

LETTERS

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Hospital Spending

With billions of dollars of hospital capital spending decisions on the line, analysis of likely demand trends such as that offered by David Shactman and colleagues and by Uwe Reinhardt (Nov/Dec 03) could help hospital administrators and trustees make wiser decisions. Unfortunately, only Reinhardt's paper sends the right message to the hospital industry. Shactman and colleagues tell us to prepare for hospital spending increases at a rate close to that of recent years, a projection greatly in excess of recent forecasts by the Centers for Medicare and Medicaid Services (CMS).¹ But as the paper's Exhibit 1 shows, there has been a striking degree of variation in hospital spending trends over five-to-ten-year periods, making an extrapolation from a short period (they use 1999–2001) particularly perilous.

I believe that recent hospital spending trend increases largely reflect the dismantling of managed care restrictions on service use and provider choice; these factors were responsible for earlier declines in the trend. Now that the dismantling is complete, a return to "normal" rates of growth is likely. Recent research shows that the first six months of 2003 represent the third straight semiannual decline in the trend.² Moreover, sharp increases in patient cost sharing for hospital care are likely to play an important short-term role in slowing the trend. Forecasters need to take into account likely employer and government responses when spending trends are high.

Reinhardt does a masterful job of debunk-

ing the far-too-common perception that aging is a major component of health spending trends, pointing out that similar results have been present in the literature for some time. What I cannot figure out is why so many hospital administrators believe the myth that aging will require large investments to expand capacity. Perhaps the concept of sharply differing rates of spending from one end of the age spectrum to the other, tempered by extremely slow changes in age distribution, is difficult to comprehend. Or perhaps hospital administrators are attempting to defend a position, believing that others will not comprehend.

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NOTES

1. S. Heffler et al., "Health Spending Projections for 2002–2012," 7 February 2003, www.healthaffairs.org/WebExclusives/Heffler_Web_Excl_020703.htm (6 November 2003).
2. B.C. Strunk and P.B. Ginsburg, *Cost Trends Continue to Slow but Remain High through First Half of 2003*, Data Bulletin no. 26 (Washington: Center for Studying Health System Change, December 2003).

Better Health, Lower Spending

I do not find the argument by Shactman and colleagues about hospital use and spending compelling. The last two years of data are not sufficient to identify a trend. If we cannot reasonably make a data-based projection, the argument must be based on theory. Making arguments based on practice patterns is difficult for reasons identified by Reinhardt. For instance, geographic analyses of practice patterns show wide variation in how specific medical problems are handled, although for many conditions the outcome does not vary significantly. Alternative modes of care can produce equivalent quality of health outcomes.

Shactman and colleagues argue that health improvement could reduce health spending,

and they accept the fact that recent improvements have slowed spending growth. They argue, however, that such improvements are unlikely to continue because of the U.S. obesity epidemic, regression to the mean, and the complex relationship between health care and health. The only argument they provide data for is obesity. What they don't acknowledge is people's growing interest in fitness and exercise at later ages. It appears that the obesity problem largely was produced by faulty epidemiological and scientific findings that led to dietary recommendations, including the U.S. Department of Agriculture food pyramid, that are rapidly being discredited. With growing awareness of this problem (the Office of Management and Budget is now directing changes in the food pyramid), obesity could be dealt with quickly. As for the relationship between health care and health change, curative treatments are not as far in the future as the authors suggest. Such treatments are now entering medical practice and will have a growing impact in the next five years that will improve health and control hospital spending growth. We do not envision any major reopening of hospital facilities, as the authors suggest.

KENNETH G. MANTON
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The authors respond:

We agree with Paul Ginsburg that population aging is not a major cost driver. In the paper we calculated that aging constitutes only about 10 percent of the growth in real hospital spending—equivalent to Ginsburg's own estimate of personal health care expenditures.¹ We also agree that weaker managed care was an important factor in recent cost growth. Our prediction, carefully if not courageously crafted, was that forces driving recent spending were more likely to continue than to abate. If that is the case, the annual growth rate of fu-

ture hospital spending will somewhat exceed the average of 4.1 percent since 1980 (but will be well below the average of 5.8 percent since 1960). But even the CMS's estimates of 3.7 percent annual real spending growth would require significant increases in hospital capacity. Ginsburg is correct about aging but does not speak to our finding that increased spending by the nonelderly will be a major factor. We identified greater spending growth among the baby-boom age cohort than among the elderly.

Boomers have demonstrated a higher propensity to consume medical services. Furthermore, technology is identifying and treating more disease in the middle of the age distribution (for example, mental disorders, diabetes, and asthma).

We have great respect for Kenneth Manton's work, and we stated in our paper that

“Our prediction, carefully if not courageously crafted, was that forces driving recent spending were more likely to continue than to abate.”

“reductions in disability could be a force to reduce both costs and use.” We hope Manton is correct that obesity can be dealt with quickly and that curative treatments are not far in the future. Technology costs are still increasing, however, and obesity rising. We just don't see evidence that the world will change that much by 2012. Of course, predictions are perilous, and either of our esteemed colleagues could be correct. Our money, however, is with those planning to build more beds.

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NOTE

1. B.C. Strunk and P.B. Ginsburg, *Aging Plays Limited Role in Health Care Cost Trends*, Data Bulletin no. 23 (Washington: Center for Studying Health System Change, September 2003).

The Uninsured And Hospital Use

Catherine McLaughlin and Karoline Mortensen (Nov/Dec 03) present a convincing case that increases in the uninsured will not likely overwhelm the hospital sector because

their use rates are not higher than those of the insured for inpatient, emergency room, or outpatient visits. Not surprisingly, the economic consequences of being uninsured appear to lead to lower use of outpatient services.

The authors raise a question that warrants further analysis: How will the share of uninsured people change by hospital type as the uninsured population grows? One could reasonably argue that hospitals that traditionally treat more uninsured patients—urban teaching hospitals—will bear the brunt of the rise. Should this occur together with cutbacks in Medicaid coverage to which the authors allude, the financial effect on those hospitals could be quite serious. This possibility has important public policy implications that go beyond just the rise in the uninsured population.

Another potentially disturbing trend is the deferral of needed care for the uninsured for ambulatory care-sensitive conditions such as diabetes, adult asthma, pneumonia, and congestive heart failure. For instance, the rate of admission for diabetes and adult asthma is much more prevalent among uninsured than privately insured patients. If the drop in use of outpatient services when a person loses insurance coverage holds true for people with these conditions, the preventable inpatient admissions and avoidable costs that result could be substantial. As the prevalence of these chronic conditions continues to grow, the resulting impact will be magnified.

RICHARD SIEGRIST
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The authors respond:

Richard Siegrist is absolutely correct: The burden of increased numbers of uninsured patients will have a larger effect on some hospitals. Space limitations did not allow us to include the results of simulations that we conducted using the Nationwide Inpatient Sample data to investigate potential differential effects. The top decile of hospitals (according to share of discharged patients who are uninsured patients) had a relatively small share of patients with private coverage and a relatively

large share of Medicaid-covered patients. We estimated that the share of discharges who are uninsured in this group of hospitals would increase, on average, from 14.6 percent to 15.8 percent in response to a decrease in employer-sponsored insurance, but from 14.6 percent to 19.9 percent for a rollback in Medicaid expansions. These estimated increases are for a constant set of 100 hospitals. If, however, we allow the composition of this group to change, reflecting the simulated increased shares, the average effect of a decrease in Medicaid coverage is considerably larger, with the share increasing from 14.6 percent to 22.5 percent. The larger increase is because almost half of the original 100 hospitals were replaced by hospitals with higher current Medicaid shares. Cutbacks in Medicaid eligibility would affect these hospitals disproportionately harder. As noted by Siegrist, these results have important public policy implications.

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Medicare Prospective Payment

The Nov/Dec 03 paper by Chantal Worzala and her colleagues is a reasonably comprehensive list of the challenges facing the twenty-year-old Medicare inpatient prospective payment system (PPS). Unfortunately, the authors address only inpatient payment and ignore the fact that most hospitals lose money when all Medicare payments are combined. Medicare faces three basic issues beyond the challenges the authors present. First, a single process sets prices for more than 500 patient categories in more than 4,000 U.S. hospitals. Yet these hospitals and community delivery systems are not uniform, leading to politically untenable inequities in some communities. Congress responds by making changes in the price-setting process. Continually adapting the program to assure that communities and their hospitals are not harmed has added great complexity to an already complex price-setting system.

Second, Medicare relies on dated informa-

tion in a dynamic marketplace. Information collected to classify patients, measure labor markets, and set annual updates is historical. But patients and their physicians expect hospitals to be up-to-date. This conflict is exacerbated when PPS modifications are limited to changes to prior-year practices and when the system relies on budget-neutrality policies that “rob Peter to pay Paul.” Finally, the multiple PPSs in place today to pay for patient care (inpatient, physician, ambulatory, rehabilitation, and home care) reinforce the fragmented nature of health care delivery. It is time to begin rethinking Medicare payment to envision a system that encourages comprehensive, coordinated care for each patient.

JAMES BENTLEY
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The authors respond:

James Bentley’s comments highlight an important philosophical difference between us about the role of Medicare payment policy. We believe that Medicare’s payment systems are intended to ensure that beneficiaries have access to high-quality care, not to ensure that all hospitals make a profit every year. As in any industry, financial performance varies across hospitals. Some of the disparities might be reduced by policy changes discussed in our paper. Even without those changes, however, most beneficiaries receive care from hospitals whose payments exceed costs across all Medicare sectors. Moreover, there is no systematic evidence of limited access to care.

Beyond this difference lie a number of areas in which we agree with Bentley. First, our paper describes ways in which the payment system is complicated, and even burdened, when it is used to pursue objectives beyond matching payments to the costs incurred by reasonably efficient providers. Second, we agree that having more timely data would be beneficial. Data for decision making come from providers.

A partnership between Medicare and providers to collect streamlined data, perhaps using sampling techniques as discussed in the Medicare Payment Advisory Commission’s June 2003 report, could address this long-standing problem.

Finally, although the issue was beyond the scope of our paper, we agree that Medicare’s payment systems are fragmented. This mirrors the fragmented nature of the entire health care system and the proliferation of new settings for providing care. Achieving better coordination across settings should be a goal for both the delivery system and Medicare’s payment policies. We welcome Bentley’s views on how to address this important problem.

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“We believe that Medicare’s payment systems are intended to ensure that beneficiaries have access to high-quality care, not to ensure that all hospitals make a profit every year.”

Affordability Sensitive To Economic Growth Rates

Michael Chernew and colleagues (July/Aug 03) rightfully draw attention to the often imprecise use of terminology, emphasizing that “affordability” should be differentiated more clearly from “willingness to pay.” They find that in the past overall income growth has been sufficient to allow substantial growth in non-health care spending despite a growing share of gross domestic product (GDP) devoted to health care.

Central to their suggestion that real health care spending rising one (or two) percentage point(s) faster than real GDP is predicted to be “affordable” beyond 2075 (or until 2039) is the idea that no downward trend in nonhealth spending would be tolerable. Economic growth rates are beyond policymakers’ control, but legislators will be interested in the sensitivity of “affordable” health care spending to the future growth of GDP, especially with

regard to the extent that the authors' conclusions also hold for smaller GDP growth rates.

We have tested this sensitivity by applying a broad range of health care spending and GDP growth rate combinations. For the time period of "affordable" health care expenditures as a function of assumed GDP growth, our main finding is that of an asymmetric S-shaped curve.¹ Our analysis demonstrates very high sensitivity to GDP growth rates at the lower end of the conceivable range, with time periods going down to zero if economic stagnation is assumed. With a real per capita GDP growth rate of 0.5 percent, "affordability" of a two-percentage-point gap between the per capita growth rates of health spending and GDP increases to thirteen years, thereafter rising more slowly to reach thirty-nine years at a GDP growth of 1 percent, and exceeding sixty years as it begins to flatten out at assumed real per capita GDP growth rates above 2 percent. This sensitivity is rapidly declining with increasing economic growth. The potential leeway for future "affordable" health care spending growth that the authors have suggested will be highly dependent on real annual per capita GDP growth rates well beyond 1 percent.

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NOTE

1. In our mathematical model we follow the approach of Chernew and colleagues, neglecting any interaction between the growth rates of GDP and health care cost. We also account for an "investment share" of 18 percent of GDP required to support assumed economic growth. We do not single out a separate demographic adjustment. Interested readers can obtain additional details and results directly from the authors, ms@michaelschlander.com.

The authors respond:

Michael Schlander and colleagues extend our analysis by performing a sensitivity analysis on the underlying rate of economic growth, showing that macroeconomic assumptions matter. We adopted the Medicare trustees' assumption that annual real per capita GDP growth would be 1.2 percent. If GDP were to stagnate over the long term (which we view as unlikely), any growth in health care spending would not be affordable by our definition because it would reduce nonhealth spending. Faster growth would extend affordability beyond our estimates. We agree with their fundamental observation that macroeconomic growth is central to the presumption that sustained health care cost growth will be affordable in the long run. We believe it is realistic to expect health care costs to be affordable for the next several decades and that stakeholders should turn their attention to financing and distributional issues in efforts to maximize the benefit we receive for the health care dollars we spend.

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