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Editorial Transition

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AJNR Am J Neuroradiol 2011, 32 (6) 979

doi: <https://doi.org/10.3174/ajnr.A2665>

<http://www.ajnr.org/content/32/6/979.1>

This information is current as
of April 19, 2024.

EDITORIAL

Editorial Transition

Due to increasing administrative responsibilities at his institution, Dr William Dillon informed me of his desire to step down from his position as Senior Editor after 13 years of dedicated service to the *American Journal of Neuroradiology* (AJNR). I thank Bill for his invaluable work and his support



during my tenure as Editor-in-Chief. After 4 years of working with him, this is how I view him: dedicated, motivated, cutting-edge, honest and fair, highly knowledgeable, down to earth, and, overall, a very nice person. Isn't this what we all strive to be? Thus, finding a replacement was not easy.

Dr Nancy Fischbein from Stanford University will take over Bill's AJNR responsibilities. She did her undergraduate and MD studies at Harvard and her radiology and neuroradiology training at the University of California, San Francisco. Nancy is currently Associate Professor and Chief of Head and Neck Imaging at Stanford. Her scholarly activities include nearly 100 peer-reviewed articles, 15 book chapters, and 2 books. These achievements are enhanced by her writing and people skills. She is a highly respected member of the head and neck imaging community. The work as Senior Editor will not be easy; the number of head and neck submissions continues to increase, particularly full-length original articles. She is not alone, as our head and neck manuscript reviewers are probably the best AJNR has. Transitions are never easy, and following Bill's steps can be intimidating. I am confident that Nancy will be able to do that and more. Please help me welcome her.

M. Castillo
Editor-in-Chief

DOI 10.3174/ajnr.A2665

EDITORIAL

Physician Payment Reform: Getting What We Pay For

It has been estimated that half¹ of all of the gains in per capita income of the world, a proxy for standard of living, during the past 2 centuries are due to improvements in human health. Much of this increase in well-being is attributable to improvements in medicine or public health derived from medical knowledge. Inspiration, invention, innovation, and incremental implementation of new developments in technology have made enormous improvements in the lives of people across the globe. They live longer healthier lives, see their children survive to adulthood, and maintain mobility and vibrancy through decades of life in which the old normal was dead or disabled.

It should not surprise us that the proportion of our in-

comes devoted to health care has risen. This has occurred for several reasons generally summarized as "Baumol's Hypothesis,"² which is the profound insight that prices in the personal services sector of the economy rise relative to the prices in other sectors of the economy with time. Personal services are those whose value is determined solely or in large part by the amount of time one human being spends with another. These activities, including fine dining, live entertainment, education, and, most important, medicine, are more difficult to industrialize, mechanize, and, in a material sense, optimize than other parts of the economy. For example, a 21st century automobile factory produces better cars more efficiently than the most skilled expert craftsman of the early 20th century, but a psychiatrist still needs 50 minutes to spend an hour with a patient, notwithstanding the greater efficiency and efficacy of cognitive behavioral therapy or pharmacotherapy compared with psychoanalysis.

The relative proportion of our economy spent on health care has risen substantially, and the amount of health care spending has increased exponentially for decades. The economist Herbert Stein once wrote, "If something cannot go on forever it won't." One need only consider the phenomenon of Elvis impersonation to understand this concept. In 1977, there was only 1 Elvis, but by the 1980s, there were 15,000 or so impersonators. If this growth had continued unabated, by 2010 their number would have been greater than the entire population of the United States, 309 million. Fortunately for all of us, growth leveled off at around 80,000. Not enough of us look good in sequins. Health care is now 17% of the economy, about half of government spending, and if one accepts the concept of tax expenditures, well over half of health care spending is governmental. Because food, clothing, shelter, transportation, and other goods are declining relatively in price, it is easy to imagine an economy with a larger and larger health care sector. It is very difficult, however, to escape dystopian imagination if the current growth rate continues and health care crowds out most of what is left.

At present a majority of the productivity gains in our economy are consumed in health care spending. Most prefer not to consider a world in which almost everyone is a doctor, nurse, pharmacist, or hospital or health insurance administrator. To mitigate Baumol's curse, we need to slow the rate of growth of health care spending and allow the productivity gains in the rest of the economy to catch up. Fortunately, the example of other developed nations, presumably subject to the same macroeconomic forces, shows us that it is possible to provide a better health care system for a lower cost per covered person, at a lower proportion of national income, and at a lower rate of growth, though it is not possible to escape Baumol's curse entirely.

Perhaps we need innovation in American health care finance and economics that is comparable with the creativity and progress that we have made in the other health sciences. The article by Manchikanti and Hirsch³ in this issue describes the latest twists, turns, and tumbles of the health care finance system in the largest economy in the world. That system is based on many of the same principles that underlay the health care finance system in the oldest civilizations. A fee-for-service (FFS) payment schedule is included in the Code of Hammurabi, the oldest code of law. Science, culture, and technology