in fact shop for services on the basis of quality and cost. Although the definition of consumerism in employer-sponsored insurance is fuzzy, more than 45% of employers are offering such account-based plans, and the number is growing. Employers' move to consumerism is having substantial effects on providers, ranging from decreased use of services and challenges in collecting deductibles to demands for public release of information on prices and quality.

An audio interview with Dr. Galvin is available at NEJM.org

In an environment of controlled health care costs and favorable tax treatment, employers competing for skilled labor will continue to sponsor health benefits and not move employees to an exchange. The situation could change if and when employers' health plans begin hitting the threshold for the Cadillac tax. Even then, however, whether to pay rather than play will be an economic decision made by individual companies, and I believe there will no rush for the exits.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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Asymmetric Thinking about Return on Investment

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Lately, we've attended many conferences about providing health care to patients with high medical and social needs — people with chronic illnesses who are frequently readmitted to the hospital. It seems as if every presentation refers to "return on investment" (ROI), which is invariably presented as a constraint — as in "Our program kept people out of the hospital, but we just couldn't get the ROI to work." Heads nod understandingly, and then participants move on to other topics.

At conferences about providing care for patients with cancer or other acute illnesses, by contrast, we almost never hear the term ROI. Instead, people talk about clinical gains, using understandable and patient-centered terms like "survival." Though high drug prices are sometimes mentioned, no one ever says the ROI is prohibitive. No one mentions ROI at all.

ROI is the net profit of an investment (the money you got back minus the money you put in) divided by the money you put in. If you invested $100 and got back $110, you gained $10 and the return on your $100 investment was 10%. That's good, as long as you can't do even better by putting your $100 somewhere else. When people in health care colloquially say the ROI doesn't work, though, they're not saying they could make more money elsewhere; they're saying they're losing money. If your ROI equation's numerator is negative — for example, if you put in $100 and got back $90 — there's no way the ROI can work.

There is no obvious reason why ROI is more relevant to some clinical situations than to others. So why do we focus so heavily on ROI when the topic is chronic illness but rarely mention it when the topic is cancer? A huge amount of the cancer care we deliver provides such small personal and social gains that, were those gains monetized, the endeavor's ROI would be deeply negative. And yet we ask, "What's the ROI of that program that keeps chronically ill patients out of the hospital?" but not "What's the ROI of treating advanced lung cancer?"

There are at least three reasons for this difference. One is that from the financial perspective of doctors and hospitals, the ROI of treating cancer is favorable. Reimbursements for cancer care are high in part because the

political and popular value of cancer care is high, and those values are both revealed and reinforced by a history of largely cost-based fee-for-service pricing explicitly designed to at least meet providers' costs. We can debate whether this kind of care is a worthy societal expense as compared with other worthy expenses — an exercise that might entail trying to match the financial ROI to a "social ROI" that reflects our values and includes everyone's costs and benefits. But for now, the main reason the financial ROI is favorable for cancer care is that we have made such care profitable by setting high pay rates for it.

In contrast, the ROI of keeping chronically ill patients out of the hospital under current payment models is often unfavorable — which means you often lose money trying it. The amount of money currently devoted to keeping some patients out of the hospital and in alternative care settings is a fraction of the amount we devote to putting other patients in the hospital. Some might argue that one reason that cancer care is reimbursed so heavily is the presence of the same kind of political pressure that led to prohibiting the Centers for Medicare and Medicaid Services (CMS) from considering cost in coverage determinations. Efforts to help chronically ill patients receive the right level of care do not seem subject to the same pressures.

A second reason is that keeping people out of the hospital is hard — typically requiring care coordination with multiple services. Although treating patients with cancer is also hard, a long history of substantial investment in cancer care has helped hospitals hone their operations. Hospitals don't have as much experience reducing demand for inpatient care as they do creating and supporting it. Merely implementing new financial incentives can't make them turn their operations on a dime.

Third, providing cancer care and averting hospitalizations are financed differently. It's hard to create a favorable ROI for reducing volume in a system dominated by fee-for-service payments for delivering care. Sometimes a favorable ROI is achieved passively when, for example, avoiding care frees up capacity for patients whose care is more profitable. More actively, the avoidance of care can be financed by establishing punishments for delivering avoidable care (penalties for readmissions, for example) or by shifting its cost to the providers themselves (e.g., through capitated or bundled payments).

It might seem that we could make the ROI for appropriate care more favorable if we imposed higher penalties on inappropriate care, just as we could make the ROI for treating cancer less favorable by paying less for cancer treatments. Despite that apparent symmetry, the choice of financing mechanisms — payments versus penalties — determines how much a health care goal will be advanced. If the ROI didn't work for some form of cancer care — because the payment received was lower than the cost incurred — doctors and hospitals would almost certainly argue for higher payments. But when the ROI doesn't work for keeping challenging patients with chronic disease out of the hospital, it's implausible that doctors or hospitals will plead for increased readmission penalties. It would be an unusual health system executive indeed who said, "If CMS just penalized us more for readmissions, we would spend a lot more money on keeping people out of the hospital." There isn't any mathematical reason to prefer payment in the form of rewards over payment in the form of avoided penalties, but you can typically generate more advocates for your cause by paying people to follow you than by penalizing them for going the other way.

So when advocates and organizations devoted to keeping people out of the hospital lament their inability to make the ROI work, they should know that the game is thrice rigged against them. In the highly regulated context of health care, the amount and structure of financing are chosen rather than preordained. The ROI is favorable or unfavorable not because of the workings of some invisible hand, but because of choices someone — usually a private or public insurer — has made regarding what amounts will be paid for various types of care and what form payments will take.

What if the financing of cancer care and of efforts to achieve population health goals traded places? Suppose doctors and hospitals were paid for cancer care by capitation or bundles or through penalties for undesired outcomes and were paid directly and adequately to keep people out of the hospital. Oncologists might begin lamenting that although new approaches to cancer care helped patients, they just couldn't get the ROI to work. And the outlook for population health might become less financially gloomy.

Rewards and penalties have

the same ultimate effect on investment income, but they influence thinking in different ways. We might encourage greater effort and innovation in keeping people out of the hospital and coordinating care if we reframed its financing as positive payments for noble work rather than punitive revenue reductions. As U.S. health care financing begins again to shift risks to hospitals and physicians through bundled payments or readmission penalties, the financing of the care for our most challenging patients might be better shifted in the other direction.

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The Doctor's New Dilemma

Suzanne Koven, M.D.

The woman sits perched on the end of my exam table, leaning forward, blond curls tumbling over her eyes, her precarious posture mirroring her emotional state. Though the symptom she describes is relatively minor — some diarrhea on and off — she appears distraught. She grips the table as if doing so will hold back her tears.

A psychiatrist colleague tells me that such moments, when there's a clear mismatch between what a patient says and the intensity of feeling with which he or she says it, are especially ripe for probing. But the psychiatrist sees patients for 45 minutes. I have 15, several of which have already passed, in which to address and document the woman's chief symptom: loose stool. I find myself in a quandary: Do I ask the patient why she's so upset, or do I order a culture, prescribe antidiarrheal medication, type my note, and send her on her way?

In 1906, George Bernard Shaw's *The Doctor's Dilemma* first appeared on the London stage. The play concerns a physician, Sir Colenso Ridgeon, who's discovered a cure for tuberculosis. Ridgeon's dilemma is that he has a limited supply of the medication and a small staff to administer it. He can treat only 10 patients at a time and so must decide whose life is most worth saving. Other conundrums Shaw highlights in the play's lengthy prologue are how to prevent doctors from being motivated by financial gain and how to rid the medical profession of charlatans.

In recent years, Shaw's turn-of-the-20th-century drama about the ethics and economics of health care has been seen as prescient, as prefiguring the establishment of the National Health Service in Britain and the Affordable Care Act in the United States. Even with these developments, modern Colenso Ridgeons still grapple with limited resources, inequality in access to health care, and unscrupulous or incompetent colleagues.

The dilemma I face most often as a primary care doctor, however, is not one that Shaw anticipated. The commodities I struggle to ration are my own time and emotional energy. Almost every day I see a patient like the woman with diarrhea and I find myself at a crossroads: Do I ask her what's really bothering her and risk a time-consuming interaction? Or do I accept what she's saying at face value and risk missing a chance to truly help her?

Often, the situation is not so dramatic. Say I walk into an exam room and find a patient waiting for me, reading a book. Do I ask what book she's reading? If it's one I've recently read myself, do I ask whether she, like me, enjoyed it but found it a bit longer than it needed to be? We might debate that point, and then she might start telling me about other novels her book group has read, and pretty soon we'd be having — horrors! — a *conversation*. Precious minutes wasted on useless chitchat.

But is chitchat really useless? Such conversations can generate the trust that, studies have suggested, improves health outcomes, such as control of blood pressure and relief of pain — indeed, that is essential to healing.[1] Once, when I was covering for a colleague, I saw an older woman I'd never met before. I pride myself on being able to put patients at ease, being able to establish rapport with almost anyone, but this woman would have none of it. She expressed skepticism about