

UCLA

UCLA Previously Published Works

Title

Cataract Extraction Rates and Insurance Status-Reply

Permalink

<https://escholarship.org/uc/item/0rq5772s>

Journal

JAMA, 278(18)

ISSN

0098-7484

Authors

Goldzweig, Caroline Lubick
Mangione, Carol M

Publication Date

1997-11-12

DOI

10.1001/jama.1997.03550180040024

Peer reviewed

It has been shown that physicians are often incorrect when trying to guess patients' preferences,³ and there is convincing evidence that physicians and patients evaluate the usefulness of therapy differently. In the absence of a validated questionnaire, the results of the patient-physician decision are not uniform, as indicated by the fact that regional rates of cataract surgery have been shown to vary significantly.

Minimum useful vision varies by occupation and leisure-time activity. Two patients who potentially have vision correctable to 20/20 may have markedly different visual requirements. For example, one patient may use a wheelchair or may be illiterate, whereas another has no such restrictions. The relative success of cataract surgery should be evaluated on an individual basis considering not only the objective visual acuity but also patient-assessed change in functional ability.

Visual acuity alone can be a poor predictor of visual impairment. Javitt et al⁴ found the correlation between subjective visual acuity and high-contrast Snellen acuity to be relatively poor ($r=0.31$), similar to the findings in the study by Steinberg et al⁵ that reported a poor correlation between the weighted average of visual acuity and the VF-14 visual impairment questionnaire ($r=0.26$). Mangione et al⁶ also noted that preoperative Snellen acuity was not significantly associated with improvement in self-reported visual functioning following surgery. Visual acuity alone has a limited association with functional status. Low correlations underscore the point that, aside from sources of variability in resource allocation, many aspects of visual functioning may not require excellent acuity. Clearly, there is variation between the consequence of visual disability and quality of life.

Thomas C. Prager, PhD, MPH
Richard G. Urso, MD
Richard S. Ruiz, MD
University of Texas Medical School
Houston

1. Goldzweig CL, Mittman BS, Carter GM, et al. Variations in cataract extraction rates in Medicare prepaid and fee-for-service settings. *JAMA*. 1997;277:1765-1768.
2. Obstbaum SA. Should rates of cataract surgery vary by insurance status? *JAMA*. 1997;277:1807.
3. McNeil BJ, Weichelbaum R, Pauker SG. Speech and survival: tradeoffs between quality and quantity of life in laryngeal cancer. *N Engl J Med*. 1981;305:982-987.
4. Javitt JC, Brenner H, Curbow B, Legro MW, Stree DA. Outcomes of cataract surgery. *Arch Ophthalmol*. 1993;111:686-691.
5. Steinberg EP, Tielsch JM, Schein OD, et al. VF-14: an index of functional impairment in patients with cataracts. *Arch Ophthalmol*. 1994;112:630-638.
6. Mangione CM, Phillips RS, Lawrence MG, Seddon JM, Orav EJ, Goldman L. Improved visual function and attenuation of declines in health-related quality of life after cataract extraction. *Arch Ophthalmol*. 1994;112:1419-1425.

To the Editor.—In his Editorial¹ discussing the results of a study that found cataract surgery to be performed twice as often in FFS settings when compared with prepaid ones,² Dr Obstbaum certainly was correct in his conclusion that “[a]ny system . . . should comply with the published standards that reflect what is in the best interest of the patient.” It should be noted, however, that the imprecision of current standards may, in fact, provide a likely basis for the difference found in the study.

The primary indication outlined in the document Obstbaum cites³—ie, surgery should be performed “when cataract impaired vision no longer meets the patient’s needs and the anticipated benefits of surgery exceed the risks”—is certainly a reasonable statement. Yet, by affording sizable discretion in surgical decisions, this indication actually facilitates the ability of financial incentives inherent in either system to act. If all decisions were “cut and dried,” there would be no reason to create incentives.

Whether or not we like to admit it, human nature is such that financial incentives can be very powerful, especially if it can be rationalized that the risks of doing (or not doing) a specific procedure are minimal. Viewed from an FFS standpoint, cata-

ract surgery can be considered as having evolved to the point where, in reasonably competent hands, the complication rate is low enough to allow concentration on potential benefits (which, of course, from the surgeon’s standpoint could include the surgeon’s fee). Viewed from a prepaid standpoint, cataract surgery can be seen as addressing a problem that typically exhibits slow progression and, thus, has limited urgency, allowing incremental postponement of extraction as long as tolerated by the patient (implying the vision still meets his or her daily needs, thus deferring an unnecessary expense).

Therefore, given the broad range of interpretation regarding when such surgery is necessary, as well as the ill-defined consequences whether or not surgery is performed, it is not difficult to understand how a surgeon in one setting might justify doing a few more procedures and a surgeon in the other a few less.

Caught in the middle of this are patients who, despite their ultimate responsibility for decisions affecting their care, in reality rely heavily on physician advice. That this advice might be prejudiced to any degree makes it that much more imperative that patients be fully informed of any potential bias.

I am not necessarily suggesting the incentives of either system would promote performing totally unwarranted surgery or withholding (absolutely) necessary surgery. What appears to be at issue are the marginal cases in which there would be less than unanimous agreement.

By stating that “[t]his study is important because it alerts us to the need to examine the requirements for surgery and to measure the outcomes of surgery in the population undergoing cataract extraction,” Obstbaum would appear to agree that these marginal cases require better standards to sort them out, potentially limiting the effects of incentives I have argued are promoted by current criteria. Given Obstbaum’s position as president of the American Academy of Ophthalmology, I am confident the academy will continue to aggressively assume a leadership role in this activity.

Craig H. Klinger, MD
Bakersfield, Calif

1. Obstbaum SA. Should rates of cataract surgery vary by insurance status? *JAMA*. 1997;277:1807.
2. Goldzweig CL, Mittman BS, Carter GM, et al. Variations in cataract extraction rates in Medicare prepaid and fee-for-service settings. *JAMA*. 1997;277:1765-1768.
3. American Academy of Ophthalmology. *Preferred Practice Pattern: Cataract in the Adult Eye*. San Francisco, Calif: American Academy of Ophthalmology; 1996.

In Reply.—Dr Dahl asserts that the large differences we found in rates of cataract extraction for Medicare patients in FFS and prepaid settings do not result from financial incentives affecting ophthalmologists in the prepaid settings. Dahl refers to the fact that cataract extraction rates in the staff-model and IPA settings were similar even though, as he incorrectly asserts, IPA ophthalmologists were reimbursed “at a higher level than traditional Medicare.” Our study demonstrated variations in rates between settings with very different financial and organizational incentives, but it cannot discern at which level these incentives are operating. Nevertheless, we believe it is naive to contend that financial incentives are not affecting ophthalmologists. In the IPAs we studied, ophthalmologists were reimbursed on a discounted FFS basis with rates that generally were lower than those paid in traditional FFS Medicare, and their behavior could well have been influenced by this.

As Dahl states, some of the HMO and IPA patients were not enrolled for all of 1993. We disagree that this would indicate that these patients were less likely to have visual problems. Because we were unable to ascertain total lifetime duration of enrollment, many of these patients could have been enrolled in these plans for some time prior to 1993. Dahl also incorrectly implies that 51% of the IPA patients were enrolled for fewer than 9 months. Most of these patients were not included in the study after 9 months because their IPAs changed their

method of reimbursement in September 1993, not because of disenrollment.

In the "Comment" section of our article, we indicated that one limitation of our study was our inability to track patients who moved between the 2 settings. We agree that patients with chronic medical problems tend to stay with physicians with whom they have developed a long-term relationship. Nevertheless, given the ease with which Medicare patients can move between health care settings, we are not as convinced as Dahl that patients with visual problems would stay in any one setting if they felt they were not getting a needed cataract extraction. In addition, there are many reasons why Medicare patients might choose to belong to an HMO, including drug benefit plans, vision plans, and smaller co-payments. These incentives may be enough to pull a patient away from a relationship with an FFS ophthalmologist, particularly if there was no current indication of a need for vision care. How this potential movement of patients between settings could affect the rates of cataract extraction is uncertain.

As indicated by Mr Peterson and Mr Silberman, our findings are important because they highlight a potential quality-of-care problem that must be studied. We agree with them and with Dr Prager and colleagues that such a study requires an assessment of visual functioning as it relates to cataracts. We believe it is crucial not only to detect cataracts when they exist but also to evaluate their significance in terms of their impact on a given patient's ability to perform his or her usual activities.

Caroline Lubick Goldzweig, MD, MSPH
Carol M. Mangione, MD, MSPH
University of California, Los Angeles, School of Medicine

In Reply.—Dr Kliger's letter raises several valid points that might influence the behaviors of practitioners working in prepaid or FFS settings. The processes involved in clinical decision making in all fields of medicine are guided by the knowledge, skill, and experience of the physician or surgeon. Yet, despite the proficiency of the practitioner, he or she needs to base clinical decisions on current thinking in a particular area of interest. The American Academy of Ophthalmology's Preferred Practice Patterns (PPPs)¹ were initially introduced in the late 1980s and have undergone review approximately every 3 years. These are evidence-based documents that rely on consensus opinion of a group of experts when evidence is lacking on a particular point.

The PPP "Cataract in the Adult Eye"¹ was written by a group that was composed of ophthalmologists, an internist, a methodologist, and a patient representative. The document is intended to serve as a clinical guide for contemporary cataract surgery and is linked to outcome measures. The key issue in any payment setting is the appropriate care of patients with a cataract. As Kliger states, "financial incentives can be very powerful" as influences in the determination to perform, withhold, or delay cataract surgery. However, the application of the recommendations of the PPP speak for appropriate care.

An essential issue raised in my Editorial is the need to assess the effect of withholding or postponing cataract surgery on the well-being and functional activity of the beneficiary population. Although published studies have acknowledged the benefits of cataract surgery, there is a paucity of information regarding the consequences of deferring this procedure. It is unlikely that such a study will be performed because the benefits of cataract surgery are so compelling. If the differences between the prepaid and the FFS settings were minimal, I would agree that my major concern would be with only the "marginal" cases. However, the dramatic disparity in the rates between the 2 groups suggests that factors other

than those that reflect the functional needs of patients are dominant.

If clinicians are guided by evidence-based practice guidelines, involve the patient in the decision-making process, and consider what is in the patient's best interest, appropriate care will be provided independent of the method of payment. Well-constructed practice guidelines lessen the variability in modes of practice. Adherence to the principles of these guidelines should also minimize the variability in rates of cataract surgery by insurance status.

Stephen A. Obstbaum, MD
Lenox Hill Hospital
New York, NY

1. American Academy of Ophthalmology. *Preferred Practice Pattern: Cataract in the Adult Eye*. San Francisco, Calif: American Academy of Ophthalmology; 1996.

The National Council on Patient Information and Education

To the Editor.—In the Medical News & Perspectives article by Mr Marwick,¹ Ray Bullman, executive director of the National Council on Patient Information and Education (NCPIE), was reported to have said that a coalition has been organized to implement the *Action Plan for the Provision of Useful Prescription Medicine Information* (MedGuide) and that all 34 original steering committee organizations responsible for drafting the plan have joined. If these statements have been correctly attributed to Mr Bullman, they are untrue. As public interest groups and members of the original steering committee responsible for drafting the MedGuide, the AIDS Treatment Data Network, Center for Medical Consumers, Citizen Advocacy Center, National Women's Health Network, and Public Citizen have not joined NCPIE in the coalition alluded to by Mr Bullman.

We have refused to associate with the NCPIE implementation program for 2 reasons. First, we view NCPIE's economic and philosophical juxtaposition to organizations long opposed to the distribution of useful written drug information to patients as not in the public interest. Second, in the 15 years since its inception, the programs and policies espoused by NCPIE have failed to provide patients with useful drug information. Testaments to this failure were the need for a congressionally mandated process that created the MedGuide, the selection by the Department of Health and Human Services (DHHS) of the Keystone Center—not NCPIE—to facilitate development of the MedGuide, and the exclusion of NCPIE from any formal role in the MedGuide.

How to implement and evaluate implementation of the MedGuide was one of the most controversial issues faced by the steering committee. Agreement was not achieved, and DHHS Secretary Donna E. Shalala was presented with 2 very different options on implementation of the MedGuide. Public interest groups favored strong oversight and enforcement by the Food and Drug Administration (FDA). Groups representing the health care industry endorsed a small "transition group" of the private sector that consisted of steering committee members. Creation of a transition group from the original steering committee to oversee the implementation process was unacceptable to the undersigned public interest groups. Of the 34 organizations constituting the steering committee, 12 are represented on NCPIE's board of directors. This, in fact, would have reconstituted a smaller version of NCPIE, which we view as a failed paradigm.

Secretary Shalala chose neither option; rather, implementation was left to the organizations participating on the steering committee, with the DHHS having authority to determine if the congressionally mandated distribution and quality goals are met by 2000. The DHHS has delegated its authority over imple-