Letters

We welcome your responses to papers that appear in Health Affairs. We ask you to keep your comments brief (250–300 words, including any endnotes) and sharply focused. Health Affairs reserves the right to edit all letters for clarity, length, and tone and to publish them in the bound copy or on our Web site. Letters can be submitted by e-mail, letters@healthaffairs.org, or the Health Affairs Web site, http://www.healthaffairs.org. It is our policy to invite every author to respond to letters submitted in response to their work.

Medicare And Mental Health Parity

Since Medicare's founding in 1965, mental health care users have not experienced parity. Beneficiaries have paid a 50 percent copayment for Part B outpatient mental health services but 20 percent for physical health care. The Medicare Improvements for Patients and Providers Act of 2008 has addressed this inequity. Incrementally, the mental health copayment will decrease to 20 percent by 2014.

In 2002, about 14.2 percent of Medicare claimants were mental health or substance abuse claimants. Approximately 22 percent of people with serious mental illnesses receive Medicare benefits.

The Medicare outpatient benefit distorts use in ways that are fiscally inefficient and clinically inappropriate. Data show that beneficiaries with mental health needs were more likely to receive inpatient than outpatient care because fewer patient resources were required. Thus, Medicare spent more per user, and had a larger percentage of users who received inpatient care, than did Medicaid. The reverse was true for outpatient care.

Using projections with no offsets, the Congressional Budget Office expects an increase in the costs to Medicare resulting from this change. However, studies have shown that improvements in mental health decrease costs for physical health care. Other cost offsets and improved cost-effectiveness can also be expected as people use more suitable outpatient care.

Some associated moral hazard may occur. This can be addressed by using improved “medical necessity” criteria that permit initial access and ensuing determination of need by qualified providers.

With the advent of national health reform and the medical home model, Medicare will be able to design and finance more effective integrated systems for mental and physical illness, a high need for this population. This letter acknowledges the progress made toward a consistent national policy of mental health care coverage and urgently calls for more research on the effects of Medicare parity.

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Ron Manderscheid
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Rewarding Innovation In Drug Discovery

Arjun Jayadev and Joseph Stiglitz (Jan/Feb 09) suggest two policies to tackle the greatest problem the pharmaceutical industry and regulators face today: how to reward innovation while achieving the maximum social benefit from new medications. Although the two ideas are sensible, they are unlikely to work, given the current state of affairs.

With pay per value, one is left wondering who decides what value is. Should it be policymakers, for whom an improvement of two months in lifespan might be seen as minimal, or patients, who actually might like to have the choice of living a bit longer, even if it's only for a day? As for public funding of clinical trials, we can seldom foresee which candidates will truly be effective drugs, and therefore the drug discovery process may become less and not more competitive, further stifling innovation.

As it relates to the cost of developing new
medications, there is a way for us to have our cake and eat it, too. Drug companies have become too large and have lost their former innovative edge. Their two main activities—drug development and commercialization—should be separated. Here one of Stiglitz’s earlier ideas might come to play a major role.1 A one-time prize to a drug discoverer, with procedures collected through an auction for manufacturing licenses (instead of from a government or private foundation, as he proposed), could be a highly successful—and market-based—way of inducing competition while still rewarding innovation, as the winning bidders would price drugs closer to their marginal cost. Such a process would allow for other companies to share the risk of developing new treatments and their monetary benefits.2

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Patient Choice: Critical For Obtaining Value

A recent Web-Exclusive package (27 January 2009) addressed the question of value in health care. As varied as health can be, we often overlook the main factor that can determine what health care is “worth”: patient choice. Health insurance, well-intentioned as a way of distributing the costs of illness across a larger group who are well, nonetheless inhibits value-based choices. At the same time, insurance—and Medicare—can skew the market into providing some types of services more than others, not because patients are demanding them, but rather because bureaucrats have decided how much a test, treatment, or procedure should be reimbursed.

To reconcile this dilemma, a simple means-based health care currency system is proposed. It would be linked with tax-free, income-adjusted health savings accounts (HSAs), similar to an individual retirement account (IRA), which could accrue tax-free, be used to pay for extended living services later in life, and be given tax-free to one’s heirs. Insurance companies would offer high-deductible, low-premium policies—which would be priced in terms of the “days’ wages” of the national average income. Most important, it would be an intermediary between patients (of diverse means) and providers (both insurance companies and doctors/hospitals)—so that providers would get paid the same amount from each patient, regardless of the patient’s individual means. Providers would not be able to “cherry-pick” the wealthier patients. Patients would pay the intermediary mechanism from their HSA—an absolute amount based on what their own income was—and the intermediary mechanism would pay the insurance company/doctor the national average “days’ wages” price that the provider had set as the price for their service.

With this approach, patients would be able to exert their own choice into the market, driving the supply, value, and innovation of health care services—while making health care equitable, independent of one’s personal financial means.

Randall Walker  
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Infrastructure For A Learning Health Care System: CaBIG

In his proposal for a new cancer care policy in a data-rich future (Jan/Feb 09), Lynn Etheredge correctly notes that the National Cancer Institute (NCI) has built the requisite infrastructure for a learning health care system. Currently, the Cancer Biomedical Informatics Grid (CaBIG) is connecting in a national network not only sixty plus NCI-
designated Cancer Centers, but also NCI community cancer centers, where 85 percent of all cancer patients are treated.

Moreover, CaBIG enables the seamless continuum that is at the heart of a learning health care system in which knowledge of aggregated clinical outcomes drives next-generation research discoveries, which in turn are validated at the bedside for improved clinical outcomes, in a seamless “virtuous cycle.” In addition, CaBIG and the Food and Drug Administration (FDA) have collaborated for electronic coordination of clinical research information. CaBIG has also demonstrated its capacity to exchange information with the emerging Nationwide Health Information Network.

While these efforts to date have been focused on cancer, the NCI is in effect prototyping a twenty-first-century knowledge-based biomedical system. The “BIG” (Biomedical Informatics Grid) in CaBIG serves as a nationwide, interoperable, interconnected information technology platform that enables information sharing. A health care ecosystem then forms—for the first time ever—that electronically links academic centers, care delivery organizations, insurers, diagnostic and pharmaceutical product innovators, government research and care institutions, and all other players in the biomedical enterprise. As data are shared among those previously siloed entities, reunification occurs between the currently divided worlds of clinical care and research. Specifically, the availability of clinical encounter and molecular characterization information permits prequalification of participants and rapid assembly of study populations; research can be conducted without reestablishing duplicative tools and infrastructure; redundancy of research activities is eliminated; real-time monitoring of safety occurs; and the development of new therapeutic inventions can be conducted faster and less expensively with near-term benefit to patients.

This prototype is already under way. We invite all sectors to participate (http://www.bighealthconsortium.org) to carry Etheredge’s bold concept even farther.

Kenneth H. Buetow and John Niederhuber
National Cancer Institute
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CaBIG: The Author Responds

I appreciate the letter from Kenneth Buetow and John Niederhuber and their invitation to all health sectors to join in extending this new Medicare cancer strategy throughout biomedicine. Resources are now available to move ahead quickly and broadly; President Barack Obama and Congress provided $1.1 billion for a national effectiveness initiative as part of the economic stimulus legislation, with funds allocated to the Agency for Healthcare Research and Quality (AHRQ; $300 million), the National Institutes of Health (NIH; $400 million), and the Office of the Secretary of Health and Human Services (HHS; $400 million). In implementing this strategy, it will be critical to create new public-use databases such as those proposed in my paper, for (1) a national new-technologies learning system; (2) national clinical research databases for publicly supported studies; (3) rapid-learning networks; and (4) disease registries that capture patient data, clinical treatment, outcomes, and quality measures.

With the new funding and these kinds of rich new data resources, the worldwide biomedical community would be able to use the new international Biomedical Informatics Grid, emerging from the National Cancer Institute (NCI), and other resources to generate and test hypotheses on a vastly expanded scale and to learn, in close to real time, from the experiences of millions of patients. Many research inquiries that would now take several years of data collection will be doable in a few
days. The new HHS leadership team has unprecedented opportunities to advance evidence-based health care for all patients.

Lynn Etheredge
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Medical Device Market: If It Ain’t Broke, Don’t Fix It

Three papers in the Nov/Dec 09 issue (by James Robinson, Mark Pauly and colleagues, and Jeffrey Lerner and colleagues) propose reforms in how medical devices are sold to hospitals. These papers ignore a fundamental fact: the medical device market is already highly competitive and functions effectively to keep price increases low.

A study by Guy King, formerly chief Medicare actuary, and Gerald Donahoe tracked medical device prices and spending over a fifteen-year period (1989–2004). Spending was a low and relatively consistent share of national health spending, in the range of 5–6 percent. With regard to pricing, they found that medical device prices increased an average of 1.2 percent a year—one-quarter as fast as the Medical Consumer Price Index (MCPI) and half as fast as the general CPI.

Data on the issue of “physician preference” items such as implants are less available, but they indicate the same pattern. For cardiac implants, according to Millennium Research Group, the average selling price for drug-eluting stents declined 14.6 percent in 2004–2007. Company data shows declining prices for implantable cardioverter-defibrillators (ICDs) and pacemakers as well. In orthopedics, prices for knee implants grew 1.5 percent per year during 2005–2009; for hips, the increase was only 0.8 percent per year.

Perhaps most compelling is the American Hospital Association’s (AHA’s) own analysis of the sources of hospital cost increases during 2001–2006. Medical device purchases were not even large enough as a category to merit a separate entry in the AHA’s pie chart of factors. Instead, they were lumped into an “all other” category that in total contributed just 12 percent to hospital cost increases. A similar analysis by the AHA for the period 1998–2003 produced the same result.

There is an old adage: “If it ain’t broke, don’t fix it.” The market for medical devices not only is not broke, it is functioning extremely well.

Stephen J. Ubl
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Medical Device Market: An Author Responds

By insisting that the market for medical devices works well, Stephen Ubl avoids addressing the evidence we presented (Nov/Dec 09) that secrecy about their price violates the public interest in fair negotiations. This evidence includes the negative effects of manufacturers’ aggressive new strategies to prevent hospitals from disclosing prices paid for implants, even to surgeons or benchmarking services that help hospitals negotiate purchases. If he is correct that prices of implantable devices have been reasonable when comparative information about those prices was available, what is the rationale for preventing hospitals from continuing to use that information? With so much money at stake, a fully competitive market, imposed by law if necessary, is justified.

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The Evidence Dilemma And Cultural Change

In their otherwise excellent paper, Muin Khoury and colleagues (Nov/Dec 08) maintain: “Setting the evidence threshold [for genomics, especially genetic tests] too high could...be a disincentive for investments in research and development.” If so, medical research has undergone a cultural change. Until 1980, universities and their faculties accepted
limits on financial gains from research. Then came the Bayh-Dole Amendments to the Patent and Trademark Act intended to improve incentives to transfer inventions made from government-sponsored research to the private sector for commercial development. While accomplishing this, Bayh-Dole and subsequent technology-transfer laws inadvertently sanctioned a transformation in academic values, one that placed profits above progress. Increasingly, universities removed limits on their faculties’ ability to seek financial gain from technology transfer.

Lower evidence thresholds, as Khoury and colleagues advocate, reinforce this new entitlement. In predictive genomic testing—whether for future complex disease or for drug response—no evidence threshold can guarantee the desired outcome; other factors intervene. Preliminary evidence based on small numbers of patients, consistency of positive results, and retrospective design might be sufficient to allow clinical genetic testing to proceed provisionally and prospectively. The challenge in gathering additional evidence is not to avoid disincentives for investment but to minimize harm while maximizing data collection to ensure decisions that will offer patients the greatest benefits with the fewest dangers. If society must accept trade-offs of the type Khoury and colleagues advocate, we have to ask whether the concomitant cultural change is good for medical research, patients’ well-being, and the acquisition of knowledge.

Neil A. Holtzman
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Evidence Dilemma: The Authors Respond

We appreciate Neil Holtzman’s comment on our paper (Nov/Dec 09)—specifically, his criticism of our statement that “setting the evidence threshold too high could be a disincentive for investments in research and development.” We call attention to the second part of the same paragraph, in which we state: “On the other hand, an undefined or excessively low threshold could encourage innovations that provide poor value and prematurely move technologies with unsubstantiated claims toward medical practice, with adverse consequences for the health system and its patients.” Currently, as we stated in our paper, this low threshold for genomic applications to enter clinical practice “approximates the current state of affairs in the United States for many laboratory developed tests (LDTs).” In fact, we do not advocate for lowering the evidence standards, as Holtzman implies. If anything, we would like to raise the evidence standards to guard against some of the issues that both Holtzman and we are concerned about. The current Evaluation of Genomic Applications in Practice and Prevention (EGAPP) initiative, sponsored by the Centers for Disease Control and Prevention, is an example of a contemporary effort to refine and apply evidentiary thresholds for clinical validity and utility for different types of genomic applications in practice. A methodology paper and three evidence-based recommendations in cancer genomic applications were published in January 2009. We also agree with Kathy Hudson in developing and implementing new ways of translation research and evaluation that allow us to move beyond our current dilemma in genomic medicine.

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Goals of Postgraduate Physician Training

I read with interest and pleasure the two Narrative Matters essays regarding resident physicians (May/Jun 08). In dealing with issues raised or ameliorated by limiting working hours for resident physicians, they paint two contrasting and complementary pictures.

Our dilemma is to determine the purpose of postgraduate training. Stigmatizing a hazing ritual, each of us senses having passed through an ordeal that made us who we are, a sense that others not experiencing that ordeal will be less worthy. A rite of passage must be difficult if it is to create a sense of self-worth. The sense of residency-as-hazing-ritual colors and impedes redesigning residency into a more humane experience.

Medical care is a twenty-four-hour-a-day job. People become sick, have crises, and need caregivers at all hours. In private practice, we juggle our hours and our commitments to get enough rest and personal time. Residents do not have this control of their own lives. How do we accommodate to that?

What are the goals of residency? There are skills to be learned and honed: industry, efficiency, teamwork; factual information to be gained; self-confidence to be acquired. If we focus on the goals absent the rite of passage, we can do a better job of designing the process.

An important aspect of postgraduate training gets lost in the emphasis on learning facts and surviving: the relational aspect of medicine. Twenty-five years of family practice convinced me that the most important skill was the ability to set aside my issues and fatigue and open the door of each patient encounter to spend time focused on that patient. I believe that the presence of an attentive, caring, validating human being is a catalyst to healing. As a profession, we seem to have lost that. Where did it go? How can we get it back?

Roger K. Howe
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Medicine As A Job, Not A Calling?

I am a medical oncologist in practice since 1981. The Narrative Matters essay by Janet Gilsdorf (May/Jun 08) brings up several important points that may even apply outside residency programs around the country.

Attitudes toward career and commitment among many new graduate physicians seem to mirror the attitude of the pediatric residents Gilsdorf describes. Her essay is perhaps pinpointing one of the sources of this new attitude among some new graduates of residency programs. I would describe this attitude as that of the “shift” worker. It is now more common to see physicians who have the notion that they can simply “clock out” and leave the care of their complicated patients to be seamlessly carried out by another person who walks in to “cover” for them. An attitude of, to quote Gilsdorf’s essay, “you must get out of here” has consequences far beyond the residency years. Those residents may carry this attitude into private practice where it may leave patients, families, and colleagues bewildered.

It appears that graduate medical educators have “forced” this clocking in, clocking out lifestyle onto this younger generation of physicians, and it has penetrated throughout medical practice. It appears to be related to graduate medical education (GME) funding and regulated by the Accreditation Committee for GME (ACGME). I propose that they have laid a foundation for a generation of physicians who see their work as a job, not their lifetime responsibility.

Our responsibility should be to our patients and their families, not to an employer.
hospital or the “medical service unit.” Our life’s work as physicians is a calling, to be a physician, one must become a physician. The practice of clinical medicine is an honor, yet each of us forgets that, as the day becomes hectic and the night long. But nonetheless, we sit in witness to life’s miracles and tragedies, and we bear a responsibility to our patients that does not stop at five o’clock. For those newer physicians who view it as just their “job,” I am concerned for them and their sense of long-term fulfillment. I am concerned that they will soon be considered as just another employee, and their patients and our profession will suffer.

Mark Hutchins
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Being There For Patients: Another View

When I read Janet Gilsdorf’s Narrative Matters essay on “The Missing Doctors” (May/Jun 08), I stood to applaud. Gilsdorf beautifully captured what so many clinician educators feel.

Although I do not wish for anyone to be in a stupor post-call in an afternoon continuity clinic, as I was during my training, I am concerned that some of the richest experiences for learning and accountability may never be known by our housestaff. I still recall a little girl admitted to me for bloody diarrhea and low platelets at 6 a.m. after a long, busy night on call. Exhausted, I still did the necessary legwork—all in time to get her to the pediatric intensive care unit (PICU) and present her case at morning report. I left that next day around 2:30 p.m.—because she was my patient. Interestingly, my attendings always modeled the same behavior, so it never occurred to me as “hazing” when I was asked to stay around for a bit. My patient expired four days later from hemolytic uremic syndrome, and I was there post-call. I wouldn't have had it any other way. She was my patient, and I believe that my presence really made a difference to the family she left behind.

As I read Gilsdorf’s essay, I remembered this pivotal experience from my residency. Under the proposed recommendations, I would have been somewhere fast asleep.

We aren’t truck drivers or pilots. It makes no difference who actually flies a particular plane or drives a particular truck, so hand-offs just aren’t the same. Thank you for this wonderful addition to the literature.

Kimberly D. Manning
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Culture Changes In Teaching Hospitals

I enjoyed reading Janet Gilsdorf’s Narrative Matters essay about the resident work schedule and the impact on medical education. I am a physician who completed my training in internal medicine/rheumatology in 2003. What was missing from the essay were issues related to changes that have occurred in teaching hospitals during the past twenty years. Many teaching hospitals use residents as laborers to facilitate the admission and discharge of patients to and from lucrative cardiology and oncology wards, the “income generators” of the hospitals. In fact, residents today see far more patients with complex medical problems per day compared to residents thirty years ago. The teaching hospital that Gilsdorf yearns for is a creature of the past and was a victim of free-market economics.

Ronen Marmur
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Work Hours: A Resident’s View

Janet Gilsdorf’s Narrative Matters essay (May/Jun 08) shows that residency is becoming very fragmented. Emergency rooms (ERs) are overburdened with uninsured and chronically ill patients whose care is complex. Paperwork has doubled, and residents who oversee fifty or sixty patients often don’t know them, unlike in the past.
Therefore, sign-out information is crucial, yet it cannot take more than a few seconds per patient to update and give, since no time is allotted. Pagers interrupt the train of thought as they beep incessantly to do tasks such as admissions. Residents on floor teams rush from morning report to rounds to noon conference, to clinic/outpatient/post-call. Half of the team is gone in the afternoons. For the remaining half, being on the patient floors often precludes attendance at core lectures, where lifesaving information is taught. Residents give orders on intensive care unit (ICU) patients within days of graduating from medical school, yet they barely know the 10,000 new terms and have had little more than a day of training on pressors, ventilators, and sedatives. Time pressures reduce the time that attendings have for resident physicians, who have scarce time for medical students.

Contrary to misconception, residents still work 100-hour weeks and 30-hour shifts. They drive home exhausted and try to find time for family while doing many work-related tasks at home, such as preparing lectures. One resident’s young daughter drew a picture of the family that did not include her mom “because she is always at the hospital.”

Patients do not want exhausted physicians making critical decisions. To save resources, change the system to eliminate redundancy. For example, reimburse for phone calls to families instead of for separate histories and physicals (H&Ps) for each consultant.

Continuity of care is more than proper signouts or working thirty hours without sleep. It is legible consultation notes. It is requiring that ICU patients life-flighted in must have a transfer/H&P note. It is using computerized records to quickly find abnormal values and not using them to log off every few minutes, wasting time in an overzealous confidentiality scare. Wastefulness of money and time in health care costs jobs and risks lives. Changes in work hours must be implemented with patient-oriented systems changes so physicians have time to learn and teach.

Teri Sanor
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Disappearing Doctors: The Author Responds

The preceding letters paint a compelling picture of the complexities of medical education today and reinforce an important question: What is the primary role of medical trainees? To learn or to meet the needs of the hospitals that “employ” them? Where do the needs of patients—current and future—fit into the equation? A related question is: What should the trainees learn, and how should they learn it?

The Accreditation Council for Graduate Medical Education (ACGME) is considering how to, or whether to, implement the most recent recommendations on resident education from the Institute of Medicine. I hope that the unintended consequences of any new requirements will be carefully considered. As medical educators, we adhere strongly to the principles of evidence-based practice. Similarly, the ACGME would be wise to demand carefully conducted studies that confirm the benefits (for resident education and for patient care) of new recommendations before broadly requiring their implementation.

Janet R. Gilsdorf
Ann Arbor, Michigan

Erratum

In “Hospital Remoteness and Thirty-Day Mortality from Three Serious Conditions,” by Joseph Ross and colleagues (Nov/Dec 08, pp. 1707–1717), in the last full paragraph on page 1707, beneath the subheading “Statistical analysis,” the words “inverse of” were erroneously included in the following sentence: “...we fitted a weighted hierarchical linear regression model that used weights equal to the inverse of hospital volume...” The authors and Health Affairs regret any confusion this error might have caused.