Social Insurance For Children?

Robert H. Binstock

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Letters

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Health Spending Differentials

In an issue devoted to child health (Sep/Oct 04), it is not surprising that authors use demographic categories to discuss their subjects. The fate of pediatric research within a single, complex institution like the National Institutes of Health (NIH) is a coherent topic, one that Daniel Gitterman and colleagues competently describe. From their paper we now know much more about the allocation of funding among the NIH’s many institutes. We also know that the great NIH funding boon of 1998–2002 lifted all boats, including pediatrics. Knowing this, however, does not mean that we understand why pediatric financing was comparably lifted or what it means for the future. Understanding this would require case studies that the authors may understand but do not convey here. Instead, they concentrate on description and caution about how to interpret the numbers. Here they have made an important contribution. Programs “for” groups may be less important than programs that affect many groups. For instance, the doubling of the NIH budget is far more important to the fate of children’s research than any particular budget allocation over the past twenty years. The question remains whether the recent cornucopia for pediatrics and other institutes should continue (even if it can or will be), given other claims on public funding.

The paper by Susmita Pati and colleagues is longer on description than on explanation or evaluation. Its main claim is not surprising to those who pay attention to public finance and governmental institutions: In recessions, welfare programs affecting children do not fare as well as federal social insurance programs like Medicare and Social Security; the elderly therefore fare better. It is not clear whether the authors knew this beforehand.

The paper harbors a tone of discovery that may reflect its authors’ composition—mainly medical researchers (in contrast to the NIH study, where Gitterman is an expert on politics and health policy). Earnestness, however, does not compensate for failing to understand major public programs. The reasons for what they found lie in the origins and structures of the programs they mention. Federal social insurance programs are by design buffered from business cycles; state welfare programs are not. Pointing out distributional consequences is a first step in a much longer process of evaluating whether those results are to be regretted or celebrated.

Ted Marmor
Yale University
New Haven, Connecticut

Social Insurance For Children?

The old-age welfare state that we incrementally created from the mid-1930s to the mid-1970s—largely in response to market failures—has been the major exception to our abhorrence of government intervention for social protection.1 As child health advocates would attest, the market has also failed millions of children with respect to adequate health care and other developmental and social supports. Perhaps the most effective remedial strategy, as implied by Pati and colleagues (Sep/Oct 04), would be to emulate the old-age welfare state by creating a social insurance health program for children rather than pitting generations against each other.

Robert H. Binstock
Case Western Reserve University
Cleveland, Ohio
Spending Differentials: The Authors Respond

Hugh Heclo once offered an insightful warning: “A politics of young versus old would reinforce an already strong tendency in America to define social welfare solely in terms of a competitive struggle for scarce resources and to ignore the shared needs occurring in everyone’s life cycle.” We approached our analysis with this in mind. We avoided framing NIH appropriations in terms of competition for scarce research dollars. Instead, we asked: Did a rising tide lift all boats? Although the data show that pediatric research enjoyed a share of the benefits of the “doubling period,” the proportion of the NIH budget devoted to pediatric research declined slightly.

Ted Marmor’s thoughtful comments push us to address key questions: Why did pediatric funding increase as it did during the funding boom, and what are the implications for the future? The “equal” growth rates may reflect a period of economic growth and a federal budget surplus. Perhaps pediatric spending increased in part because Congress recognized the funding disparity. Biomedical research interest in genetics and fetal development may have highlighted the importance of pediatric research. Marmor points to the need to get inside the NIH black box and pursue case studies to understand the internal allocation of dollars. In resource allocation, many factors must be weighed in deciding how the NIH will spend its money. The selection of research areas to be funded remains the NIH’s responsibility, based on a system of investigator-initiated projects selected through peer view. The NIH now collects data and reports annually on the status of the pediatric research portfolio. We need to probe further. And we challenge the NIH—in an era of limited increases in discretionary spending—to think collaboratively about how investments in pediatric research can influence health and human development across the life cycle.

Daniel P. Gitterman for the authors
University of North Carolina
Chapel Hill, North Carolina

Generational Spending: The Authors Respond

We agree with Marmor that these results are the first step in contributing to an informed evaluation of the distributional consequences of current public spending programs. Our work was an extension of a study of how programs benefiting children did not fare as well as programs benefiting elders during the recessions from 1965 to 1985. Given that the structures of the programs in question have not changed, we were not entirely surprised that this pattern continued through 2000. It is surprising, however, that despite more than forty years of disparities in public spending, most Americans are unaware that there is an eightfold difference in health care spending on children and elders and that there is clear and widespread support for a government role in ensuring adequate health care for both groups. A reevaluation of the government programs that produced these differences may be necessary to guarantee coverage for children, eight million of whom are now uninsured. These steps also should be taken to provide the level of preventive care needed to control childhood problems such as the obesity epidemic and adolescent tobacco use. Both problems have grave consequences for the future health care costs and the well-being of the U.S. labor force.

Susmita Pati for the authors
Children’s Hospital of Philadelphia
and University of Pennsylvania
School of Medicine
Philadelphia, Pennsylvania

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CareFirst Conversion
James Robinson (July/Aug 04) summarizes nicely the CareFirst story and presents a conceptual framework of four options to prevent nonprofit “mission drift.” Regarding the first option he presents—conversion with transfer of assets to a foundation—he does not discuss the Maryland Insurance Administration’s finding that conversion foundations have a limited ability to make systematic changes and improvements in access to health care. Maryland policymakers apparently recognized this finding. As for the first option and a second one—conversion with transfer of assets to the public treasury—Robinson sees a “national tide of public opinion” against them, “absent serious financial threats to the insurer.” Recent efforts by politicians in New York and New Jersey to bring about more conversions to address state budget problems suggest otherwise. Politicians’ greed may be the most serious threat to the preservation of nonprofit health insurance, which has served this country well since the Great Depression. Executive greed can be avoided if state conversion statutes have well-defined bans on private inurement.

The CareFirst story should provide a strong message to all nonprofit organizations about where government intervention can lead absent good governance. In fact, demands for greater public accountability and transparency in governance are emerging from many sources, not just individual states. My organization is developing best-practice guidelines for governance of nonprofit health care organizations to help meet these demands.

Bruce McPherson
Alliance for Advancing Nonprofit Healthcare
Washington, D.C.

For-Profit Accountability
Robinson makes comprehensible the labyrinthine political fights that surrounded the attempt by WellPoint to purchase CareFirst. He gives appropriate credit to the management of CareFirst for turning the failing Blues plans around while also noting how they totally misread the temper of the Maryland legislature. He rightly notes that what looked like “a victory of people over profits” in Maryland looked to regulators in Delaware and the District of Columbia as a rejection of “a conversion that would have generated millions of dollars for health-related projects” while “forcing the firm to subsidize unprofitable products in Maryland with surpluses earned elsewhere.” The heart of the issue, as Robinson notes, is whether nonprofit health plans have an obligation to be more socially accountable than their for-profit competitors. We have all seen the bumper stickers that read “Health Care Is Not a Business; Health Care Is a Right!” That may be a nice sentiment, but it does not describe today’s U.S. health care system. Health plans, whether nonprofit or for-profit, are highly competitive businesses. All businesses have an obligation to be both socially accountable and financially sound, and many for-profit health plans do much more for their communities than competing nonprofit plans do. The “nonprofit/for-profit” distinction is a red herring. We need well-managed, community-minded institutions that treat policyholders and providers fairly, regardless of their corporate form.

Lawrence H. Mirel
Government of the District of Columbia
Washington, D.C.

Disclosure Of Errors
Carol Liebman and Chris Stern Hyman (July/Aug 04) highlight a valid bioethical concern associated with medical errors. We have presented a no-fault model in which disclosure of adverse events to patients is an integral part of accreditation standards.1 We agree that open disclosures by health care providers should lead to trusting and satisfying relation-
ships with their patients. However, we won-
der about the feasibility of full disclosure in
the context of prevailing health care culture
tort laws. The authors recognize that some
professionals run the risk of having an apology
be construed as evidence of liability. In such a
setting, it is doubtful whether any provider
would cede the right of self-protection with-
out appropriate laws to address the issue. Un-
less cultural changes accommodating honest
disclosure are made, the results will be meager.
We must develop a culture that recognizes that
an apology does not necessarily mean admis-
sion of guilt. This is essential in view of com-
ensation claims that are made solely for mone-
tary reasons. Should we make these claims
easier? Another consideration could be a policy
adopted by England's National Health Service
(NHS) that proposes compensation for affected
patients in return for waiving their right to sue.2

Pennsylvania's laudable efforts to mandate
disclosure of adverse events and errors need to
be complemented by other legal and regula-
tory measures to encourage providers to dis-
lose adverse events and errors to their pa-
tients. In a review of disclosure policies across
Canada, we found that error disclosure is not a
standard of practice and has not been mand-
ated. Few provincial or federal policies are in
place. The model proposed by the authors
along with a no-fault approach is a sound be-
ingin the implementation of system-
oriented error disclosure policies that are es-
sential in the practice of error management.

Jawahar Kalra, K. Lorne Massey, and
Amith Mulla
University of Saskatchewan and Royal
University Hospital (Saskatoon)

NOTES

Nurses' Working Hours

Ann Rogers and colleagues (July/Aug 04)
provide clear evidence that nurse overtime is a
threat to patient safety. Awareness of this
threat has prompted professional nursing or-
ganizations to lobby federal and state govern-
ments to enact curbs on mandatory overtime
and require disclosure of nurse-to-patient
staffing ratios. The authors note that “the like-
lihood of making an error increased with lon-
ger work hours and was three times higher
when nurses worked shifts lasting...12.5 hours
or more.” The risk of error was statistically sig-
nificant when the shift exceeded 12.5 hours.
They also emphasized that when nurses were
scheduled to work longer shifts, there was no
significant increase in errors, presumably be-
cause these nurses were prepared to work
those hours. Despite these findings, the au-
thors chose to conclude that the routine use of
twelve-hour shifts should be curtailed, argu-
ing that overtime practices would result in
nurses’ working more than 12.5 hours.

This conclusion is flawed. Nurses’ work
schedules should not be based on the expecta-
tion that unscheduled overtime will drive
them past the window of safety. Rather, sched-
ules should be based on principles that ensure
adequate staff with the appropriate skills to
meet patients' needs. Then no one would have
to work unscheduled overtime, and every
nurse could safely provide patient care.

Lolita B. Compas
New York State Nurses Association
Latham, New York

Nurses' Working Hours: The
Authors Respond

We wholeheartedly agree that hospitals
must ensure that there are enough registered
nurses with the appropriate skills to meet pa-
tients’ needs. However, having a sufficient
number of staff is not enough, if nurses are
working long hours or overtime to cover staff
vacancies. Further, the suggestion that nurses
who were scheduled to work longer shifts did
not have a significant increase in errors is in-
correct. Nurses who work overtime, whether
scheduled or unscheduled, are at a higher risk of making errors. Likewise, nurses working more than twelve consecutive hours per day or more than forty hours per week also are more likely to make errors. In fact, extended shifts (twelve hours or more) are not recommended in occupations where staffing shortages occur, when there are large numbers of single parents in the workforce, when workers spend the majority of the work shift on their feet, and where there is the potential for exposure to hazardous materials such as chemotherapeutic and anesthesia agents—all of which characterize the nursing profession. This is congruent with the recommendations of a recent Institute of Medicine report.

Both reduced staff nurse work hours and adequate numbers of staff nurses are necessary to ensure patient safety.

Ann E. Rogers for the authors
University of Pennsylvania
Philadelphia, Pennsylvania

NOTES

Views Of Public Health

The ecologic theory of health extends the writ of the public health profession so far and wide that war has now been declared to be a health issue for the nation’s public health professionals. Lawrence Gostin and colleagues (July/Aug 04) know that the broad view of public health has engendered controversy, so they try to “address, head-on, the major critiques posed by scholars and politicians who prefer a narrow scope for public health action.” They did not succeed. The broad view of public health has created a boundless profession that is viewed as excessively concerned with social justice, politically correct to the extreme, and exclusively identified with the political left. The unsurprising result is that the public health profession is widely distrusted by elected officials and legislators.

Scholars who have criticized the broad view of public health include Sally Satel, Mark Rothstein, Richard Epstein, and Mark Hall.

The concerns of these scholars and others cannot be swept away by characterizing the ecologic theory of public health as based on “scientific research.” The same authors who claim that science supports the ecologic theory make the excuse that taking the time to do good science and establish the causal pathways between poverty and health “would indefinitely delay policies that could powerfully affect people’s health and longevity.” So we see that the broad view is more about social justice than science.

Gostin might reread his 2001 article in which he astutely observed, “The problem with an expansive view is that public health... becomes limitless, as almost everything human beings undertake affects public health... To many, this all inclusive notion of public health is counterproductive.”

Jason W. Mann
Doctoral student, University of Pittsburgh
Pittsburgh, Pennsylvania

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Public Health: The Authors Respond

In our paper we examine emerging evidence that physical, social, and economic determinants profoundly affect the population’s health. We do not perceive this as a “social justice” agenda. Public health officials have the responsibility to devise science-based policies to ameliorate health threats to the population.1 By stressing the health effects of the built environment and socioeconomic disparities, agencies are providing an essential public service. Should public health officials ignore scientific findings because of the political ramifications? We think not. Many critiques of the ecological approach to public health contest the strength of the science. For example, critics may concede the accuracy of data showing a strong, persistent association between health and socioeconomic status but argue that the precise causal pathways are unknown. Certainly, public health should seek to understand the causal relationships better but should not be expected to meet higher standards than those in medicine or other scientific pursuits.

It is important to remember that debate over the legitimate scope of public health is in part political. Critics of public health are not neutral purveyors of science but hold their own biases.2 Their embrace of the “old” public health and antipathy to modern interventions are designed to prevent certain social changes. One of us did caution against a limitless scope for public health, but not as a way to impede or delay essential policies that have a good prospect of improving the public’s health.

Lawrence O. Gostin for the authors
Georgetown University
Washington, D.C.

NOTES

Reducing Drug Prices

Much should be done to deal with the ills of the drug industry, from both a regulatory and a business perspective. But the proposal by Peter Stein and Ernst Valery (July/Aug 04) to “genericize” part or all of the drug industry misreads the source of the current difficulties and how to cure them. The authors posit that the drug industry is dominated by parallel noncompeting firms on the manufacturing and marketing sides. However true this may be for the retail pharmacy business, it overlooks the intense competition that occurs when mass purchasers such as health maintenance organizations (HMOs) aggressively play off one producer against another. The high rates of return on drugs are needed to compensate investors for high business and regulatory risks—of which the proposal to introduce state-subsidized competition surely counts as one. Right now, free entry into the research end of the business takes place, often by smaller firms. Do Stein and Valery think that no one would go after any huge unearned rents? Or that small firms would be unaffected by the state subsidies?

Next, the authors point to the financial and insurance difficulties that plague the drug market, but these apply to all health care spending. Family medical spending tends to spike for serious illnesses; insurance copayments tend to produce excessive health care spending. But in light of the massive inefficiencies of centralized planning, attacking these issues hardly calls for the nationalization of health care. The authors’ scheme for national funding of royalty-free patented products commendably aims to price drugs at their marginal cost. But it is subject to the standard objections to marginal cost pricing generally. The new taxes produce dislocations in other sectors, and public decisionmakers, even if insulated from political pressure, get insufficient feedback to learn whether nonpatented drugs produce social benefits in excess of their full discovery cost. The injection of new subsidies raises research and development (R&D) risk by forcing patent race winners to compete with subsidized products. It would be better...
to look elsewhere for improvements, starting by simplifying clinical tests, reducing product liability and class-action suits, and offering more freedom of contract in insurance markets.

Richard A. Epstein
University of Chicago
Chicago, Illinois

Drug Prices: The Authors Respond

Richard Epstein’s picture of intense competition between producers for an HMO’s business may describe the marketplace environment of mature drugs and their “me-too” followers. But it has little in common with the marketplace of new breakthrough drugs—the goal of the public program we propose—in which patent protection deprives HMOs of me-too competitors for many years. As we point out, unearned rents generated by patents do spark much competition by R&D sectors of established and new firms. However, the most socially beneficial R&D competition seeks new unearned rent from breakthrough drugs rather than from shares of an existing breakthrough drug’s rent. Although all but one of the factors we cite as the source of high drug prices are shared by other health sectors, only the drug marketplace is dominated by patent protection. It is the addition of patents to the mix that drives the rise of drug prices. “Nationalization” seems an inaccurate sobriquet for a program that just allows publicly funded R&D to enter competition for drug patents with private-sector firms. That competition protects against the “inefficiencies of central planning” by providing a built-in evaluation: the quantity and quality of resulting patents. Any new tax produces some marginal market distortion. It is hard to believe, however, that our proposed uniform tax of two dollars per prescription could seriously distort the drug marketplace or that the number of prescriptions filled would not provide a significant measurement of social benefit. Our proposal would discourage private R&D aimed at conditions treatable by publicly licensed drugs, such as “me-too” copies, but this would be a social benefit, not a social cost.

Peter Stein and Ernst Valery
Cornell University
Ithaca, New York

Measuring Diabetes Management

We have argued that results of disease management (DM) interventions must be based on credible methods and inferences.1 The claim of Victor Villagra and Tamim Ahmed (July/Aug 04) that the decreases in the cost and use of CIGNA members with diabetes were attributable to DM are not supported by the evidence. In the pre-post study, the stratification of members in the program for ten months and less than ten months both resulted in decreases of cost and use. However, decreases are typically seen in these measures shortly after the claims-based event that identified the patient(s). This short-term drop in costs and use in as little as two months of exposure to DM would not likely be attributable to the program, even if the entire defined population were selected. Similar decreases are reported in the “parallel group” study. Unfortunately, no information is presented to suggest that the intervention and reference groups were equivalent at baseline. Reported differences could be due to regional variations in treatment patterns, dissimilarity in case-mix, or other reasons.2

The addition of a few meaningful tables would improve the inferences made in the paper. First, we suggest presenting results from the “all” group in the pre-post study stratified by program tenure (2–8 months). Second, a table showing the baseline differences/similarities in demographics, Health Plan Employer Data and Information Set (HEDIS) scores, claims costs, and utilization, as well as rates of self-referral, provider referral, and “false positives” in both the intervention and reference groups, would be useful.

Thomas Wilson
Wilson Research
Loveland, Ohio

Ariel Linden
Linden Consulting Group
Hillsboro, Oregon
NOTES

Lowering Diabetes Costs

Villagra and Ahmed report a prompt 5 percent decline in health care costs after implementing a diabetes disease management program (DDMP) in a large network-model health plan. A larger difference (22 percent) was observed when post-implementation costs were compared with those of patients from sites without a DDMP. We have several concerns about these findings. What proportion of intervention-group patients were referred versus identified from claims data? Referred patients may be more adherent to DDMP recommendations (selection bias), and also more likely to be high users who regress toward the mean in coming years. In the pre-post comparison, 11,000 more people appear in the post-intervention year. Who are they? Newly diagnosed patients? Patients not identified until year two because they had fewer claims? In either case, they bias toward finding lower year-two costs. We focus on “all participants” because full participants (program completers) are a selected subset who can’t be identified in advance. It is unclear, however, what proportion of all diabetic patients are included in the “all participants” analysis. The authors state that this group includes program completers and those who participated for at least a month. Were there no patients who refused to participate or dropped out before one month? One way to check the completeness of patient identification is to estimate the prevalence of diabetes from the identified patients. If prevalence is unexpectedly low, we must again suspect selection biases.

In light of the large discrepancy in effect size between pre-post and cross-sectional analyses, it is puzzling that the authors separated these two analyses. If intervention-site patients did regress toward the mean or if patients added in year two were predominantly lower users, we would expect comparison groups drawn from a single year to have higher use. A standard quasi-experimental approach would compare the pre-post experience of the intervention and comparison groups. It is unclear how program costs were calculated or prorated or if charges for the program actually covered true program costs. Without all of this information, we are unable to determine whether dollars were indeed saved, how they were saved, or for whom.

Joe V. Selby for the TRIAD Study
Kaiser Permanente Northern California
Oakland, California

K.M. Venkat Narayan
Centers for Disease Control and Prevention
Atlanta, Georgia

Diabetes Management: The Authors Respond

Thomas Wilson and Ariel Linden raise potential regression to the mean (RTM) concerns, which we acknowledge. Joe Selby and K.M. Venkat Narayan ask about patient selection in year two and its possible effect on results. The 11,000 new participants in year two represent plan membership growth, new DDMP accounts, and new diabetic members. Note that the pre-post analysis consisted of two cross-sections with most patients overlapping. Any bias occurring under these conditions would be in the opposite direction to that suggested by Selby and Narayan, because patients missed in year one (low claims) become “visible” (higher claim) to the query logic in year two. This approach, plus the inclusion of all risk patients, tends to blunt RTM.

The program did not separately track referral sources. The overall “non-claims” patient recruitment between 1998 and 2001 was 3.3 percent. The net direction of referred patients’ behavior was unpredictable—some entered...
the program poorly motivated, while others showed high motivation for self-care. This, together with their small numbers, would have had a negligible effect on results. Space limitations precluded exhibits showing the baseline attributes of intervention-control pairs. For more information, see www.healthandtechnologyvector.com/pubs. Pair assembly from within the same company—matched temporally and by geographic proximity; using identical patient selection criteria; operating under uniform national contracts for pharmacy, labs, and home health; using uniform case and utilization management policies and similar benefit designs and provider contracts—offers nearly ideal conditions for establishing equivalency outside of randomized trials.

Because the word “prevalence” has precise connotations to epidemiologists, we deliberately avoided using it when referring to “all participants.” The term “all participants” refers to a subset of members who meet strict criteria that emphasize true positives over high sensitivity. This approach necessarily underrecognizes patients with diabetes, but this does not make the method inappropriate.

Victor G. Villagra
Health and Technology Vector Inc.
Farmington, Connecticut

Tamim Ahmed
CIGNA HealthCare
Bloomfield, Connecticut

Long-Term Care Choices

Deborah Stone’s dissection (July/Aug 04) of the myth of the economic man when it comes to long-term care is dead on. I am going through a similar process with my parents—both frail and in their mid-eighties—attempting to persuade them to move to a more appropriate setting. We cannot convince them to make the “best” choice (to the children) and enter assisted living. But we will settle for a single-story apartment over their huge house with its curving staircase, an invitation to fracture a hip. The process has gone on for two years; we are gradually moving from flat refusal to planning for a change. Issues of autonomy, as Stone notes, are a strong part of their resistance, as are fear of the unknown and of outliving their money. In early 2004 I met with a roomful of congressional aides, none over thirty years old, who were adamantly opposed to any federally supported services aimed at keeping frail elders in the community. They feared the “workwood” effect: If money were available, all of these geezers would dash out to get services. When I suggested that the problem was more that elders refuse to seek services they need, I got condescending looks. I hope that these kids read Stone’s story and begin to reassess the “view of care as an undisputed economic good.”

Janice C. Probst
University of South Carolina
Columbia, South Carolina

Don’t Blame The Physicians

I read with interest Paul Roache’s letter and Hoangmai Pham’s response (July/Aug 04). Roache noted that physician fees are a modest part of health care spending, but Pham refuted this, saying they are a quarter of all spending. There is a definition problem here, however. Roache is correct that doctors’ take-home income is a modest part of U.S. health spending. “Physician fees” include overhead expenses, income for employed medical and nonmedical staff, supplies, rent, and so on. Physicians do not take home a quarter of all spending as income. They are middlepersons for a vast array of expenses, many imposed by the insurance industry and government. The target-income hypothesis views physicians as economic agents protective of their desired income. When the price of a service falls, the physician will increase volume to maintain total income. A macro-budgetary consequence of this, however, is that volume may beget volume so that total spending increases. As a physician works for one more dollar, several more are spent elsewhere in the health economy.

Is the solution to pay physicians more so that they spend less time in the office? Given
that patients are demanding services and products and in some areas wait weeks to see specialists, this may not have the desired effect. Nonetheless, it may return to medicine some of the extras that seem so desired and are increasingly rare in general practice. A physician who hits a target income level can return phone calls, coordinate complex care, spend time on research and education, take steps to reduce utilization, refill prescriptions, and fill out forms without charging for such services. This is the doctor most Americans wish they had and would not cost as much as some would lead the public to believe. For example, incomes of $200,000 would likely be sufficient to incur desirable ends from full-time physicians and prevent doctors from seeking extracurricular activities to garner more income. This would cost $120 billion, less than one-tenth of all health spending.

Evan Fieldston  
Children’s Hospital of Philadelphia  
Philadelphia, Pennsylvania

Physicians: The Authors Respond

We agree with Evan Fieldston that the definition we used for spending on physician services includes more than physicians’ take-home pay. However, as a measure of their gross revenues, this is no more misleading than how Bradley Strunk and Paul Ginsburg defined spending in other sectors (for instance, hospital spending would measure gross hospital revenues, not profits).1

Fieldston asks whether compensating for recent real income declines or, more generously, providing “target incomes” for physicians would provide them with the lifestyles sufficient to remove incentives for their entrepreneurial activities. We believe that this theory is overly optimistic. First, physicians’ expectations are not homogeneous. An income of $200,000 may be attractive to some primary care physicians but would seem a step down for most cardiothoracic surgeons. Second, absent regulation or modified reimbursements for overpaid services, we are skeptical that income incentives alone would be sufficient to “put the genie back in the bottle” in terms of ancillary services or specialty facilities. To the degree that physicians act based on target incomes, perhaps the long-term policy objective should be to gradually adjust their expectations through the rational prioritization of payment levels for different services. More generally, we agree that payment systems do not now adequately compensate for many activities and services that physicians, particularly in primary care, would like to be able to provide. To the degree that fee-for-service structures limit our ability to appropriately pay for these activities, policymakers might consider special care management fees to promote care coordination, paying by episodes of care, or even an improved form of capitation.

Hoangmai H. Pham for the authors  
Center for Studying Health System Change  
Washington, D.C.

NOTE

Health Spending By Age

The findings of Ellen Meara and colleagues (Jul/Aug 04) on historical trends in health spending by age are a valuable addition to the limited body of research on this important topic. However, the authors’ assertion that the cost of the Medicare drug benefit is understated relies on the incorrect impression that Medicare drug spending is assumed to grow at the same rate as other Medicare-covered services. The Congressional Budget Office (CBO) and the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary both used the per capita prescription drug spending growth rate in the national health expenditures projections for their cost estimates, whose average annual growth rate is 4.3 percentage points higher than Medicare-covered services from 2003 to 2013.1

Also, this paper would benefit from more
analysis in two critical areas. First, the authors do not state if their finding that cost growth of the nonelderly was above that for the elderly is expected to be temporary or permanent. Second, they do not discuss the impact of high per capita spending levels for hospital and nursing home care of the elderly. The average person age sixty-five and older spends much more on hospital and nursing home care than on prescription drugs. These differences are even greater for people age eighty-five and older.\textsuperscript{2} With the population of the elderly anticipated to grow so much faster than the nonelderly over the next several decades, these high spending levels will have a much greater aggregate impact on Medicare, Medicaid, and elderly households than drug spending will.

Sean Keehan  
Centers for Medicare and Medicaid Services Office of the Actuary  
Baltimore, Maryland

NOTES


2. Estimates and analysis from our study of health estimates by age, including per capita spending of people age eighty-five and older, are at cms.hhs.gov/statistics/nhe/age (17 September 2004).

\textbf{Health Spending: The Authors Respond}

Most of the issues Sean Keehan raises have to do with how fast costs by category will rise. We agree that this is the appropriate focus; we hope that our results provide a basis for understanding these trends. Since we wrote our paper, the CBO has released \textit{A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit}, which clarifies the assumptions used in the CBO's projections. Our main point remains: Projections of drug spending under the new Medicare benefit assume decelerating growth over the coming decade, while historical trends show accelerating growth. Our intent was to illustrate the difference between projections and spending growth that would result if the rapid growth of drug spending among the elderly continues.

Ellen Meara for the authors  
Harvard University  
Cambridge, Massachusetts

\textbf{Erratum}

“Health Benefits In 2004: Four Years Of Double-Digit Premium Increases Take Their Toll On Coverage,” by Jon Gabel and colleagues (Sep/Oct 2004) contains two errors. The third sentence of the abstract should read, “Since 2000, premiums have risen 59 percent. Since 2001, employee contributions have grown by 57 percent for single coverage and 49 percent for family coverage...”; all other references to 2001 in the abstract are correct.

In the paragraph below the subheading “Outlook For The Future,” the second sentence should read, “Since 2000, premiums have risen 59 percent. Since 2001, employee contributions for single coverage have risen 57 percent, and contributions for family coverage have risen 49 percent.” All remaining references to 2001 in this paragraph are correct.