. Carmack
Southern California Healthcare Systems
Pasadena, California

California's Hospitals

To the Editor:

Harrison and Montalvo raise a fundamental question about the role of markets and of government in financing health care. With one of the highest rates of managed care penetration, California has been viewed as a dynamic and competitive market for more than a decade. As the authors note, these conditions helped to keep growth in both expenses and revenues below the medical inflation rate through the late 1990s. Therefore, does the crisis in California represent the future of competitive markets, in which hospital profits are placed under such tremendous financial pressure that adequate capital investment is virtually impossible? Or is the state simply jeopardizing its hospitals with unfunded regulatory mandates that would be difficult to meet even in the most prosperous times?

More recent national data suggest that although hospital margins improved during the first half of 2001, implementation of the new Medicare outpatient prospective payment system and the rapid increase in national medical spending are likely to create new financial pressures. Also, California is facing a projected budget deficit of $12 billion in large part due to an ill-conceived effort at deregulating energy markets. Political expediency suggests that postponing deadlines for seismic retrofitting may be the only viable short-term option for the state to pursue to avoid hospital closures. In the longer term, however, Californians and the nation will need to reexamine whether we can afford to depend on markets alone to provide adequate support for our basic health care infrastructure. This latest financial crisis is an opportunity to reevaluate unfunded regulatory mandates and also the assumption that competitive markets are more effective in providing high-quality care than regulated markets.

Gerald F. Kominski
University of California, Los Angeles
Los Angeles, California

New York Hospital Leaders Bear The Blame

To the Editor:

Sharon Salit and colleagues (Jan/Feb 02) would give readers a more complete picture of the condition of New York City hospitals if they had examined a longer time span and the quality of management as an independent variable. The weak financial condition of New York City hospitals was evident twenty years ago. In the early 1980s a report commissioned by the Commonwealth Fund found that New York's voluntary hospitals were in worse financial condition than hospitals in the rest of the nation and that the trend had been worsening since the late 1970s.1 Subsequent analysis revealed that the weakest institutions were not consistently those with the lowest occupancy rates, greatest outpatient volume, or highest level of uncompensated care; other factors were at work.2

The persistence of poor performance in periods of regulation and deregulation suggests that a major cause is the low quality of the institutions' management as evident in three recurring, strategic errors. First, leaders rely too heavily on revenue-based solutions to
their financial problems and avoid spending cuts despite the need for cost containment (cost per admission in New York hospitals is well above the national average). Instead of making a serious effort to bring costs into line, New York’s leaders spend millions annually to lobby in Albany and Washington for more favorable treatment under government payment programs.

Also, hospital leaders are reluctant to curtail their excessive commitment to GME for fear of losing prestige and antagonizing their medical staffs. New York City institutions account for about 10 percent of residency positions nationally but only 3 percent of the national population. This makes neither social nor fiscal sense. The residencies add to the overall cost of medical care in the region, and new physicians produced are concentrated in specialties for which there is already a surplus.

Finally, hospital leaders have gone heavily into debt to finance misguided capital projects. New York institutions recently borrowed billions, including some of the largest hospital bond issues on record. While some rebuilding of aged plant was appropriate, needed expansion of ambulatory care facilities was neglected. Much of the money was used to enhance amenities, including architectural embellishments that executives believed would improve their institution’s competitiveness for upper-income patients. But the investments are not paying off as intended, and the enlarged debt service is another reason for poor financial performance.

Charles Brecher
New York University
New York, New York

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Hospital Deregulation In New York

To the Editor:

The paper by Salit and colleagues provides an opportunity to reflect on New York’s decision to deregulate its hospital payment system. The New York Prospective Hospital Reimbursement Methodology (NYPHRM), implemented nearly twenty years ago, met its goals. During this period hospital costs in New York State increased at or below the national average, the volume of care to the uninsured increased, and the system financed the graduate training mission of New York’s teaching hospitals.

A variety of external pressures doomed the NYPHRM approach over time. As Salit and colleagues note, the state abandoned the rest of its rate-setting system by 1997.

How have New York hospitals and patients fared? On the one hand, two-thirds of all New York hospitals are in the red, compared with a third prior to the Balanced Budget Act (BBA) and deregulation. On the other, my tabulations show that the volume of uncompensated care per uninsured person has remained the same since 1996 but has risen 10 percent nationally. In short, one apparent objective of deregulation has been met: New York now looks like the rest of the hospital industry, only with fewer resources!

What’s next is more difficult to predict. Under the previous rate-setting system, control over system design and spending distribution rested in Albany. Although the NYPHRM approach kept the industry in a sort of time warp, it also allowed for corrective actions through its rate-setting formulae. Control over the financial future of New York hospitals is now decentralized, resting in Washington and in competitive negotiations among payers and providers. Whether decentralization and competition prove to be a better “solution” to achieving New York’s health policy goals is an open question requiring continued monitoring and evaluation.

Kenneth E. Thorpe
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Atlanta, Georgia

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New York Legislature Got It Right
To the Editor:

The paper by Salit and colleagues on New York City hospitals identifies an industry in great fiscal trouble. New York’s deregulation of the private insurance market included the adoption of community rating and the creation of two pools, both to address aspects of predictable and unpredictable differences in selection. Hospital deregulation also included two pools, one to finance half the cost of GME and one to finance a portion of uncompensated care (UC). The legislature thought that teaching hospitals could demand a premium in the marketplace equal to about half their added cost as a result of their teaching mission. The annual pool payment to be made on behalf of each subscriber who is a New York City resident is $116.75, and for each family, $385.29. The payment required on behalf of residents of other parts of the state is lower. The second pool, to help fund UC and some health initiatives, is financed by a statewide surcharge of 8.18 percent.

I believe that the legislature got it about right. Competition in the private insurance market is more about insurer efficiency and quality and less about selection. Competition for insured patients is more about hospital efficiency and quality and less about mission. Hospitals’ ability to generate 50 percent of GME and unfunded UC relates to prestige and network strength. The increased dispersion of profits occurs because competition produces winners and losers, while regulation tends to produce “limp-alongers.”

Many of the distressed hospitals are safety-net hospitals serving mostly Medicaid, Medicare, and uninsured patients. The deregulation of privately insured patients affects those hospitals through reductions in cross-subsidies that the GME and UC pools were meant to contain. If competitive markets do not adequately finance UC costs at the levels New Yorkers wish, the legislature will need to provide additional funding. I would much prefer that the UC problem be solved by nationally mandated health insurance with appropriate subsidies for the poor. New York’s safety-net hospitals cannot wait.

Harold A. Cohen
Hal Cohen, Inc.
Baltimore, Maryland

New York Working Through Its Problems
To the Editor:

Salit and colleagues very aptly describe the history of the hospital system in New York City and the unfortunate confluence of events in the late 1990s that stressed the system and could have destabilized it. Deregulation of private payer rates at the height of managed care coupled with rate cuts by government payers could have driven critical institutions into bankruptcy.

What has kept the system afloat, however, has been an unusual but highly effective partnership between the leadership of the hospital industry, our principal labor union led by Dennis Rivera, Gov. George E. Pataki, and the state’s legislative leaders. This partnership led to a landmark piece of legislation, the Health Care Reform Act (HCRA). HCRA 1996 deregulated private payer reimbursement rates, which created a private market for inpatient hospital care for the first time in a generation. To temper the potential dislocations of the new market, however, HCRA also established several pools to ensure the continued provision of public benefits such as charity care and GME. HCRA 2000 reauthorized these pools and created a new insurance program, Family Health Plus, which is modeled on New York’s Child Health Plus program and provides coverage to low-income adults.

As I write this, Governor Pataki and the legislature are enacting a new pool to address the severe labor shortage we are experiencing in many occupational categories and to retain
our dedicated workforce. This is occurring in the context of severe state budget difficulties in the wake of the September 11 attack on the World Trade Center. Through the outstanding vision of these leaders, New York has found the right balance between market forces and public support and thus has been able to maintain its excellent health care infrastructure despite its very real problems.

Kenneth E. Raske
Greater New York Hospital Association
New York, New York

The authors respond:

Charles Brecher believes that poor management may be a major cause of financial stress at New York City hospitals, based on his early 1980s studies. He cites high costs, an excessive commitment to GME, and misguided capital projects as continuing evidence of this problem. Hospital costs in New York City, as he notes, are still above national norms, but they are below average when compared with other large U.S. cities, as we report. Our finding that nearly all of the most financially troubled hospitals in the city were safety-net and small community hospitals also runs counter to his theory, because these hospitals tend to have relatively low costs, teaching intensity, and debt burdens. High GME costs and large hospital bond issues are more characteristic of the city’s academic medical centers and other major teaching hospitals. Although these hospitals were not in financial jeopardy during the late 1990s, their financial performance was weaker than that of other large U.S. urban teaching hospitals and has been for decades, possibly due in part to the management issues Brecher describes.

We agree with Kenneth Thorpe that the effectiveness of deregulation in achieving New York’s health policy goals needs continual monitoring and evaluation. However, some of the flaws are now apparent. Although, as Thorpe notes, the state relinquished powers to take corrective actions through the commercial rate-setting mechanism, other options remain. These include allocating pool funds (for UC and GME) and setting Medicaid inpatient and outpatient rates, which together constitute 40 percent of hospital patient revenues in New York City. Harold Cohen favors competition because it produces winners and losers on the basis of hospital efficiency and quality, while regulation supports mediocrity. In New York City it’s not clear that competition has worked out that way for various reasons, including monopoly power, lack of reliable information about the quality of care, and, as Cohen points out, the lack of universal health insurance.

Sharon Salit, Steven Fass, and Mark Nowak
United Hospital Fund
New York, New York

Top-Down Nursing Changes Needed

To the Editor:

Barry Adams and Ray Bingham (Jan/Feb 02) have provided devastating stories of clinical nursing that leave me full of concern for the nurses, the system, and the patients we serve. The need for solutions must take precedence over melancholy, but the solutions, like the problems, are complex.

For instance, setting national standards for staffing ratios is no panacea for current nursing conditions. Case-mix variations across hospitals and between units within hospitals, and variations in nurses’ skill-mix and in hospital organizational structures, render standardized staffing ratios problematic—even if they could be enforced. Perhaps a more appropriate way to go is for hospitals to seek and for the public to demand the “magnet hospital” designation. Remarkably few hospitals have sought this accreditation from the American Nurses Credentialing Center. Its standards could be used as a guide to high-quality nursing care by administrators and patients; its use is a “no-brainer” as we look for solutions.

System improvement must come from the top. If Adams and Bingham had received support from their supervisors and their physician colleagues, despite exhaustion and frustration, their work probably would have still
felt rewarding and doable. But they were being pilloried by the very people who should have been offering them praise, understanding, and a hand in finding solutions. This may be the most reprehensible part of the story.

Most programs for nurse executives or mid-level nurse managers over the past decade have focused on preparing them in business and management. The idea is that new graduates will have a better sense of the exigencies of the health care system and be better able to function as nurses in today’s varied nursing environments. I have been part of these developments and believe that such integration of content is important in training nursing leaders. However, given the failures of management in understanding and planning for the major mission of health care institutions—providing high-quality care—it may be equally important to develop programs to help managers and administrators understand more about the basic business they are entering—the care part of health care.

Some improvement must be organized at the front line, but unless it is institutionalized, it cannot last and will have little transitory. Only boards, senior executives, and clinical leaders can deliver systemwide change and improved performance. Where are the national-level nursing and medical leaders, the visionaries who, instead of being driven by the current environment, are attempting to speak up for their professions and the public? It is their influence on the policy agenda rather than that of managers with little health experience that will bring improvement. Asking nurses and patients to take the rap for changing health care missions over the past ten years is dangerous and misguided.

Claire Fagin
John A. Hartford Foundation
New York, New York

Nurses Devalued And Abandoned

To the Editor:

As a professional nurse, I found it painful to read the commentaries of Adams and Bingham. Twenty-five years ago, when I was studying nursing, staffing was tight, salaries were low, and providing care was challenging. Countering these constraints were movements to improve basic nursing education, better delineate nursing science, and provide ongoing clinical support and education both within hospitals and through nursing organizations. During the first decade of my career I was proud to work within an institution that valued and supported excellence in patient care. Collaborative practice was encouraged, staffing levels were improved, and nurses’ contributions to patient care were publicly acknowledged.

Over the past ten years, however, most of these gains have eroded as a result of fiscal pressure. Approaching the care of sick people as if they were running a factory, consultants now refer to our most complex and vulnerable patients as “product lines,” focusing on “throughput” instead of healing. Sadly, most health care institutions have followed this industrial model. Large numbers of nurses have been diverted to case management, where their interventions aim to ensure insurance reimbursement and rapid patient discharge. Gone are the monitoring, evaluation, intervention, and compassion that were once the pride of inpatient nursing services.

Long before nurses such as Adams and Bingham, who attempt to provide excellent patient care, were demonized and fired for “insubordination,” the nursing administrators and leadership of once caring institutions had been largely eliminated, and those left, marginalized. Those remaining in positions of power are unwilling to stand up for the restoration and support of excellent nursing care. Amid the attention on the nursing shortage, it is important to focus on the real issues. All of the tuition assistance in the world to train new nurses will not help to restore a profession whose work is devalued by the very institutions within whose walls the majority of nurses are employed.

Jean Chaisson
Community Health Network
Holliston, Massachusetts
Improving Nursing Conditions

To the Editor:

We read the Bingham and Adams narratives with compassion. Their experiences in the mid-1990s were concurrent with peaking capitation, mandated cost containment, and agonizing service restructuring. We too have witnessed the struggles of nurses, their clinical leaders, and administrators to reconcile marketplace imperatives without authoritative evidence to guide them.

That said, since the mid-1990s the nursing profession has advanced its capacity to measure nursing quality and to study nurse staffing effectiveness. The American Nurses Association’s (ANA’s) National Database for Nursing Quality Indicators, launched in 1997, collects data from hospitals nationwide and returns reports to assist them in benchmarking nurse staffing, falls, pressure ulcers, and nurse satisfaction using ANA indicators first published in 1995. The California Nursing Outcomes Database Project began in 1996 and is the nation’s largest ongoing statewide project to benchmark nurse-sensitive outcomes.

Bingham’s mention of the report by Linda Aiken and colleagues (May/June 01) failed to note that they sampled only nurses in Pennsylvania, so the findings cannot be construed as representative of all nurses nationwide. U.S. nurses’ experiences, reported by Aiken, were also similar to those nurses in four other countries. Importantly, since publication of the Institute of Medicine’s To Err Is Human, multifaceted efforts have been undertaken by the health care system, policymakers, and providers to ensure staffing effectiveness and patient safety. These efforts include new Joint Commission on Accreditation of Healthcare Organizations criteria, federal research initiatives, and a general commitment in health care to a blame-free culture of safety.

A preponderance of evidence links nurse staffing to patient care safety; however, the evidence is inconsistent and not yet specific enough to inform public policy or clinical staffing. California’s Title 22 has mandated staffing ratios in critical care areas for years, but no evidence exists that ratios have improved patient care, safety, or quality. Until science is able to prescribe ratios, institutional staffing effectiveness must be constantly observed and analyzed to inform staffing budgets and work assignments that work in each setting.

Nancy Donaldson
University of California, San Francisco, School of Nursing

Jane Hirsch
UCSF Medical Center

The author responds:

Ray Bingham’s and my experiences are in no way unique. Certainly there is no single solution for the almost endless ills affecting nursing and U.S. health care. However, the fundamental problem is not complex. There is inherent conflict in a market-driven health-care system where economic profit is given as much consideration as the final product, if not more. All too often patient outcomes may be viewed simply as externalities or spillover costs or benefits. So entrenched is our economic consciousness that greater financial incentives have been proposed as a solution to attract nurses back to patient “care.” The irony cannot be missed. Experienced nurses know that this is not the answer. In fact, nurses around the country (even recent graduates) are walking away from salaries that, under any other circumstances, would be considered substantial.

For too long the nurses who provide hands-on patient care have looked to the “top” for change—change that would consider patients’ needs before money, egos, and careers. As Claire Fagin and Jean Chaisson clearly point out, that has not occurred and will not occur as long as those remaining in positions of power are unwilling to stand up. As a result of that vacuum, bedside nurses have become the visionaries needed to speak for their profession and the public by, for instance, demanding regulated staffing ratios.

Further research may also inform policy, as Nancy Donaldson suggests. However, scientific evidence is often overlooked in the world
of politics and the marketplace. (For instance, science was not considered when reducing RNs at the bedside.) As policymakers and analysts struggle to undo the damage, the voices of the nurses and physicians who provide direct patient care should inform them.

Barry Adams
Boston, Massachusetts

Value Purchasing And Quality

To the Editor:
Robert Berenson (<www.healthaffairs.org>, 28 November 01) discussed incentives for Medicare+Choice (M+C) health plans that demonstrate higher quality of care. In their response, Patricia Salber and Bruce Bradley recommend that the Centers for Medicare and Medicaid Services (CMS) consider a value purchasing strategy employing lessons learned by General Motors that have attracted more GM workers to higher-quality plans. These proposals are applicable beyond M+C and have the potential to improve the quality of care for a wide range of consumers.

To give impetus to value-based purchasing on a wider scale, it seems both feasible and essential for the CMS and the Office of Personnel Management (OPM) to coordinate a strategy. Action by these two large purchasers would leverage purchasing power consistent with the lessons learned by GM and thereby encourage quality improvement. The tools to begin this strategy are available. While the Health Plan Employer Data Information Set (HEDIS) and Consumer Assessment of Health Plans (CAHPS) may be less-than-optimal measures of quality and performance, they can identify clearly sustained high performance. The CMS and the OPM can apply them now in combination with other measures such as commitment to program stability through sustained contracting over consecutive years.

Both papers recognize the major impact of financial incentives in motivating contractors to improve quality. The lack of adequate legislative authority for these public programs to employ financial incentives need not be a reason to refrain from initiating any value-based purchasing activity. Both programs could use other incentives, such as less burdensome reporting requirements, less frequent program audits/site visits, and increased risk-adjusted payments for certain diagnoses (for M+C plans). The CMS and OPM could make the public aware of which plans were the higher performers, while awaiting more flexible statutory authority. These and other options deserve consideration.

David Abernethy and George Strumpf
HIP Health Plans
Washington, D.C.

Public Reporting On Nursing Homes

To the Editor:
Kieran Walshe (Nov/Dec 01) encourages efforts to help align the marketplace with quality assurance regulation—in particular, the public dissemination of information allowing consumers and other decisionmakers to readily comparison shop for high-quality nursing homes. Recently the CMS announced a pilot project that will begin publicly reporting on eleven quality measures, with the goal of implementing similar reporting in every state by 2002.

The California HealthCare Foundation is funding a coalition of the University of California, the University of Wisconsin, and RAND to create a public report for consumers that compares the quality of individual nursing homes in California. The report will be released in fall 2002. Nearly half of the $2.4 million grant is being spent to independently validate the clinical data contained in the federally collected Minimum Data Set (MDS) before releasing the data to the public. Researchers and other stakeholders already have identified irregularities and inconsistencies in the MDS data, which are self-reported by the facilities. Concerned about these irregularities, and intent on using Medi-Cal dollars to reward quality in the future, California’s Department of Health and Human Services plans to undertake its own MDS validation effort over the next three years.

California’s MDS data validation model
and protocols could be applied elsewhere. Based on our experience, we are concerned that otherwise laudable public reporting efforts could be severely jeopardized unless MDS data validation is built into the process.

Ann Monroe
California HealthCare Foundation
Oakland, California

Acute Illness Pilot Projects Needed

To the Editor:

Molly Coye makes an analogy in treating patients with chronic illness to the U.S. automobile manufacturers’ learning “how good a car could be” (Nov/Dec 01). In health care, however, physicians are acting as a repair service, not a manufacturer. Although some of the repairs we undertake are affected by individuals’ own maintenance (preventive medicine), much of what we see is influenced by genetics, lifestyle, environment, and a host of factors that no one understands. The main problem is rapidly growing costs because of technology, an aging population, and higher wage rates. No amount of provider incentives can affect those areas.

Any lessons we learn in treating chronic illnesses like those described by Edward Wagner and colleagues (Nov/Dec 01) will not necessarily translate into designing efficiencies in treating acute illnesses. The key is developing more pilot projects for acute illnesses, like those that Wagner and his colleagues develop to treat chronic illnesses. Money is being spent on costly statistical studies to try to find a cheaper Holy Grail way to deliver health care. So far those studies have produced few good results. But few dollars are even available to develop pilot projects so that we can discover the most effective methods.

Industry and health care planners should specify whether they are looking for improved health or merely decreased costs. These two goals do not necessarily go together.

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Improving Chronic Care

To the Editor:

In your Nov/Dec 01 issue I see glimmers of opportunity that should make us redouble our efforts to improve health and supportive services for Americans with severe chronic illnesses and disabilities. The existence of a community-based population poorly served by the existing multitiel, fragmented system is not new. The “boutique” projects cited by Robert Master and Catherine Eng have been struggling with the barriers described by Alan Weil, Bruce Vladeck, and others for years. What is hopeful is that key players recognize that the environment is changing as more is learned about chronic care. I am heartened by the increasing capacity to stratify the heterogeneous population of people with chronic conditions, increasing intelligence about testing and rapidly improving community-based projects, and the potential power of the consumer rights movement to overcome barriers to changing the system.

Hopefulness and pragmatism make me look for targets of greatest opportunity: Medicaid managed care has inherent incentives, especially with the most high-risk cases, to emphasize primary care and to prevent unnecessary institutionalization. Moreover, it can offer nonelderly beneficiaries with severe illnesses and disabilities the chance to collaborate in designing care packages that improve their quality of life in the community.

All of the authors seem to place great faith in philanthropy-sponsored social entrepreneurship. Foundations may indeed be best suited to finding strategies that are the most innovative. With ongoing funding from the Robert Wood Johnson, Annie E. Casey, David and Lucile Packard, and California HealthCare Foundations, the Center for Health Care Strategies will continue to seek out state Medicaid purchasers, Medicaid managed care plans, and consumer groups willing to help improve the quality of care for persons with chronic conditions.

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To the Editor:

One point made by Michelle Mello and Troyen Brennan (Sep/Oct 01) deserves more emphasis. They write that “a handful of prominent oncology researchers” provided “enthusiastic and aggressive support” for the patients who sued to obtain coverage for autologous bone marrow transplantation (ABMT) in breast cancer, including strong testimony in court. These researchers, in fact, were willing to offer conclusions in legal testimony that they would not have given to their colleagues or to an institutional review board.

For example, in 1991 William Peters testified in a federal court in Maryland that women with early Stage IV breast cancer who obtained a complete response following induction chemotherapy and ABMT would experience a 5 percent improvement in disease-free survival after five years of follow-up.1 One year earlier Peters was much more cautious, writing that ABMT for the same patients “may translate into improved overall outcomes [but] further follow-up of this patient population will be required.”2 Of course, follow-up of the definitive clinical trials failed to identify any benefit at all for ABMT over conventional treatment.

Other researchers rushed to oppose their more circumspect peers in court. In 1990 Marc Lippman authored a widely circulated but unpublished monograph, described by a court in 1992 as the “dream team” publication on ABMT.3 In it he concluded that in high-risk primary disease, ABMT was “superior to alternative currently available therapies.” Lippman agreed to testify to that conclusion on behalf of plaintiffs all over the country.

Now, as Mello and Brennan report, Lippman has decided that ABMT for all breast cancer diagnoses “has been proved to be ineffective and should be abandoned.”

The effect that the early, unsubstantiated claims had on otherwise thoughtful judges cannot be underestimated. The courts traditionally evaluate testimony based on the credibility of the witness who offers it; judges and juries are less able to make an objective assessment of the scientific evidence itself.4 As the history of ABMT for breast cancer demonstrates, the physicians who are most deeply invested in a particular treatment and are most willing to offer the most extreme conclusions are also the witnesses best equipped to manipulate the system for their own personal ends.

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