an affordable cost (some estimates suggest approximately $66 million). This goal is surely one to aspire to, given the human cost of maintaining the status quo.

Eliminating cholera transmission in Haiti with a combined, integrated approach at the population level would be a major achievement for the government and people of Haiti. It would also have broad implications for the control of cholera in other affected populations around the world. The time for ambitious action on cholera control and elimination in Haiti is now.

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

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Care for the Vulnerable vs. Cash for the Powerful — Trump's Pick for HHS

Sherry A. Glied, Ph.D., and Richard G. Frank, Ph.D.

Representative Tom Price of Georgia, an orthopedic surgeon, will be President-elect Donald Trump's nominee for secretary of health and human services (HHS). In the 63-year history of the HHS Department and its predecessor, the Department of Health, Education, and Welfare, only two previous secretaries have been physicians. Otis Bowen, President Ronald Reagan's second HHS secretary, engineered the first major expansion of Medicare, championed comparative effectiveness research and, with Surgeon General C. Everett Koop, led the fight against HIV–AIDS.[1] Louis Sullivan, HHS secretary under President George H.W. Bush, focused his attention on care for vulnerable populations, campaigned against tobacco use, led the development of federally sponsored clinical guidelines,[2] and introduced President Bush's health insurance plan, which incorporated income-related tax credits[3] and a system of risk adjustment. In their work at HHS, both men, serving in Republican administrations, drew on a long tradition of physicians as advocates for the most vulnerable, defenders of public health, and enthusiastic proponents of scientific approaches to clinical care.

Tom Price represents a different tradition. Ostensibly, he emphasizes the importance of making our health care system "more responsive and affordable to meet the needs of America's patients and those who care for them."[4] But as compared with his predecessors' actions, Price's record demonstrates less concern for the sick, the poor, and the health of the public and much greater concern for the economic well-being of their physician caregivers.

Price has sponsored legislation that supports making armor-piercing bullets more accessible and opposing regulations on cigars, and he has voted against regulating tobacco as a drug. His voting record shows long-standing opposition to policies aimed at improving access to care for the most vulnerable Americans. In 2007–2008, during the presidency of George W. Bush, he was one of only 47 representatives to vote

against the Domenici–Wellstone Mental Health Parity and Addiction Equity Act, which improved coverage for mental health care in private insurance plans. He also voted against funding for combating AIDS, malaria, and tuberculosis; against expansion of the State Children's Health Insurance Program; and in favor of allowing hospitals to turn away Medicaid and Medicare patients seeking nonemergency care if they could not afford copayments.

Price favors converting Medicare to a premium-support system and changing the structure of Medicaid to a block grant — policy options that shift financial risk from the federal government to vulnerable populations. He also opposed reauthorization of the Violence Against Women Act and has voted against legislation prohibiting job discrimination against lesbian, gay, bisexual, and transgender (LGBT) people and against enforcement of laws against anti-LGBT hate crimes. He favors amending the Constitution to outlaw same-sex marriage.

In addition, he has been inconsistent in supporting investments in biomedical science. He opposes stem-cell research and voted against expanding the National Institutes of Health budget and against the recently enacted 21st Century Cures Act, showing particular animus toward the Cancer Moonshot.

Price has also been a vociferous opponent of the Affordable Care Act (ACA) and a leader of the repeal-and-replace movement. His proposal for replacing the ACA is H.R. 2300, the Empowering Patients First Act,[5] which would eliminate the ACA's Medicaid expansion and replace its subsidies with flat tax credits based on age, not income ($1,200 per year for someone 18 to 35 years of age; $3,000 for someone 50 or older, with an additional one-time credit of $1,000 toward a health savings account). Price's plan is regressive: it offers much greater subsidies relative to income for purchasers with high incomes and much more meager subsidies for those with low incomes. In today's market, these credits would pay only about one third of the premium of a low-cost plan, leaving a 30-year-old with a premium bill for $2,532, and a 60-year-old with a bill for $5,916 — along with a potential out-of-pocket liability of as much as $7,000. By contrast, subsidies under the ACA are based on income and the price of health insurance. Today, a low-income person (with an income of 200% of the federal poverty level) pays, on average, a premium of $1,528 per year (regardless of age) for a plan with an out-of-pocket maximum of $2,350, and that payment does not change even if health insurance premiums rise.

To put the plan's subsidies into perspective, consider that in 1992, when per capita health expenditures were just one third of what they are today, President Bush and HHS Secretary Sullivan proposed a slightly larger individual tax credit ($1,250) for the purchase of insurance than Price proposes today. Even in 1992, analysts reported that the credit would be insufficient to induce most people to buy coverage.

The Price plan would eliminate the guaranteed-issue and community-rating requirements in the ACA and create anemic substitutes for these commitments to access to comprehensive coverage for Americans with preexisting conditions. These replacements include an extension to the nongroup market of the continuous-coverage rules that have long existed in the group market with little benefit; penalties on reentering the market for anyone who has had a break in coverage; and a very limited offer of funding for states to establish high-risk pools. In combination with relatively small tax credits, these provisions are likely to lead low-income and even middle-class healthy people to forgo seeking coverage until a serious health problem develops. Without the income- and premium-based subsidies in the ACA acting as market stabilizers, Price's provisions would erode the nongroup health insurance market.

Price's plan would withdraw almost all the ACA's federal consumer-protection regulations, including limits on insurer profits and requirements that plans cover essential health benefits. By allowing the sale of health insurance across state lines, the plan would also effectively eliminate all state regulation of health insurance plans, encouraging a race to the bottom among insurance carriers. Finally, Price would fund his plan by capping the tax exclusion for employer-sponsored health insurance at $8,000 per individual or $20,000 per family. These caps are well below those legislated through the Cadillac tax in the ACA, a provision that Price himself has voted to repeal.

In sum, Price's replacement proposal would make it much more difficult for low-income Americans to afford health insurance. It would divert federal tax dollars to people who can already buy individual coverage

without subsidies and substantially reduce protections for those with preexisting conditions. The end result would be a shaky market dominated by health plans that offer limited coverage and high cost sharing.

Whereas Price's actions to date have not reflected the tradition of the physician as advocate for the poor and vulnerable, they do harken back to an earlier tradition in American medicine: the physician advocate as protector of the guild. His Empowering Patients First Act would directly advance physicians' economic interests by permitting them to bill Medicare patients for amounts above those covered by the Medicare fee schedule and allowing them to join together and negotiate with insurance carriers without violating antitrust statutes. Both these provisions would increase physicians' incomes at the expense of patients. Price has consistently fought strategies for value-based purchasing and guideline development, opposing the use of bundled payments for lower-extremity joint replacements and proposing that physician specialty societies hold veto power over the release of comparative effectiveness findings. These positions reduce regulatory burdens on physicians at the cost of increased inefficiency and reduced quality of care — and reflect a striking departure from the ethos of his physician predecessors, Secretaries Bowen and Sullivan.

The HHS Department oversees a broad set of health programs that touch about half of all Americans. Over five decades and the administrations of nine presidents, both Democratic and Republican secretaries have used these programs to protect the most vulnerable Americans. The proposed nomination of Tom Price to HHS highlights a sharp contrast between this tradition of compassionate leadership and the priorities of the incoming administration.

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Patient-Reported Outcomes — Harnessing Patients' Voices to Improve Clinical Care

Ethan Basch, M.D.

Symptom management is a cornerstone of clinical care, particularly for patients with chronic conditions. Yet patients' symptoms and physical impairments go undetected by health care providers as much as half the time, particularly between clinic visits.[1] As a result, we miss opportunities to intervene and alleviate suffering. Moreover, incomplete documentation of this information in the electronic health record (EHR) limits our ability to understand key patient outcomes when we aggregate EHR data for comparative effectiveness research or quality-of-care assessments.[2]

Recent advances in technology and survey methods provide a potential solution in the form of patient-reported outcomes (PROs) recorded electronically — using simple but methodologically robust questionnaires, completed by patients at or between visits over the Internet or on a smart device, with data transmitted into the EHR.[3] Clinicians can receive automated notifications about worrisome symptoms or functional issues, such as severe dyspnea or reduced physical activity in an outpatient with heart failure. They can review longitudinal PRO reports at visits and import that information into their EHR notes as a part of the review of systems. There is evidence that this approach can improve patients' quality of life, enhance patient–clinician communication, reduce emergency de-