Reaching Outside the Beltway for Health Solutions

The 15 members of a new working group include physicians, nurses, and hospital administrators.

ARTICLES BY
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WASHINGTON — Sen. Ron Wyden (D-Ore.) says that the answer to America's health care problem does not lie with Congress—at least, not initially.

"I spent 2 years studying what went wrong in the Clinton debacle," he said at a meeting sponsored by America's Health Insurance Plans. Sen. Wyden was referring to President Bill Clinton's unsuccessful effort to get Congress to pass health care reform in the 1990s. He also looked at a similar effort in the 1940s by President Harry S Truman.

His conclusion: "There is a remarkable parallel in 60 years of failure. … For 6 decades, the effort has involved trying to write a piece of federal legislation in Washington, D.C. [But] the special interests would attack the legislation and each other, and everything would fail."

Instead, "I decided to go 180 degrees the other way," he said. "We'll start it outside [Washington]."

In March, Sen. Wyden, along with Sen. Orrin Hatch (R-Utah) and Comptroller General David Walker, announced the formation of the Citizens' Working Group on Health Care. The group is composed of 14 people from across the country, including physicians, health advocates, hospital administrators, academicians, nurses, and a union representative. Health and Human Services Secretary Mike Leavitt will serve as the 15th member.

The group is one result of a new law known as the Health Care That Works for All Americans Act, which was cosponsored by the two senators. One thing that the working group will do, according to Sen. Wyden, is "tell people where the $1.8 trillion spent on health care actually goes. . . . I think people will be pretty surprised." The information will be made available online as well as in booklets and in libraries.

The working group also will hold public hearings to get input on what should be done to reform the system.

"No one has walked the public through the choices and tradeoffs that come with a health care system that works for everybody," Sen. Wyden commented. "We're now going to have a real debate about how we create a system that works for everybody."

After publishing the spending information and listening to public comment, the working group will develop a set of tentative recommendations on a system that works for everybody.

"When they have the tentative set of recommendations, they go back to the public again for another crack, so people will get to weigh in twice," Sen. Wyden said.

Then the recommendations will go to Congress, and all committees with jurisdiction over health care will have to hold hearings within 60 days of getting the recommendations.

Although there is no mandate for Congress to take any further action on the recommendations once it has held hearings, "you will have a citizens' road map of where the country feels we ought to be headed in health care, and if at that point the Congressional committees decide they want to ignore what the citizens have to say, then it will be really clear who they're siding with—powerful Washington interests rather than the citizens," Sen. Wyden said.

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He offered a specific example of the type of issue he hopes the working group will address. "We know that a big chunk of the health care dollar gets spent in the last few months of someone's life. And we know in many of those instances, the best doctors and hospitals can't do anything to increase the quality of the person's life, and they can't do anything that's medically effective," he said.

"So the question for the country that the political leaders have been ducking—and that they aren't going to be able to duck any longer—is, in those kinds of instances, do we want to start spending more money on hospice and in-home services and less on expensive treatments and interventions, and use the savings for children, pregnant moms, and people who've fallen through the cracks in the system? It's a difficult conversation to have, but this is the kind of issue that we've got to have a discussion about," he said.

Even the semantics surrounding these issues are difficult to deal with, Sen. Wyden noted. For example, "it took me 3 months to negotiate the title of this bill. When we started, the Democrats wanted the words 'universal coverage,' but the Republicans said, 'We're not going there—that's socialism.' The Republicans wanted to call it universal access, but the Democrats said, 'We're not going there—no one will ever get anything.' "

Finally, the senator came up with the current title, which "the Democrats think sounds a little universal and the Republicans say has enough flexibility. Before anybody could change their minds, I made them sign the press release and that was it." ■

For more information on the working group, go to www.gao.gov/special.pubs/citizenshealthpr0228.pdf.

State Laws Vary on Who May Do Imaging

Although the recent spotlight has been on what the federal government will do to rein in the rising numbers of medical imaging procedures, states also are doing their part.

In Maryland, for example, state law requires that only licensed radiologists perform advanced imaging procedures such as CTs, MRIs, or PET scans. Radiologists say that laws like this help decrease the use of inappropriate imaging, which they say is done largely by nonradiologists who use the equipment in their offices.

"We believe Maryland's law is a model that we would like to see in other states," said Josh Cooper, senior director of government relations at the American College of Radiology, in Reston, Va. Florida has a similar law, but it is not as restrictive as Maryland's, he said.

Another way states are trying to manage the use of imaging equipment is through "certificate of need" laws that require physicians and others setting up imaging facilities to obtain a certificate of need to document that there is a demand in the community for such a facility. Rhode Island has such a law, according to Mr. Cooper.

While the radiologists and their college are keen to support state and federal laws that limit imaging utilization, other physicians say the radiologists are just trying to keep the business for themselves.

"The radiology community … claims that growth in imaging is due to 'self-referral' by physicians who own their imaging equipment, and that the quality of images and interpretations by nonradiologists is inferior to those by radiologists," the Lewin Group, a Falls Church, Va., consulting firm, said in a report for the Coalition for Patient-Centered Imaging, a coalition of medical specialties that wants specialists to be able to perform in-office imaging procedures.

"Our findings suggest that self-referral is not the primary driver of growth in imaging services. Some of the fastest-growing imaging services, such as MRI and CT scans, are primarily done by radiologists."

State legislatures are seeking fresh approaches to the issue. A bill currently in the California legislature would exempt only radiologists and cardiac rehabilitation physicians from a ban on physician self-referral.

The California Medical Association (CMA) is opposed to the bill, according to spokeswoman Karen Nikos.

The group's opposition is based on its self-referral policy, adopted in 1993, which states, "While CMA recognizes that there is nothing inherently wrong when a physician invests in a facility or when a physician refers a patient to a facility in which the physician has an ownership interest, CMA recognizes that serious ethical questions are raised when referrals are made purely for a profit motive. CMA has a responsibility to create policy and support legislation that would prevent abusive practices such as overutilization and overcharging."

Advocates on both sides of the issue say they expect these battles to continue.

"Our sense is that we will continue to see attempts to both legislate and regulate medical imaging at the state level," said Barbara Greenan, senior director for advocacy at the American College of Cardiology in Bethesda, Md.

"The ACC will continue to proactively educate state policy makers and payers about the value of office-based imaging, and to oppose efforts to restrict specialist physicians' ability to provide imaging services," she said.

One way to make sure that cardiovascular imaging is not overutilized is to develop standards for performing such procedures, Ms. Greenan continued, noting that the college is currently developing appropriateness criteria for cardiovascular imaging procedures.

However, insurers and government agencies interested in following imaging criteria will be faced with a choice: whether to use the ACC's criteria or criteria developed by the American College of Radiology. ■

Public Mental Health Spending Is Increasing

The percentage of mental health and substance abuse services that are paid for with public funding is increasing, according to a study that was conducted by the Substance Abuse and Mental Health Services Administration.

Public sources paid for 63% of mental health spending in 2001, up from 57% 10 years earlier, according to the study.

Similarly, the percentage of substance abuse treatment services paid for by public sources rose from 62% to 76% over the same period, the study found.

Public spending was defined, for the purposes of this study, as including Medicaid, Medicare, and spending by all levels of government—federal, state, and local.

"Overall, we have seen a decline in inpatient spending and a shift to publicly financed care," said SAMHSA administrator Charles Curie.

"As we continue to work to improve the community-based services available to people in need, it is clear the public sector is now the major financial driver," Mr. Curie added. ■