Letters

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Specialty Hospitals: Pro And Kahn

On behalf of the American Surgical Hospital Association (ASHA), I am writing about the papers on specialty hospitals (Jan/Feb 06). Many of them dealt fairly with current issues about specialty hospitals and their role in delivering health care. I believe, however, that the journal fell short in its scholarly obligation—and misled many readers—by presenting a Perspective about research findings on physician-owned specialty facilities only by Charles Kahn, executive director of the Federation of American Hospitals (FAH). The FAH has spent years trying to persuade Congress to legislate specialty hospitals out of business. Although Kahn and the FAH are entitled to their opinions, his bias should not have been allowed to stand alone in these pages. We are disappointed that Health Affairs did not also invite the ASHA (or some other representative of specialty hospitals) to present its views.

I would challenge Kahn, for instance, to substantiate his claim that “unfair competition” posed by specialty hospitals has harmed general hospitals. On 7 November 2005 Modern Healthcare reported that the hospital industry’s profits “rose to an all-time record and its net profit margin hit a six-year high.” This was followed, on 3 January 2006, by USA Today reporting that the hospital industry is “in the middle of the biggest hospital-construction boom” in more than fifty years.

Opponents of physician-owned specialty hospitals often engage in personal invective because they have no other argument to make. Instead, the debate should concern fact, and it should focus on how our patients and communities can best be served. Competition and innovation have served this country well, and they should be allowed to continue as we all search for improved care and access at the lowest cost. It is regrettable that the otherwise excellent discussion of specialty hospitals did not provide a response to Kahn’s unsubstantiated arguments.

James Grant
American Surgical Hospital Association
Sioux Falls, South Dakota

Specialty Hospitals: The Author Responds

James Grant’s accusation that discussions opposing physician-owned specialty hospitals often contain “personal invective” (by which I assume he means mine) is untrue and inflammatory. My commentary in this journal focused on facts that are well documented.

Grant might benefit from reflecting on the paper’s clear sympathy for physicians and its sentiment that payment policies must do a better job of responding to their legitimate concerns about payment and more properly valuing their services.

When Grant asserts that all is well with community general hospitals, he is missing the signals from the marketplace. Overall margins might have improved somewhat, yet Medicare margins have deteriorated dramatically and are now negative.1 The same cannot be said about Medicare margins for specialty hospitals, which much evidence shows target patients in profitable service lines who are less ill. Further, Medicaid margins have been mired in negative territory for most of the program’s history—although I would excuse Grant for not knowing this, as specialty hospitals rarely treat Medicaid or uninsured patients. As to the building boom Grant cites, isn’t it ironic, as

James Kahn
Robert Berenson notes, that “purchasers generally believe specialty hospitals are contributing to a medical arms race that is driving up costs without demonstrating clear quality advantages.” I don’t believe that this is the “competition and innovation”—the banner under which Grant would parade specialty hospitals—that the health care system needs or wants.

Charles N. Kahn III
Federation of American Hospitals
Washington, D.C.

Examining Hospital Costs
For someone who spends as much time in airplanes as Stuart Altman does, his nostalgia for the legacy U.S. air carriers (Jan/Feb 06) is puzzling. Most frequent fliers will not mourn these failed enterprises that treated their passengers like cattle and their workers with unbridled contempt. The legacy airlines were not destroyed by point-to-point carriers or by deregulation, but by arrogant, inept, and shortsighted managements and unions that failed to change with the times and produce a product that people were willing to buy.

Altman and colleagues’ analysis of the contemporary hospital raises a lot of questions. One of the most important: Do hospital costs just rise like global temperatures, or do management choices and discipline have some constructive influence on cost? To argue, as the authors do, against price transparency for hospitals is hard to defend in today’s cost climate. Of the $571 billion spent on hospital care in 2004, 3.3 percent ($18.6 billion) was actually paid by the end user; the remainder was “reimbursed” by third parties. Hospital consolidation, a collapse of antitrust enforcement, and a deferential political system have effectively neutered third-party purchasing power.

After one reads Altman’s paper, it is not clear what he and his colleagues are advocating: tightening certificate-of-need regulation, returning to cost-based payment, outlawing high-deductible plans, not disclosing hospital costs to consumers, or building tall fences either to prevent physicians from leaving the hospital campus or to keep people from leaving the country to get less expensive care?

It is obvious what we need to do, isn’t it? We need to plug the yawning gap in our health care financing system. Let’s get on with it. Altman’s yearning for a return to 1970s paternalism and protectionism in health policy is a sad reminder that old regulators never die; they just wait for the next administration.

Jeff Goldsmith
Health Futures Inc.
Charlottesville, Virginia

Examining Hospital Costs: The Authors Respond
Oh, Jeff, there you go again! A careful reading of our paper would demonstrate that we neither opposed price transparency nor advocated regulation. The crux of our paper was a warning: Hospitals can’t be expected to provide free care to the uninsured plus treat Medicaid and Medicare patients for less than cost and still compete with those that only skim the cream. Easy to simply say, “Plug the gap in our financing system,” while safety-net hospitals struggle to stay alive.

We did not support any particular solution; instead, we warned that “until the political system is willing to level the playing field by explicitly paying for under- and unfunded services, market changes such as price transparency and specialization, although beneficial in their own right, could have severe negative consequences” (emphasis added).

This was not a call to return to “paternal-
ism or protectionism,” but a concerned prediction. Such predictions are risky, as Jeff Goldsmith knows well. After all, he erroneously predicted the demise of the American hospital in 1981, and, when we predicted a boom in hospital construction in 2004, he wrote that we “gave in to the temptation to tell people what they want to hear.”1 He should visit any hospital today and tell us if there isn’t a building crane in the parking lot.

Undaunted, Goldsmith instructs us “old regulators” that “it is obvious what we need to do.” Perhaps what we need from Goldsmith is a bit more humility. Otherwise, the “arrogant, inept, and shortsighted” airlines might not serve him steak in first class.

Stuart H. Altman for the authors
Brandeis University
Waltham, Massachusetts

NOTE

Nurse Staffing And Quality
The research on increasing the number of registered nurses presented by Jack Needleman and his colleagues (Jan/Feb 06) raises a provocative question—is there a business case for quality?—but doesn’t really come through with a useful answer.

The authors’ work appears to be sound at a macro level, but the results are not helpful for a chief executive officer and other decision-makers at the micro level of a given health care system. Why? Because context is everything. Differences among hospitals are critical contextual factors that make it almost certain that a one-size-fits-all staffing policy will fail.

Instead of relying on data from the 799 acute general care hospitals reported on in the paper, health care systems need to find what actually works in their respective organizations by conducting system-specific research. This research should account for their unique business model, capital spending, case-mix, labor market(s), staffing profiles, tenure, demographics, and so on.

Our firm’s micro research does, indeed, reinforce the thrust of the aggregated study, but it also points to major differences among hospitals—even within the same system. For example, one major health care system was cutting productivity by 3 percent (ten of millions of dollars a year) by cutting staff overall. Yet a few hospitals within the system were doing well, while many others were in deep trouble. At another system, adding registered nurses improved measures for both quality of care and financials generally across the board.

Only with this kind of system-specific analysis can executives know what the bottom line is on this make-or-break strategic issue.

Dave Kieffer
Mercer Human Resource Consulting
Washington, D.C.

Nurse-To-Patient Ratios
Needleman and colleagues estimate the cost per avoided death associated with increasing nurse staffing. They conclude that there is an “unequivocal business case for hospitals to improve nurse staffing” by “raising the proportion of [registered nurses] without changing licensed hours.” This policy recommendation, along with others in the paper, is not supported by the existing empirical evidence. Unfortunately, no credible studies identify the causal effect of nursing resources on patient outcomes. At best, available research is sufficient to conclude only that there appears to be a negative association between nurse staffing levels and adverse patient outcomes.

To properly assess the value of past research, one first needs to ask, Why do hospitals have different nurse-to-patient ratios? Previous research proceeded as if the answer was that the differences were random. But this position is difficult to justify, even taking account of the adjustments researchers made for patient and hospital characteristics. Researchers are suggesting that two hospitals, which
are identical in all other ways relevant to patient health, have different ratios. The obvious question is, Why?

The likely answer is that these hospitals are not otherwise identical; a variety of factors might differ. Researchers cannot adequately control for severity of patient illness, level of other hospital inputs, nurse and physician quality, and hospital finances. This lack of adequate control will result in biased estimates of the association between nurse staffing levels and patient outcomes. Moreover, most of these studies use crude constructs of nursing resources that are usually hospitalwide; therefore, annual measures are likely to be subject to significant ecological bias. Consequently, there is simply not sufficient evidence to allow policymakers and hospital administrators to make well-informed decisions about the best level of nurse staffing.

Robert Kaestner
University of Illinois, Chicago

Cost Sharing Revisited

Although nominally discussing the initial track record of various consumer-directed health plan models, the paper by Meredith Rosenthal and colleagues (Nov/Dec 05) indirectly points to a more fundamental problem: the underlying lack of comparative cost and quality data needed to improve the entire U.S. health care system. Given research findings about the disappointing quality of care delivered to most Americans in largely conventional health plans and Medicare, it should not be that hard for consumer-directed plans to match—or exceed—the performance of their preferred provider organization (PPO) and health maintenance organization (HMO) competitors.1 The strategy of paying for nearly everything at the insurance level (with little if any cost sharing) also has failed to “signal” the relative quality or comparative cost-effectiveness of the care consumers are to choose among. Should consumer-directed plans be faulted for failing to do much better initially or saluted for making more urgent the importance of developing relevant provider-level data?

The authors’ critique of cost-sharing practices in the freshman class of consumer-directed plans is similarly selective. In fact, the average gap between account funds and deductibles in most first-generation plans offered by large employers was comparable to PPO deductibles in the same markets and market segments. Total out-of-pocket stop-loss levels also appeared to be roughly similar. Perhaps the broader problem is that cost sharing in most plans, not just health reimbursement arrangements (HRAs), has been too small, let alone too crude, to make a big enough difference in spending levels.

One might criticize consumer-directed plans for falling short in controlling the costs of higher-spending consumers or for not protecting them against substantial out-of-pocket costs—but probably not both at the same time.

Tom Miller
Congressional Staffer
Washington, D.C.

NOTE


Cost Sharing: Authors Respond

Consumer-directed health plans have, indeed, done no worse than managed care plans when it comes to providing cost and quality information to consumers. And we certainly agree, as we noted in our paper, that bringing transparency to the health care market is not the sole responsibility of consumer-directed plans. Nonetheless, our goal was to examine whether these plans might provide a vehicle for addressing the shortfalls in affordability.
and quality identified by the Institute of Medicine and many health services researchers. The ability of a consumer-centered rationing model—unlike the supply-side rationing model of managed care—hinges on whether consumers have access to cost and quality information. Tom Miller's question about whether consumer-directed plans should be “saluted for making more urgent the importance of developing relevant provider-level data” ignores the consequences borne by enrollees in high-deductible plans who must muddle through without good decision support.

We acknowledge the presumptuousness of indicting consumer-directed plans on the basis of weak incentives and lack of risk protection for low-income consumers, but this is the reality of rationing by using a deductible. For lower-income enrollees, a deductible of as little as $1,000 (the doughnut hole) might pose a real barrier to seeking needed care. At the same time, since the vast majority of spending is related to high-cost patients, deductibles do little to alter patterns of care that affect how most health care dollars are spent. If cost sharing is to be the principal means of rationing care, as proposed by consumer-directed plans, then it needs to come into play across a broader scope of care-seeking decisions than a deductible permits. Finally, it is possible to both protect against excessive risk and leverage the power of consumer incentives more effectively by using cost sharing that is more sensitive (to both income and value of services) and continuous.

Meredith Rosenthal for the authors
Harvard School of Public Health
Boston, Massachusetts

Managing Consumerism

In his discussion of managed consumerism (Nov/Dec 05), James Robinson juxtaposed consumerism and managed competition philosophies and noted their shared “market paradigm” that medical resources should be allocated on the basis of individual decisions rather than collective decisions. The market-oriented approach, he said, must always put consumers before providers. But his further discussion revealed an antagonism to individual liberty that would thwart even the most sincere attempts to understand contemporary consumer-driven health care.

According to Robinson, consumerism, through demand-side insurance innovations, seeks to use cost sharing where spending is “discretionary” and sensitive to patients’ preferences, while at the same time minimizing cost sharing where it is not. But an all-or-nothing interpretation of consumer discretion conflicts with individual sovereignty in medicine—specifically, with the concept that all acts performed on a person's body require consent, and without it the acts cannot occur. This medical-liberty paradigm undercuts Robinson's interpretation because all spending becomes discretionary and preference-sensitive.

If he intended differentiation by price-elasticity of demand—as suggested in his exhibit categorizing care by consumer demand responses to cost sharing (perceived price)—this is acceptable. But a total denial of consumer discretion that Robinson himself conceded is “difficult to conceptualize” forces a move into dangerous territory, including that in some cases care can be driven by supply systems, or as he put it, “without regard to…patients' preferences.”

It is the spirit of individual liberty—not a cost-sharing nuance—that is the core of consumer-driven health care philosophy. If people don’t understand that point, they’ll never understand the concept.

Trapier K. Michael
Nashville, Tennessee