the ACA has changed this behavior. The authors found that, relative to older patients, the number of emergency visits for younger patients decreased by 2.1% from 2009 to 2011. One assumes that this decrease is a good thing, as acute emergency care tends to be more costly than outpatient preventive or primary care in a nonacute setting. Improving access to preventive services and transferring the care setting in the manner described in this study are certainly among the stated goals of the ACA, and it appears that these goals are being achieved.

David F. Penson, MD, MPH

Re: A Comparison of Hospital Administrative Costs in Eight Nations: US Costs Exceed All Others by Far

D. U. Himmelstein, M. Jun, R. Busse, K. Chevreul, A. Geissler, P. Jeurissen, S. Thomson, M. A. Vinet and S. Woolhandler

School of Public Health and Hunter College, CUNY, New York, New York, Department of Social Policy, London School of Economics and Political Science, and European Observatory on Health Systems and Policies, London, England, Department of Health Care Management, Technische Universität Berlin–World Health Organization Collaborating Centre for Health Systems Research and Management, Berlin, Germany, Paris Health Services and Health Economics Research Unit, Assistance Publique-Hôpitaux de Paris and ECEVE (UMR 1123), French Institute of Health and Medical Research, Paris, France, and Celsus Academy on Sustainable Healthcare, Nijmegen Medical Centre, Radboud University, Nijmegen, The Netherlands

Health Aff (Millwood) 2014; ***33:*** *1586–1594.*

Abstract for this article http://dx.doi.org/10.1016/j.juro.2014.12.014 available at http://jurology.com/

Editorial Comment: Ask any urologist about increasing health care costs, and he or she will no doubt tell you that administrative costs are a key driver of these increases. This study confirms this widely held belief and actually illustrates that it is much worse than we thought. When urologists discuss administrative costs, they are usually referring to the costs of dealing with insurance companies who pay for outpatient care and professional fees. This study shows that that is just a part of the problem. The United States also has the highest hospital administrative costs in the world, by far. Administrative costs account for 25% of total hospital expenditures. The next closest country is far behind us, which is The Netherlands, at 20%. What drives these costs? The authors assert, and I agree, that it is the complicated United States health care reimbursement system, with multiple payers and a myriad of arcane and complicated rules and regulations around payment. The authors imply that the solution is a single payer system. I do not know if this system is truly the magic bullet that they imply, but I certainly believe that some consolidation among payers would simplify things and reduce administrative costs.

David F. Penson, MD, MPH

Re: Long-Term Effect of Hospital Pay for Performance on Mortality in England

S. R. Kristensen, R. Meacock, A. J. Turner, R. Boaden, R. McDonald, M. Roland and M. Sutton

Manchester Centre for Health Economics, Institute of Population Health and Manchester Business School, University of Manchester, Manchester, Warwick Business School, University of Warwick, Warwick and Cambridge Centre for Health Services Research, University of Cambridge, Cambridge, United Kingdom

N Engl J Med 2014; ***371:*** *540–548.*

Abstract for this article http://dx.doi.org/10.1016/j.juro.2014.12.015 available at http://jurology.com/

Editorial Comment: In 2008 all 24 hospitals in the northwest region of England began participating in a hospital pay for performance program that in many ways appears similar to such programs in the United States. The authors had previously explored the short-term effects of the program on mortality and found that the program improved mortality outcomes. They now report the long-term results and compare the findings to control hospitals in England that did not participate in the program. They found that in the long term the mortality improvements were not maintained, while

noting mortality decreases in control hospitals and for conditions not covered in the program. The authors attribute this finding to a positive spillover effect.

This study confirms that pay for performance is a blunt and at best minimally effective way of improving the quality of care. Behavioral economics dictate that we can incentivize providers and hospitals to try to improve care but invariably people will game the system, and at some point the effort required to garner additional improvements will outpace the rewards for achieving these benefits. To really improve quality, we have to change culture, and the only way to permanently change culture is to use a bottom-up approach. One example of such an approach is the Urological Surgery Quality Collaborative, which has consistently improved the quality of urological care in the practices that participate. As urologists, we really need to take this approach going forward and encourage payers to help support these initiatives.

David F. Penson, MD, MPH

Suggested Reading

Miller DC, Murtagh DS, Suh RS et al: Establishment of a urological surgery quality collaborative. J Urol 2010; **184:** 2485.

Miller DC, Murtagh DS, Suh RS et al: Regional collaboration to improve radiographic staging practices among men with early stage prostate cancer. J Urol 2011; **186:** 844.

Burks FN, Liu AB, Suh RS et al: Understanding the use of immediate intravesical chemotherapy for patients with bladder cancer. J Urol 2012; **188:** 2108.

Geriatrics

Re: American Geriatrics Society Identifies another Five Things that Healthcare Providers and Patients Should Question

AGS Choosing Wisely Workgroup

J Am Geriatr Soc 2014; ***62:*** *950–960.*

Abstract for this article http://dx.doi.org/10.1016/j.juro.2014.12.073 available at http://jurology.com/

Editorial Comment: Evidence-based medicine continues to evolve, with increased information available to guide clinical choices. This includes not only guidance on what to do for certain conditions, but also an understanding of what not to do in specific circumstances based on the available data. The American Board of Internal Medicine Foundation has partnered with multiple professional organizations, including the American Urological Association and the American Geriatrics Society (AGS). In this article the AGS highlights its second list of things that providers and patients should question in care for older adults. Three that are directly applicable to geriatric urology cases are 1) avoiding prostate, breast and colorectal cancer screening without considering life expectancy and the potential risks of testing, over diagnosis and overtreatment in the geriatric population, 2) not prescribing medications without conducting a drug regimen review and 3) avoiding the use of physical restraints to manage behavioral symptoms for hospitalized elderly individuals with delirium. In their prior list the AGS recommended avoiding use of antimicrobials to treat bacteriuia in older adults unless specific urinary tract symptoms are present.[1] These recommendations provide practical guidance to clinicians providing care for geriatric urology patients.

Tomas L. Griebling, MD, MPH

1. AGS Choosing Wisely Workgroup: American Geriatrics Society identifies five things that healthcare providers and patients should question. J Am Geriatr Soc 2013; **61:** 622.

Suggested Reading

Carter HB, Albertsen PC, Barry MJ et al: Early detection of prostate cancer: AUA Guideline. J Urol 2013; **190:** 419.