A Physician Shortfall Is Coming

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cialized medical care, drugs, or therapies for the management of acute or chronic pain and/or the control of symptoms administered by specially trained physicians and other clinicians; and supportive care services, such as counseling on advanced directives, spiritual care, and social services, to patients with advanced disease and their families."

The researchers identified all programs that self-reported the presence of a hospital-owned palliative care program and acute medical and surgical beds, and then used multivariate logistic regression to pinpoint factors that were associated with the presence of an adult palliative care program in the 2003 survey data (J. Palliat. Med. 2005;8:1127-34).

They found that hospitals in the Northeast, Pacific, and Mountain areas of the country are more likely than those in other geographic regions to have programs. The greater the number of hospital beds and acute care beds, the more likely a facility has a palliative care program. Similarly, being a Veterans Affairs hospital or a not-for-profit hospital increases the likelihood.

Among the factors associated with having a palliative care program are being a member of the American Association of Medical Colleges Council of Teaching Hospitals and being a cancer hospital approved by the American College of Surgeons.

"The fact that the American College of Surgeons would want to incorporate access to palliative care as one of their benchmarks of good care in a cancer setting is a sign that palliative care has been very successful in legitimizing its place in the continuum of medical practice," said Dr. Geoffrey P. Dunn, an Erie, Pa.–based surgeon who cochairs the ACS's Surgical Palliative Care Task Force.

"People are becoming increasingly aware that palliative care is an extension of the already well-known and very successful hospice programs in this country. As this study shows, there are more occasions where they will have the opportunity for those services. I think that's going to increasingly generate that expectation in care, whether it's at a cancer center or elsewhere," said Dr. Dunn.

Dr. Daniel B. Hinshaw, medical director of the palliative care consult team at the Ann Arbor (Mich.) VA Medical Center, said the increasing presence of palliative care programs in the nation's hospitals "gives us an opportunity to keep that message out there that this [component of care] is not just a matter of fighting disease. It's really about caring for the whole person who might have a bad disease," he said.

"We may not always be able to cure their problem, but we should always try our best to provide comfort and relief of distress and symptoms," Dr. Hinshaw continued.

For-profit hospitals, however, are significantly less likely to have programs, according to the study. Dr. Morrison said part of the reason may be the fact that palliative care programs started in academic medical centers and branched out to teaching hospitals. "The majority of teaching hospitals in the United States are still not-for-profit," he said. "I don't think there is a lot of communication [about palliative care programs] between the not-for-profit sector and the for-profit sector, but it's something we'd like to address."

Dr. Dunn called the current funding landscape for hospital-based palliative care programs "tenuous" even though numerous demonstration projects have shown them to be cost effective. "What will be a challenge in 5-10 years will be the physician staffing of these [programs]," he said. "Very shortly the American Board of Hospice and Palliative Medicine is expecting to receive credentialing from the American Board of Medical Specialties. Once that happens, that is going to put a pretty narrow lock on the pool of people who are considered certified and qualified to run these programs. I'm concerned that with this rapid proliferation of programs, how are we going to fill the demand for physicians who have some degree of training in this to do it?"

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DR. MORRISON

Dr. Morrison's study noted that there were 1,892 certified palliative medicine physicians as of July 2005 and 5,500 certified palliative nurses as of March 2005. It also noted that the number of postgraduate palliative medicine fellowships increased from 17 in 2000 to 53 in 2005.

Dr. Morrison said that the cost of a hospital-based palliative care program is directly related to the size of the hospital. At Mount Sinai Medical Center, which is a 1,000-bed teaching hospital, the palliative care program consists of two full-time physicians, four full-time nurse-practitioners, two full-time social workers, and consultation with chaplaincy and physical therapy.

"The expense of the program is far outweighed by the cost savings to our hospital for having it," said Dr. Morrison, whose study was funded by the Robert Wood Johnson Foundation. "For a 300-bed hospital, the team is probably going to be a physician, a nurse, a social worker, and consultation with other core services. For a 50-bed rural hospital, it may be that the primary person is a nurse-practitioner with a part-time physician as backup in consultation with other services in the hospital."

To access a financial calculator that helps you estimate the cost of a palliative care program and the cost savings to your hospital, visit the Center to Advance Palliative Care's Web site at www.capc.org. Look for the "CAPC Impact Calculator" icon. ■

POLICY & PRACTICE

Bill Halts 4.4% Cut

Congress' long-awaited passage of the budget reconciliation package (also called the Deficit Reduction Act) put a freeze on a 4.4% Medicare pay cut that physicians experienced in the month of January. The congressional action stopped any further reductions but did not increase Medicare physician pay for 2006. The Centers for Medicare and Medicaid Services will reimburse physicians retroactively for the January reductions, and has instructed its contractors to automatically reprocess claims. But work on this issue is far from over, Dr. J. Edward Hill, president of the American Medical Association, said in a statement. "With 6 years of cuts still scheduled to come as practice costs continue to rise—we fear more physicians will make difficult practice decisions about treating Medicare patients. … We must build on the momentum and awareness raised in 2005 to make 2006 the year Congress permanently repeals the broken Medicare physician payment formula." President Bush's fiscal year 2007 budget request to Congress briefly mentioned the impending cuts, but it also expounded on CMS's efforts to expand pay-for-performance initiatives to "achieve better outcomes at a lower overall cost."

And on to the 2007 Budget

The President's 2007 budget request for the Department of Health and Human Services—$698 billion—is a $58 billion increase from 2006, but contains cost containment measures that would whittle down or eliminate certain programs. Medicare initiatives to "encourage efficient and appropriate payment for services; foster competition; and promote beneficiary involvement in their health care decisions" would save nearly $36 billion from 2007 to 2011, according to an HHS statement. But Part A hospital payments would incur $22 billion of these cuts— "the wrong policy at the wrong time," as hospitals have been losing money caring for Medicare beneficiaries since 2003, said Chip Kahn, president of the Federation of American Hospitals. Aiming to meet the president's goal of cutting the federal deficit in half by 2009, the budget request proposes other targeted reductions or elimination of certain programs whose performance ratings were low or whose purposes are being covered by other HHS programs. These cuts include $133 million to rural health programs run by the Health Resources and Services Administration, and elimination of the $630 million Community Services Block Grant program. Several organizations decried the proposed cuts to National Institutes of Health research programs. The National Institute of Diabetes and Digestive and Kidney Diseases would be funded at $11 million less than in 2006, according to the American Diabetes Association. Also, the Centers for Disease Control and Prevention would receive only $819 million for chronic disease programs, a $20 million reduction from last year, the ADA reported. Some programs took special priority in the request—the president, for example, asked for $4.4 billion for bioterrorism-related spending in 2007, a $178 million increase over 2006. To achieve the president's goal for most Americans to have secure personal electronic health records by 2014, $169 million was requested for 2007 ($59 million more than in 2006) for health information technology. The Food and Drug Administration's 2007 budget request totaled $1.95 billion, a 3.8% increase over 2006. Much of these additional FDA funds would be used for pandemic prevention, promotion of molecular medicine, and protection of the food supply from bioterrorism.

Not So Sure on Quarantines

Americans are in favor of quarantines as a protection against infectious diseases—but when it comes to the enforcement and monitoring of quarantines, they're not as receptive as people in other countries, according to a Web-exclusive Health Affairs study titled "Attitudes toward the Use of Quarantine in a Public Health Emergency in Four Countries." Residents of the United States, Hong Kong, Singapore, and Taiwan were polled for the study. Certain enforcement measures received wide support in the Asian nations, but only 53% of Americans said they would favor a requirement for everyone to wear masks in public in the event of disease outbreak. Only 44% supported screening for illness by taking people's temperature before they entered public places. Americans were also less supportive of quarantine compliance measures such as guards, electronic ankle bracelets, and periodic video surveillance, compared with residents of the Asian nations. The use of arrest to maintain quarantine had limited support in all of the countries. Only 42% of the U.S. respondents supported a compulsory quarantine where noncompliant individuals could be arrested, the study indicated.

CVD Awareness Rises

More women are aware of cardiovascular disease, and that knowledge is causing them to take positive preventive health steps for themselves and family members, according to a recent study published in the journal Circulation. A survey of more than 1,000 women aged 25 and older found that awareness has nearly doubled since 1997. Among the women who completed the full survey in July 2005, 55% said that heart disease/heart attack is the leading cause of death. This is up from 30% in 1997. In addition, about 54% of women who reported seeing a health care professional on a regular basis said they had discussed their risk of heart disease within the past 6 months. The top reason women cited for not speaking to a physician or other health care professional about heart disease in the last year was that the provider did not bring it up.

—Jennifer Lubell