



INTERNAL MEDICINE • GERIATRICS • WOMENS HEALTH

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Monday, February 8, 2010

To: The Medical Inefficiency Committee


From: Jay Kaplan, M.D.

Thank you for inviting me to send some information on the present state of our local health care crisis. I am a practicing internist in Connecticut for the past 30 years. I am a member of ProHealth Physicians and my office is in Meriden. I have a large Medicare practice. I am affiliated with MidState Medical Center and I utilize the hospitalist service for all admissions. I am the medical director of two nursing homes with busy short term admissions. I would like to list some suggestions for the committee to consider. I must state that all the points I will present are my own and I am not speaking on behalf of ProHealth Physicians or any other organization.

1. If a patient goes to the ER outside the doctor's local area, that patient's doctor will never receive an ER report. No laboratory or x-ray reports will be sent. Besides being responsible for the patient, we often have to repeat studies at a great expense to the system.
2. Hospital discharge summaries are almost never sent to the PCP (primary care physician) if that physician is not on staff at that hospital. The PCP is again responsible for the coordination of care without all the data.
3. If medications are denied by a Drug Benefit Program, they must include alternative drugs that will be covered. This will eliminate the guessing game we play with the drug programs.
4. Require all SNF's (skilled nursing facilities) to identify who is the patient's PCP. Discharge summaries with current medications, important laboratory results and any new vaccinations must be included. This information must be sent to the patient's PCP at the time of discharge.
5. The annual rewriting of patient's medications for drug programs requiring prior authorization is a waste of everyone's time.
6. Mammography reports, regardless of who orders them, must be sent to the patient's PCP.
7. Gynecologist's reports should be sent to the patient's PCP to coordinate care.
8. Specialist's reports should be sent to the PCP to coordinate care.
9. Hospice care should send notification of death to the patient's PCP and other caregivers involved in the case.
10. Reinstate the Medicaid secondary insurance coverage for Medicare patients. Physicians who attend to patients at SNF's are burdened with more work for 20% less pay for the dual eligible patients. Soon there will be no physicians who will be willing to see these patients.

11. It is time for Connecticut to move forward with Tort Reform. The defensive practice of physicians ordering additional tests is a large part of the escalating cost of health care.
12. Restrict lawyers from TV ads. The information stated in these advertisements is very misleading and causes great difficulty in doing the best for our patients.
13. Restrict drug advertisements that name medications. Insist that only the type of disease or condition is mentioned.
14. Promote good health. Reward physicians who keep patients healthy. Consider a tax break for patients who do not smoke. Use some of the tobacco settlement money for good health measures rather than keeping it in the general fund.
15. Use the cigarette tax for health related care.
16. Allow pharmacies to notify physicians when they suspect a patient is abusing drugs. It is time for the pharmacists and the physicians to work together on this problem.
17. Insist on the reduction of regulations at SNF's that don't enhance the quality of care. We have drug reduction programs. It is time to streamline the regulations to promote greater efficiency.
18. Develop "Pay for Performance" programs at SNF's to encourage better quality. This bonus to physician will help by rewarding better outcomes and quality of care.
19. The State of Connecticut is the payment source for both the Title 19 recipients and the State employees. The state needs to evaluate this cost of care as compared to the commercial plans. There are many cost saving measures that could be put into place by utilizing some of the restraints imposed by the private insurers. Unlimited use of the ER, multi specialist care, and brand name drug use are three areas that should be reviewed.
20. A health care card that includes the name of each patient's PCP will help identify where all health related data should be sent.
21. The United States is ranked 37th in the world for health care. Connecticut has some of the highest insurance premiums in the country. As the insurance industry is centered in our state, it is time for us to lead the way in health care reform. We cannot continue to move backwards.

Thank you for your time and consideration. I have enclosed two articles which may be helpful.


Jay Kaplan, M.D.

Ranking 37th — Measuring the Performance of the U.S. Health Care System

Christopher J.L. Murray, M.D., D.Phil., and Julio Frenk, M.D., Ph.D., M.P.H.

Evidence that other countries perform better than the United States in ensuring the health of their populations is a sure prod to the reformist impulse. The World Health Report 2000, *Health Systems: Improving Performance*, ranked the U.S. health care system 37th in the world¹ — a result that has been discussed frequently during the current debate on U.S. health care reform.

The conceptual framework underlying the rankings² proposed that health systems should be assessed by comparing the extent to which investments in public health and medical care were contributing to critical social objectives: improving health, reducing health disparities, protecting households from impoverishment due to medical expenses, and providing responsive services that respect the dignity of patients. Despite the limitations of the available data, those who compiled the report undertook the task of applying this framework to a quantitative assessment of the performance of 191 national health care systems. These comparisons prompted extensive media coverage and political debate in many countries. In some, such as Mexico, they catalyzed the enactment of far-reaching reforms aimed at achieving universal health coverage. The comparative analysis of performance also triggered intense academic debate, which led to proposals for better performance assessment.

Despite the claim by many in the U.S. health policy community that international comparison is

not useful because of the uniqueness of the United States, the rankings have figured prominently in many arenas. It is hard to ignore that in 2006, the United States was number 1 in terms of health care spending per capita but ranked 39th for infant mortality, 43rd for adult female mortality, 42nd for adult male mortality, and 36th for life expectancy.³ These facts have fueled a question now being discussed in academic circles, as well as by government and the public: Why do we spend so much to get so little?

Comparisons also reveal that the United States is falling farther behind each year (see graph). In 1974, mortality among boys and men 15 to 60 years of age was nearly the same in Australia and the United States and was one third lower in Sweden. Every year since 1974, the rate of death decreased more in Australia than it did in the United States, and in 2006, Australia's rate dipped lower than Sweden's and was 40% lower than the U.S. rate. There are no published studies investigating the combination of policies and programs that might account for the marked progress in Australia. But the comparison makes clear that U.S. performance not only is poor at any given moment but also is improving much more slowly than that of other countries over time. These observations and the reflections they should trigger are made possible only by careful comparative quantification of various facets of health care systems.

The current proposals for U.S.

health care reform focus mostly on extending insurance coverage, decreasing the growth of costs through improved efficiency, and expanding prevention and wellness programs. The policy debate has been overwhelmingly centered on the first two of these elements. Achieving universal insurance coverage in the United States would protect households against undue financial burdens at the same time that it was saving an estimated 18,000 to 44,000 lives.^{4,5} However, narrowing the gap in health outcomes between the United States and other high-income countries or even slowing its descent in the rankings would require much more than insurance expansion. Given the vast number of preventable deaths associated with smoking (465,000 per year), hypertension (395,000), obesity (216,000), physical inactivity (191,000), high blood glucose levels (190,000), high levels of low-density lipoprotein cholesterol (113,000), and other dietary risk factors, there are huge opportunities to enact policies that could make a substantial difference in health system performance — and in the population's health.⁴ More investments that are targeted at promoting proven strategies — including tobacco taxation and smoking-cessation programs, screening and treatment for high cholesterol and blood pressure, banning of trans fat, creating incentives for people to engage in physical activity, and subsidizing the cost of consumption of n-3 fatty acids — could dramatically reduce mortality and

Table 2. Number of Quality-Adjusted Life-Years (QALYs) Gained with an Annual Budget of \$180 Billion, According to the Cost per QALY Gained.^a

Cost per QALY Gained	Type of Service Provided	No. of QALYs Gained
<\$100,000	Coronary artery bypass grafting Ultrasound-guided prostate biopsy Exercise electrocardiography for screening in 40-year-old women	600,000
\$100,000–\$500,000	CABG for single-vessel disease with moderate angina Exercise electrocardiography for screening in 40-year-old women	600,000
>\$500,000	Bladder cancer treatment HIV treatment Liver cancer treatment Prostate cancer treatment Testicular cancer treatment	600,000

* CABG denotes coronary-artery bypass grafting, and HIV human immunodeficiency virus.

resources are devoted exclusively to services that cost less than \$100,000 per QALY. But if the threshold is raised to include less effective services so that the average cost per QALY gained is \$300,000, the same budget will result in only 600,000 additional QALYs. (Of course, cost-effectiveness should be only one of many criteria used to design public health insurance programs; the purpose of health insurance is to reduce financial uncertainty and increase access in the case of large and uncertain medical expenses.)

Although the benefits of successfully targeting limited resources could be dramatic, the mechanisms by which spending might be targeted toward the highest-value uses are complex. One state offers a potential template: in Oregon, a commission that includes both patients and providers ranks treatments according to their effectiveness, with the goal of having the public insurance program cover only services whose value is above a certain threshold.² In practice, however, there has been very little limiting of services on the basis of these

rankings — a fact that highlights the tremendous political difficulties of making such trade-offs explicit.

Mandating what is covered and what is not isn't the only approach for increasing the reach of limited public dollars. Competition among private plans for enrollees (who could receive government-subsidized vouchers based on their income and health risks) is another strategy for moving people into plans that offer higher-value care. Lessons from the behavioral economics literature, however, imply that unregulated competition alone is unlikely to result in patients' choosing the highest-value plans, suggesting that there is a powerful role for more nuanced plan design. All these strategies, however, will involve implicit or explicit trade-offs between the generosity of subsidies and the number of people who are eligible for them, as well as the resources that will be available for other public programs.

Unfortunately, the mere recognition of the existence of trade-offs does not tell us how best to make them. There are no easy solutions

in which all people receive all care that might potentially benefit their health. There is only 100% of Gross Domestic Product to go around, whereas we could theoretically spend a virtually unlimited amount of money on health care. As medical technology advances, there will continue to be new treatments that will offer incremental improvements in health at increasingly high costs, and we will have to decide how to allocate scarce resources among treatments and among people. To date, there has been little debate in Congress about the generosity of public benefit packages, except for whether such benefits should cover abortion. But eventually, we will have to engage in the difficult discussions required to choose whom and what our public insurance programs should cover. Some might call this rationing, but the reality is that millions of Americans now have no access to life-saving medical technologies at the same time that public resources are being devoted to covering less-effective therapies for less-serious conditions. We find that sort of rationing hard to justify.

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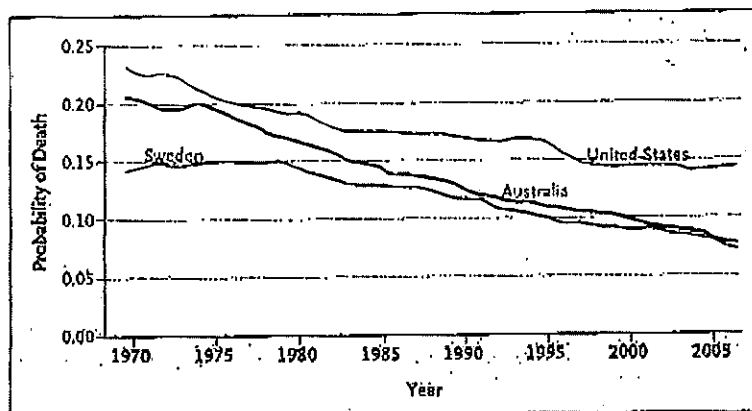
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Probability of Death for Boys and Men 15 to 60 Years of Age in Sweden, Australia, and the United States, 1970–2007.

Data are from the Australian Bureau of Statistics, the U.S. National Center for Health Statistics, and the World Health Organization.

enhance the performance of the U.S. health care system.

Of course, international comparisons are not the only rankings that should inform the debate about reforming the health care system. Within the United States, there are dramatic variations among regions and racial or ethnic groups in the rates of death from preventable causes. While aiming to provide solutions to the problems of incomplete insurance coverage and inefficiency of care delivery, health care reformers have given insufficient attention to the design, funding, and evaluation of interventions that are tailored to local realities and address preventable causes of death. The big picture — the poor and declining performance of the United States, which goes far beyond the challenge of universal insurance — will inevitably get lost if we do not routinely track performance and compare the results both among countries and among states and counties within the United States.

Although many challenges remain, the available methods and

data are better now than they were when the World Health Organization's rankings were determined. As part of its reform efforts, the U.S. government should support and participate in international comparisons while commissioning regular performance assessments at the state and local levels.

Experience has shown that whenever a country embarks on large-scale reform of its health care system, periodic evaluations become a key instrument of stewardship to ensure that initial objectives are being met and that midcourse corrections can be made in a timely and effective manner. To be valid and useful, such evaluations cannot be an afterthought that is introduced once reform is under way. Instead, scientifically designed evaluations must be an integral part of the design of reform. For instance, the recent Mexican reform adopted from the outset an explicit evaluation framework that included a randomized trial to compare communities that were introducing insurance in the first phase of reform with matched

communities that were scheduled to adopt the plan later. This external evaluation was coupled with internal monitoring meant to enable policymakers to learn from implementation.

In addition to its technical value, the explicit assessment of reform efforts contributes to transparency and accountability. Such assessments can also boost popular support for reform initiatives that inevitably stir up fears of the unknown. In the polarized political climate surrounding the current U.S. health care reform debate, the prospect of periodic evaluations may help reformers to counter many objections by offering a transparent and timely way of dealing with unintended effects. Built-in evaluations may be the missing ingredient that will allow us to finally reform health care in the United States.

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Putting U.S. Health Care on the Right Track

Denis A. Cortese, M.D., and Jeffrey O. Korsmo, M.S.

Americans do not consistently receive high-value health care. Collectively, our country spends more on health care than any other nation, but our people do not receive the best outcomes, safety, service, or access in return. Although some organizations, regions, and states deliver high-quality, affordable care, many do not. It's time to make high-value health care the norm in the United States.

To reach that goal, we must hold physicians and other providers accountable for providing high-value health care, defined in terms of both quality and cost: $\text{value} = \text{quality} \div \text{cost}$. In this equation, quality includes clinical outcomes, safety, and patient-reported satisfaction, and cost encompasses the cost of care over time. Outcomes for hospital care, procedures, and chronic conditions can be assessed with the use of such measures as hospital admissions, emergency department visits, unplanned readmissions, death rates, postoperative complications, missed days of school or work, measures of organ function, and scores on general health surveys. Safety can be evaluated by means of such measures as central-line infection rates, medication errors, and postoperative complications. And patient satisfaction can be quantified with tools like those used by the National Research Corporation's Healthcare Market Guide. Performance data are available from such respected sources as the Agency for Healthcare Research and Quality, the National Quality Forum, the Leapfrog Group, the AQA Alliance, the University HealthSystem Consortium, the Medicare Provider

Analysis and Review File, and the Commonwealth Fund. Regional Medicare spending data from the Centers for Medicare and Medicaid Services (CMS) or from the Dartmouth Atlas of Health Care could provide the equation's denominator.

We could thus create a value score for each medical institution and make it publicly available. Such a score would offer clearer information than is currently available on many aspects of providers' care. If one institution can diagnose a patient's condition with \$10,000 worth of tests whereas another must spend \$15,000 to achieve the same result, there is a clear value gap. Armed with concrete data, patients could choose a high-value facility over one that charges more but delivers less. Health care professionals would then begin to compete on the elements that matter most — outcomes, safety, service, and cost. Providers with worse outcomes, less-satisfied patients, and higher costs would lose patients, which would spur them to improve value.

Some critics argue that it's not fair to use currently available metrics to compare providers, since the data may not have been adjusted properly for severity of illness or the poverty level or minority status of patients. It's true that the available data are imperfect, and they should be risk-adjusted to the extent that current expertise permits. However, given the vacuum within which Americans currently make health care choices and third parties pay for services, paying for value would be a significant step toward evidence-based purchasing.

Researchers at the Dartmouth

Institute for Health Policy and Clinical Practice who study regional variation in health care quality and spending have documented that more care does not necessarily translate into better care. Dartmouth research suggests that the United States could reduce its health care costs by 30% or more if all regions practiced to the standard of the best-performing medical centers.¹

Organizations offering higher-value care tend to have several common attributes. In his report on a meeting held in Washington in July, entitled "How Do They Do That? Low-Cost, High-Quality Health Care in America," John Iglehart noted three characteristics that unified the 10 high-value communities that were represented at the gathering: a patient-centered culture, physician leadership, and not-for-profit status.²

In addition, several other factors foster high-value care. First, organizations that deliver value focus on its elements: outcomes, safety, patient satisfaction, and costs. They consistently collect performance metrics, conduct benchmarking studies, and use systems-engineering principles to improve outcomes, streamline clinical processes, and wring waste out of the system.

Second, patient care services must be coordinated across people, functions, activities, sites, and time. Physicians can organize themselves in a variety of ways — group practices, integrated networks of independent physicians, physician-hospital organizations, or "virtual" groups — to accomplish this goal. The point is to develop mechanisms for coordinating care among medical

common in the West and upper Midwest — that are able to accept prospective payment and that could make care more efficient as a consequence. Other health care communities, on the other hand, are still quite disaggregated. In such places, the transition from fee-for-service and solo or small-group practices to prospective payment and integrated delivery systems will need to proceed in a more stepwise fashion. This process can begin with early forms of payment reform, which will in turn drive greater structural integration, which can increase the capacity for additional payment reform, and so on. The ultimate degree of integration will depend on local market realities — not every accountable system of care must be cut from the same structural mold. Similarly, assumption of all risk on the part of delivery systems is not a necessary component of a successful model. Kaiser Permanente's history shows that risk sharing between the payer and the care delivery system can work quite well.

The development of more integrated, accountable care systems should bring other benefits in addition to the opportunity to reduce costs. A number of studies have shown that integrated care is positively correlated with improved quality, which is achieved through the coordination of care among specialties, the effective use of information technology-based decision-support tools, and other key aspects of integrated systems. Such integrated health care entities are increasingly attractive to newly minted physicians, particularly primary care physicians, who perceive them as offering a supportive environment and recognize the ability of group

practices to moderate, at least to some degree, the growing income disparity between primary care physicians and specialists. The growth of integrated care systems may thus be at least a partial correction to the growing tendency of U.S. medical students to shun primary care as a career.

How long would it take to achieve a stepwise transition from complete disaggregation to accountable care systems? Some observers believe that it will be impossible to attain this goal at least until the older generation of physicians retires. Others, who recall some constructive responses from physicians and hospitals to the apparent inevitability of managed care in the early 1990s, believe that the shift could proceed much more quickly — especially because many physicians are more dissatisfied with the status quo than they were 15 years ago. In addition, many hospitals, observing the disintegration of the traditional hospital-staff model of physician self-governance, are seeking new ways of "clinically integrating" with physicians. Finally, the advances in clinical information technology that have occurred in the past decade provide a practical integration tool that was largely absent previously.

What would need to happen to launch the process? Public and private payers would have to initiate the cascade of changes by offering new payment opportunities to delivery organizations that are willing and able to accept them. I, among others, have called for the Centers for Medicare and Medicaid Services, the country's largest payer, to build on the Medicare Physician Group Practice Demonstration by devel-

oping new models that will allow the agency to share financial risk with delivery systems.^{4,5} Models that prove successful could be adopted by private payers as well. Regulators would need to remove certain barriers to integration while ensuring that system development does not lead to abusive pricing. As in Massachusetts, government leaders could seal the deal by establishing a stable long-term vision for delivery-system reform that could be counted on by physicians and hospitals seeking to lead the necessary changes. Most important, though, is that we begin this process of incremental change as soon as possible.

Dr. Crosson reports serving as chairman of the Council of Accountable Physician Practices. No other potential conflict of interest relevant to this article was reported.

All opinions expressed in this article are those of the author and do not necessarily represent the views of the Medicare Payment Advisory Commission (MedPAC), on which the author currently serves as vice-chairman.

From the Kaiser Permanente Institute for Health Policy, Oakland, CA.

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and surgical specialists so that patients have access to teams of physicians who can meet their needs. All team members in such systems are accountable to patients, to one another, and to the group's leadership for high-quality results. These providers share a unified (electronic) medical record, which "builds in" continuous peer review as part of daily patient care activities.

Finally, many observers have suggested that a salary structure for physicians can reduce the incentives that drive overutilization. It is one of several payment schemes that can help to align the delivery system toward high-value care. The goal is to reduce conflict of interest so that physicians have less of a personal financial incentive to order unnecessary tests or procedures. Instead, they can focus on providing the right level of coordinated care for each patient — no more and no less.

In addition to a salary system, certain incentives can encourage high-value care. Some institutions add a value- or quality-based bonus (e.g., on the basis of patient-satisfaction scores) to physicians' annual salaries. Unlike productivity-based rewards that drive increases in volume, incentives to produce better outcomes, safety, and service reward physicians for high scores on one or more of these components of value.

In general, a key way of spread-

ing high-value health care is to pay for it. Indeed, we believe that paying for value is a fundamental requirement for effective health care reform. Unfortunately, much of the financing in proposed health care reform bills comes from continued across-the-board reductions in Medicare's price-controlled fee-for-service payments. That won't work.

Legislators must establish new ways of providing fair payment to doctors and hospitals offering high-quality, lower-cost care. Congress can use the Medicare program to start us along this path. We believe that Congress should set a 3-year deadline for creating and implementing new Medicare payment methods. The CMS could initially establish new value-based payment methods, incorporating metrics for outcomes, safety, and service for the most expensive three to five conditions and procedures — sending providers the message that they must begin re-engineering care delivery to create better value for patients.

One idea is to base a portion of Medicare payments to physicians and hospitals on value scores, rewarding those who offer high-value care and providing an incentive for others to improve. Value scores can be constructed for many types of payment models, including hospital diagnosis-related-group payments, physicians' fees, payment updates, and other payment formulas, includ-

ing those for bundled payments. Providers would then be paid on the basis of their value scores. Over time, we believe that health care professionals would change their behavior — for example, sharing information and eliminating unnecessary tests — in order to increase value.

The philosopher Seneca said, "We most often go astray on a well trodden and much frequented road." There is a clear path to higher-quality, more affordable health care, if we are willing to veer from the familiar route. We must define value, publicly display understandable value scores, and pay for value. If tools and incentives are aligned to support this goal, we'll be on the right track to transform U.S. health care.

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From the Mayo Clinic, Rochester, MN.

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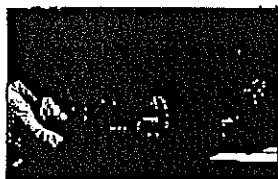
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The Cost of Health Care



A video is available at NEJM.org



Is it possible to pay for health care coverage for all Americans without moderating the country's rapidly rising health care costs? In a roundtable discussion moderated by Atul Gawande, three experts — Elliott Fisher, Jonathan Gruber, and Meredith Rosenthal — examine the most promising ways of slowing the growth of health care costs, their potential effects on medical practice, and the likelihood that the current health care reform effort will be a step in the right direction.