

Hatchet vs. Scalpel Approach to Reform Debated

BY JOYCE FRIEDEN
Senior Editor

WASHINGTON — Can President-elect Barack Obama really shepherd through major health reform? Not until the Medicare physician payment system gets fixed, according to Robert Laszewski.

"How do you plan a health care budget in Medicare and the private sector for years on out if you haven't agreed on how you're going to pay the doctors?" Mr. Laszewski said at a conference on the impact of the November elections sponsored by Congressional Quarterly and the Public Affairs Council.

Many obstacles lie ahead before the payment system can be fixed, said Mr. Laszewski, president of Health Policy and Strategy Associates, a health care consulting firm. "The primary care physicians are clearly underpaid, and a lot of people think that the specialists are overpaid."

Although everyone agrees the Medicare payment system needs to be reformed and that Medicare costs need to be trimmed, "the problem is, who's going to give up the money?" he continued. "The definition of physician payment reform is to pay the primary care physicians more and pay the rest of us more, and that's not going to fly."

Congress can't keep making temporary fixes, Mr. Laszewski said, because a fix that lasts for, say, 3 years will be followed by a 36% fee cut because of the way the Sustainable Growth Rate (SGR) payment formula works.

In the meantime, analysts and legislative aides are con-

sidering whether smaller health reforms might be possible.

"Do you have to do something big?" asked Robert Blendon, Ph.D., professor of health policy and political analysis at the Harvard University School of Public Health. "I believe not, but it has to be something that looks like a big down payment."

And policy makers have to be clear about their overall goals, said Christine Ferguson, J.D., of the department of health policy at George Washington University, Washington. "[Some] want to use health reform to improve health outcomes; [others want] to control costs [in terms of] the percentage of gross domestic product that goes to health care; and a third group wants to protect people from high [out-of-pocket] costs. It's important that we're very clear about which of those goals we're trying to achieve."

Rather than passing a major health reform bill right away, the panelists suggested that President-elect Obama could urge Congress to pass a package of smaller reforms, which could include less-controversial items as expanding the State Children's Health Insurance Program (CHIP), setting up a cost containment board to come up with ideas for reducing health spending, and helping individuals and small businesses buy health insurance—possibly by giving them subsidies to help pay for it.

"These items are all no-brainers," said Mr. Laszewski.

But some Senate Democrats are looking to take a more aggressive approach. Sen. Edward M. Kennedy (D-Mass.), who chairs the Senate Health, Education, Labor and Pensions Committee, wants to craft comprehensive health re-

form legislation that follows the framework of the Obama plan, said Michael Myers, staff director for the committee.

"With the Obama victory, the question is no longer whether we'll pursue comprehensive health reform but when and exactly what form," Mr. Myers said during a postelection briefing sponsored by the advocacy group, Families USA. There are many health reform proposals circulating, but the best chance for success is a single-bill strategy, he said, and Sen. Kennedy is urging fellow Democrats to unite behind the proposal from President-elect Obama.

No legislation has been drafted yet, but whatever comes out of the Congress will need to address the cost and quality of health care and expanding coverage to the uninsured, Mr. Myers said. "It's going to be kind of an organic process. I'm sure there will be fits and starts."

In the weeks before the election, aides to Senate Democrats tried to lay the groundwork for this legislation by meeting with stakeholders from across the spectrum. Now that the election is over, Mr. Myers said there will be more discussions with Republicans in Congress.

The interest in achieving comprehensive health reform and the cooperation among stakeholders is higher now than at any point in the last 25 years, said Ron Pollack, executive director of Families USA. "There's a very significant likelihood that meaningful health reform will be a top and early priority for action in the 111th Congress," he said. ■

Mary Ellen Schneider, New York Bureau, contributed to this report.

Physician Survey Shows Widespread Use Of Active Placebos; AMA Policy Murky

BY ALICIA AULT
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A survey of internists and rheumatologists suggests that prescribing active "placebos" is relatively common, even though ethicists generally frown on the use of such therapies, especially if the patient is not informed.

The survey was conducted by five ethicists from the National Institutes of Health; the University of Chicago; and Harvard Medical School, Boston, who said they were interested in exploring physicians' attitudes about placebo treatments because there is little systematic data on the topic (BMJ 2008;337:a1938 [doi: 10.1136/bmj.a1938]).

They surveyed 1,200 randomly selected physicians, half of whom were internists, and half, rheumatologists; 679 physicians (57%) agreed to participate and received \$20 for completing the survey. The respondents comprised 334 internists and 345 rheumatologists.

Depending on how the question was asked, 46%-58% of the physicians said they prescribed placebos on a regular basis, and 399 of 642 said it was ethically permissible to do so.

The study was somewhat deceptive, however, said Dr. Roy Altman, a rheumatologist in Agua Dulce, Calif., who was not involved with the study. The authors did not ask the physicians if they were merely going along with patients who were already taking placebos, Dr. Altman said in an interview.

He said that if a patient is taking a placebo that he knows is not harmful, he

generally won't stop him or her. "I'm not supporting the practice of giving placebos," he said, adding, "[but] I think it's something that's a part of medicine and I don't think you can take it away."

The authors noted that, to avoid using the word "placebo," they began with broad questions. For example, they asked physicians to respond to a hypothetical scenario in which a dextrose tablet had proven superior to no treatment. Would they recommend it as a therapy for nondiabetics with fibromyalgia? Twenty-four percent of physicians (160 of the 654 who answered these questions) said it was very likely they'd use the sugar pill; 34% (221 of 654) said it was moderately likely. But 31% (205) said it was unlikely and 10% (68) said definitely not.

They were then asked how often they recommend a therapy because they believe it will enhance the patient's experience. Fifty-nine percent (380 of 642) said it was permissible to recommend such a treatment; 31% (197) said it was permissible, but only in rare circumstances; and only 7% (46) said it was never permissible.

Finally, physicians were asked what therapies they had used primarily as a placebo treatment. Placebo was defined as "a treatment whose benefits derive from positive patient expectations and not from the physiological mechanism of the treatment itself."

Fifty-five percent of the respondents (370 of 679) said they had recommended—but not necessarily prescribed—some type of placebo in the past year. A total of 267 of 648 physicians (41%) pre-

scribed over-the-counter analgesics and 243 of 648 physicians (38%) prescribed vitamins. Sedatives were prescribed by 86 of 652 physicians (13%); the same number prescribed antibiotics. Saline and sugar pills were used by 18 of 623 and 12 of 642 physicians (3% and 2%, respectively).

When asked how these treatments were described to patients, 18% (62 of the 352 who actually prescribed placebos) said they were "medicine." About 285 physicians said they had not prescribed placebos. Only 18 physicians (5%) said they identify the treatments as a placebo. A large percentage—68%, or 241 of the 352—described the placebo as a medicine not typically used for the condition that might benefit the patient.

An American Medical Association policy on the use of placebos is a bit murky; it advises against their use without the patient's knowledge or if the placebo could cause medical harm. A placebo can be prescribed "only if the patient is informed of and agrees to its use," but the physician does not have to identify the placebo, or explain its potential effect, according to the policy.

In an interview, Dr. Norman Gaylis said that he believes the use of active placebos is "an inappropriate way to treat a patient." Giving a patient naproxen, for instance, "has potential for significant side effects to the kidney, so that's not a placebo," said Dr. Gaylis, a rheumatologist in private practice in Aventura, Fla.

Although the placebo effect is well documented in medicine and can be effective, he said, "the first thing for us is to not harm our patients." ■

Aetna's Physician Rating Program Meets Standards

Aetna Inc.'s physician-rating program recently received a passing grade from the National Committee for Quality Assurance.

The evaluation was conducted under a 2007 agreement between Aetna and New York Attorney General Andrew Cuomo, and was aimed at addressing allegations that health plans were using physician-rating programs to steer members to less expensive providers.

To date, seven state, regional, and national insurers have signed on to the agreement and pledged not to base their physician rankings entirely on cost. The health plans have also agreed to involve physicians in measure development and to allow physicians to review their performance data and request changes.

In the most recent evaluation, NCQA reviewed the compliance efforts of Aetna Health Inc., an HMO-point of service plan, and Aetna Life Insurance Co., a preferred-provider organization, both operating in New York. The plans were found to be in full compliance with the eight requirements reviewed by NCQA.

Aetna officials said they were pleased with the results and committed to continuing to offer physician-rating information to members. "We will continue to base our programs on available evidence-based and externally validated measures to help ensure our programs are credible and useful to consumers," Dr. James Coates, senior medical director for Aetna Informatics, said in a statement.

NCQA published reviews of CIGNA Healthcare of New York, an HMO, and Connecticut General Life Insurance Company, a PPO, in July. The organization is currently reviewing United Healthcare's physician-rating program.

—Mary Ellen Schneider