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.

PhRMA’s Patient Assistance Programs

The Partnership for Prescription Assistance (PPA), cited by Niteesh Choudhry and colleagues and by Ken Johnson (May/Jun 09), was launched in 2003 as part of a national effort to avoid further government-imposed discounts by persuading people that voluntary programs would suffice. In California that same year, drug companies’ record-setting campaign spending helped defeat legislative and voter initiatives to create state-administered drug discounts for limited-income residents. Why should members of Pharmaceutical Research and Manufacturers of America (PhRMA) be shy about better describing the accomplishments of their patient assistance program (PAP)? Johnson’s anecdote reaffirms our finding that a majority of safety-net clinic staff members appreciate PAPs’ bringing expanded access to new, expensive medications.1

Medicare Part D’s relationship to PAPs can illuminate other dynamics between private and public efforts to fill insurance gaps. Shortly before Part D began, federal officials apparently recognized that PAPs can support drug companies’ financial interests by helping increase insured patients’ use of certain products. The U.S. Department of Health and Human Services (HHS) issued guidance on “independent, bona fide charitable[s]” and on ways to reduce legal risks of fraud or kickback liability for their sponsors.2 Some Part D related—PAPs have been discontinued, but others re-

main, restructured to reflect Part D’s expansion of public financing and coverage in ways that could inform broader health reform.

Kathryn Saenz Duke
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NOTES

Patient Assistance Programs: An Author Responds

Kathryn Duke’s assertion that the Partnership for Prescription Assistance (PPA) was created to thwart a California ballot initiative in 2005 is simply not true. In fact, research, planning, and development began in early 2002—more than three years before the ballot initiative was launched. Furthermore, many patient assistance programs (PAPs) and pharmacy discount cards offered by America’s pharmaceutical research and biotechnology companies predated California’s ballot initiative by decades. As the U.S. Department of Health and Human Services Office of Inspector General noted in the November 2003 bulletin that Duke references, PAPs “have long provided important safety net assistance to patients of limited means.”

As described in my Perspective (May/Jun 09), the PPA shines a spotlight on public and private patient assistance programs, provides a toll-free phone bank with trained specialists fluent in 150 languages to help people obtain the medicines they need, and staffs our PPA buses as they crisscross the nation. It has been a bold, ambitious, and—ultimately—success-

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ful effort. In the past four years, the bright orange PPA buses have visited all fifty states, stopping in more than 2,500 cities and helping connect nearly six million Americans with prescription assistance. And, in that time, Pharmaceutical Research and Manufacturers of America (PhRMA) member companies alone have provided more than 115 million prescriptions worth $14 billion—absolutely free. For that reason, Congress and others sought to draw a bright line around these critical programs, to ensure that they would coexist with Medicare Part D. “Beneficiaries need these programs,” Sen. Chuck Grassley (R-IA) said in 2006. These programs are “vital,” Sen. John D. Rockefeller (D-WV) added. We couldn’t agree more. During these uncertain economic times, PhRMA member companies remain committed to helping financially struggling patients obtain the medicines they need to live longer, healthier, and more productive lives.

Ken Johnson
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Effects Of Mental Health Parity

Peter Cunningham (Web Exclusive, 14 April 2009) reports that two-thirds of primary care physicians cannot get outpatient mental health services for their patients. Physicians in states with mental health parity laws fared only marginally better than those in states without such laws.

Cunningham’s abstract states that the Wellstone and Domenici Mental Health Parity and Addiction Equity Act of 2008, which requires most group health plans to provide equivalent benefits for mental health and physical conditions, “will reduce some but not all of the barriers to mental health care.” The new law goes into effect in January 2010; it is long overdue. However, as Cunningham cautions, policymakers must recognize that parity alone cannot “fix” a system that currently leaves fifty-nine million Americans without needed mental health or addiction treatment. For example, parity does not help people who are under- or uninsured, does not eliminate restrictive benefit management by health plans, and is likely to exacerbate the already severe provider shortage.

These barriers can be addressed only by comprehensive health and health care reform. As policymakers seek to transform our “sick” care system into one that promotes health and wellness, we must recognize that this goal cannot be realized without expanding, integrating, and promoting mental health and addiction services. People with serious mental illnesses die an average of twenty-five years younger than those without a mental illness.1 Nearly one-quarter of deaths are caused by alcohol, tobacco, or other drug use.2 Mental illness and addiction are at the core of our nation’s health care problem and therefore must be at the heart of our reform efforts.

Ron Manderscheid
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NOTES

Medical Team Training In The VA System

The Department of Veterans Affairs (VA) has an ongoing, robust program of medical team training modeled on crew resource management, similar to that described by Peter Pronovost and colleagues (Web Exclusive, 7 April 2009). This program is supported by monthly conference calls from the VA National Center for Patient Safety. Arguably, the VA’s model could be used as a template for the Public Private Partnership to Promote Patient Safety (P5S).

Charles P. Clericuzio
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Medical Team Training: The Authors Respond

We appreciate the thoughtful comments from Charles Clericuzio in response to our Web Exclusive (7 April 2009). The Department of Veterans Affairs (VA) is a leader in patient safety, and undoubtedly the Public Private Partnership to Promote Patient Safety (P5S) and the entire country can learn much from it. Team training is important and long overdue in health care, and P5S will certainly build upon the VA experiences. We hope to mimic the VA’s success in working as a large, networked entity in influencing health care trends (for example, in electronic medical records, or EMRs). However, P5S will also use other methods, such as product and process redesigns, in our efforts to greatly reduce the risk of error and subsequent patient harm on a broad scale. Toward that end, we hope to—and can—learn from many organizations. For example, the Anesthesia Patient Safety Foundation (APSF) has worked diligently for decades to design safe anesthesia equipment.1 If we are to reduce preventable harm, safe product design needs to be coupled with a culture that ensures and rewards effective teamwork, including measurement, feedback, and continuous opportunities for learning, participation, and improvement.

At a recent U.S. Senate hearing on quality of care, Senator Hagen stated, “I cannot stick a diesel fuel pump into my gas-powered car because it does not fit. I am protected from making this mistake. Yet caregivers can connect an epidural to an intravenous catheter and harm patients. How can that be?” It is unlikely that health care provider organizations working alone will make notable progress in improving patient safety. It is equally unlikely that telling nurses and doctors to be more careful will be an effective or efficient method to comprehensively improve safety. Rather, we need to partner with a variety of stakeholders and manufacturers, identify specific hazards, and design interventions that reduce risks to all patients. Our hope is that comprehensive approaches such as P5S will complement and expand upon previous efforts so that health care is safer because we have redesigned it to make it harder to make mistakes.

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NOTE

Data On Thailand: A Different Perspective

I read the Web Exclusive by Kannika Damrongplasit and Glenn Melnick (31 March 2009) with interest. Having lived in Thailand for more than ten years, I would like to offer my perspective.

First, analysis of data alone is meaningless. The authors primarily rely on government data of people covered by national health programs in Thailand during 2001–2005. By their nature, such data are highly politicized. It is absolutely impossible to draw any meaningful conclusions from assessing these numbers alone without understanding related issues such as “quality, waiting times, satisfaction, and long-term sustainability” of services, all of which the authors admit to ignoring.

Also, the authors appear not to have conducted any fieldwork or interviews in Thailand as part of their research. Citing only an increase in coverage rates during 2001–2005, they conclude that the 30 baht program in Thailand has succeeded. In reality, hospitals have routinely refused to treat people under this program, telling them to “go home and rest.”

Even as 13.6 million people became newly covered in this country of 64 million, the authors imply that there have been no corresponding problems of “supply constraints” in providing services. To the contrary, queues for services in public hospitals have increased, especially as doctors have migrated to private hospitals for better pay and lower workloads.

Finally, in concluding that “there is no evidence that the practice of informal under-the...
table payments, seen in many other Asian countries, has arisen in Thailand," the authors are simply wrong. Many doctors working in public hospitals also work in private hospitals or operate their own clinics. Because public hospitals have long queues and inadequate equipment, they readily refer patients to private providers to obtain required treatments.

From my experience in Thailand, I believe that the authors should have conducted far more research into this issue than the cursory analysis of politicized government data that they appear to have performed. Because of shortcuts in their research methodology, their conclusions are wrong in all respects.

Patrick Holert
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Thailand: The Authors Respond

Our methodology (Web Exclusive, 31 March 2009) combined field and telephone interviews with empirical analysis of data from Thailand’s National Health and Welfare Survey (HWS) collected by Thailand’s National Statistical Office. This national, multipurpose household survey has been in place for many years and, as such, predates the specific program we investigated. HWS survey data have been used by researchers throughout the world to investigate a wide range of topics without any suggestion that the data collected from it are manipulated or biased. As such, we believe that these data provide reliable estimates of our key performance measures: contact rates and actual out-of-pocket payments. We limited our study questions to those that could be validly addressed by the available data. Our conclusions, based on empirical findings, show that contacts rates for the previously uninsured improved without lowering access for others and that those covered by the 30 baht program report limited or no out-of-pocket payments when they go to approved settings for care. Although the scope of our inquiry was limited, it did address important system-level measures of performance of this new national program. At the same time, we agree—and so state in the paper—that other dimensions of performance, such as waiting times, quality, and availability of specific services, along with long-term sustainability, need to be studied. This will require a much larger study than we could undertake. However, for the questions we sought to address, we believe that empirical analysis rather than case-study interviews provide a more systematic and valid approach.

Kannika Damrongplasit
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Glenn Melnick
University of Southern California

Measuring The Report Card: The Validity Of P4P

Timothy Bhattacharyya and colleagues (Mar/Apr 09) argue that the hip and knee performance measures of the Centers for Medicare and Medicaid Services (CMS)/Premier Hospital Quality Initiative Demonstration (HQID) do a poor job of measuring quality. They make the tacit assumption that their chosen measures of “quality” are the gold standard by which the HQID and other process measures should be judged. In-hospital mortality is, thankfully, a rare event in this population, providing only the crudest assessment of quality. As such, it’s not surprising that there is no correlation with other quality indicators. The authors also assume that the proportion of hospital-acquired conditions, including urinary tract infections, is a more accurate measure of quality than evidence-based measures, such as delivering antibiotics within an hour of incision.

Despite the authors’ claim to the contrary, the third of their proposed measures, surgical volume, does appear to agree well with the quality composite score in specific circumstances: institutions performing large numbers of hip/knee procedures consistently perform well, and those with lower volumes of procedures perform more randomly. This serves to illustrate the problems associated
with the use of a correlation statistic without first considering the distribution of the data.

The authors also fail to recognize the role of process measures in improving care. We know from well-vetted, peer-reviewed research that specific processes can improve overall care. Therefore, it only makes sense that such measures should be set as a minimum standard to be expected by all patients, all the time.

The Institute of Medicine has defined quality using a broad, multifaceted framework, including measures of effectiveness, efficiency, patient safety, patient-centeredness, equity, and access. We must cease the practice of presenting practitioners and patients with what amounts to a false choice between measures of outcomes and measure of processes. Useful measures of quality must incorporate both.

Richard Bankowitz
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Report Card Measuring: The Authors Respond

We thank Richard Bankowitz for his interest in our paper (Mar/Apr 09). We support process measurement and public reporting in hip and knee arthroplasty. It is an interim step on the road to higher quality. However, a level of scientific rigor is needed as quality programs go from simple measurement and reporting to financial incentives and penalties. Our data document that current systems for measuring quality are not ready to make that leap: the variation in process measurement is too low, and the outcome measures are too crude.

Our paper indeed notes that there was some correlation between surgical volume and composite quality measures. But the system was best for discriminating low-quality/low-volume hospitals and could not truly differentiate average from high-quality hospitals. Our patients and payers are seeking the ability to accurately identify hospitals and surgeons with outstanding outcomes.

Timothy Bhattacharyya for the authors
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Computerized Order Entry

The seven-country comparison of computerized prescriber-order entry (CPOE) implementation in hospitals by Jos Aarts and Ross Koppel (Mar/Apr 09) offers a platform for discussing information technology (IT) applications in hospital medication use. Data collected by the American Society of Health-System Pharmacists further elucidate the status of CPOE in the United States. In 2007, 18 percent of hospitals had implemented CPOE, and two-thirds of them had clinical decision-support systems. In 16 percent of hospitals with CPOE, medication orders still needed to be manually reentered into pharmacy computer systems (thereby diluting one benefit of CPOE). Slightly more than half of the hospitals without CPOE said that they planned to implement it within three years.

Hospital IT priorities should exploit the opportunities to improve patient safety in each step of the medication-use process. The potential for harm is nearly equal in the prescribing and drug-administration steps. Thus, it is noteworthy that 24 percent of hospitals have invested in bar-code drug administration technology, and 56 percent of the rest plan to do so within three years. Computerized infusion pumps that check doses against preset limits are used by 44 percent of hospitals; 47 percent of the rest plan to acquire this technology within three years.

Hospitals are investing significant human resources in the application of IT to the medi-
cation-use process. For example, 36 percent of hospitals employ dedicated pharmacy personnel to collaborate with physicians, nurses, and IT staff in this cause.

Karl F. Gumpper and William A. Zellmer
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NOTES

Computerized Order Entry: The Authors Respond

We welcome the additional information on computerized prescriber order entry (CPOE) adoption in the United States, in response to our paper (Mar/Apr 09). Although Craig Pedersen and Karl Gumpper’s study (Note 1 in Gumpper and William Zellmer’s letter) was not available when we submitted our paper, the figures concur with our findings and estimates. Their work also reflects how hard it is to obtain reliable data on CPOE market penetration, which we also pointed out.

Gumpper and Zellmer, however, also observe that about half of the hospitals currently without CPOE reported that they intend to implement it within the next three years. Here we differ with their views. We doubt the veracity of that prediction (but neither their reporting nor the honest intentions of the respondents). A dramatic shift of that scale is unlikely both because of the recent economic crisis and, more important, because of the painstaking and difficult process of implementing CPOE in reality. We agree that bar-coded medication administration systems will reduce pharmacy dispensing errors. However, the evidence to date does not suggest that such systems are as effective in reducing administration errors because of design and implementation faults and the resulting staff workarounds that mitigate the efficacy of bar-coding.1

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NOTE

Improved Models Of Health Care Delivery

Janet Corrigan and Dwight McNeill (Mar/Apr 09) conclude that new organizational models will be needed to improve the way health care is delivered in this country. What their paper fails to point out, and what has been left out of much of the debate on health reform, is that physicians have already created a new delivery model that works well, improves the quality of care, and reduces costs for both payers and consumers.

Ambulatory surgery centers (ASCs) provide exactly the focus and care environment outlined by Corrigan and McNeill. This comes from being owned by physicians who have risked their own capital to create a model that delivers outstanding care efficiently, and that is patient-focused and cost-effective. ASCs are the “focused factory” that health care expert Regina Herzlinger says are critical to fixing our health care system.

For more than twenty years there has been a steady movement of surgical procedures from inpatient acute care hospitals to ASCs and other outpatient surgical facilities. More than 40 percent of the fifty million surgical
procedures performed annually in the United States have moved out of the hospital and are now done in the 5,000-plus ASCs or other outpatient settings. Procedures in the ASC are reimbursed by Medicare at an average of 59 percent of the cost of the same procedure done in a hospital outpatient facility, which saves billions of dollars each year.

As our population ages, the need for frequently used procedures such as diagnostic colonoscopies and cataract surgery will continue to increase, and the demand will be met only if we continue to have a strong outpatient delivery model, such as the ASC. These facilities are a critical component of a delivery system that provides consumers with convenient, efficient, affordable, high-quality care.

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**National Health Care Policy: Key To Reform**

Americans are now hearing discussion of a publicly funded health insurance plan as an alternative to private health insurance. Such a plan would represent an entirely new relationship between government and the health insurance industry. This could represent an efficient partnership with lower costs and improved outcomes. Or it could collapse into the nation's costliest entitlement program with long waiting times and no improvements in outcomes. A lot depends on this partnership. And partnerships depend on enforceable contracts.

Last month I visited with thoughtful men who have held executive and mid-level management positions in health care industries. Each agreed with the following: (1) Government is capricious in its payment structure and enrollment regulations. (2) Simply spending money on information technology (IT), encouraging best practices and medical homes, implementing tobacco taxes, and so on are insufficient measures. (3) Insurers' hostility toward a public/private relationship is not about the inability of the private sector to compete with a government plan; it is about government's changing the rules on a whim and not being a reliable partner. Therefore, the need for a national health care policy.

No true partnership survives when one partner capriciously alters the rules. Well-meaning insurers do want health reform, but they need clear rules to support their attempts. Just as all of U.S. law has a reference point—the Constitution—health care contracts at every level need a similar reference point—a national health care policy.

One person volunteered this analogy: “This system had better go the distance right from launch; there'll be no changing the O-ring at 500 feet.” The analogy is a fair one. The national health care policy—the navigation system—must be in place from lift-off, or the ensuing explosion will become fodder for legend.

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**Erratum**

In Exhibit 4 in the paper by Denise Anthony (May/Jun 09, pp. 864–873), the legend was inadvertently inverted. The top (black) bars, labeled “Quintile 5 (high),” should have been labeled “Quintile 1 (low),” with subsequent bars following in ascending rather than descending order. The exhibit has been corrected online. *Health Affairs* regrets any confusion this may have caused.