

Commentary:

## NUCLEAR MEDICINE—ICONS OR IDEAS?

**N**uclear Medicine cannot escape the effects of decreasing budgets for the delivery of health care and the conduct of biomedical research. Health care providers, policy makers, and economists agree that sophisticated technology, such as positron tomography and nuclear magnetic resonance, can lead to improved treatment of disease—but they believe that the costs may be too great. The development of diagnosis-related groups (DRGs) has



already changed the structure of health care financing, and further modifications in reimbursement seem inevitable. Are we in nuclear medicine responding to the new forces affecting our profession? Diagnostic tests have traditionally borne the brunt of cost-containment efforts. I have long maintained, however, that the greatest savings in medical costs can be derived from improved planning and conduct of treatment, as in, for example, avoiding elective surgery in patients likely to have costly complications which are unanticipated because of insufficient data prior to surgery.

already changed the structure of health care financing, and further modifications in reimbursement seem inevitable.

Are we in nuclear medicine responding to the new forces affecting our profession? Diagnostic tests have traditionally borne the brunt of cost-containment efforts. I have long maintained, however, that the great-

It behooves us to promulgate these principles and become more aggressive in presenting our case to the medical community, to our patients, and to our governmental policy makers. We cannot afford to miss opportunities to present the case for a scientific approach, rather than a purely fiscal approach, to our patients and their problems.

The very economic factors that threaten traditional imaging methods can be the springboard for the expanded use of radionuclide-based, nonimaging information systems in patient diagnosis and treatment monitoring. Nonimaging nuclear methods can provide more organ-function information than competitive nonradioactive tests, and at a lower cost. The opportunity is open to move nuclear medicine more into day-to-day clinical use, while at the same time contributing substantially to improved hospital economics.

If we are to accomplish this desirable and necessary goal, we must focus an increased portion of our research and clinical attention on these complementary, cost-effective techniques. It requires a reawakened interest in these methods, and considerably more imagination and action in their development and clinical utilization. We should realize that we can provide ideas as well as icons.

—Henry N. Wagner, Jr., MD

*Johns Hopkins Medical Institutions, Baltimore, MD*

## ADAPTING NUCLEAR MEDICINE TO PROSPECTIVE PAYMENT

**D**iagnosis-related groups (DRGs) have shifted the ground out from under certain established practices in health care delivery. Moreover, most observers of the medical field would agree that DRGs are only the first tremors of an imminent quake in cost-containment rules.

Leaders in nuclear medicine, how-

ever, have recognized the fault line beneath the surface of economic reforms, and have found safer ground on which to build the future of this specialty.

Even before DRGs were implemented in October 1984 to set standard rates of Medicare reimbursement for 470 categories, hospitals were transferring costs to nongovernmental

third-party payers and private patients. These over-charged consumers are now developing their own DRG systems, and thus the cost-shifting solution is no longer viable.

Another anticipated economic reform is the possible inclusion of physician fees under a DRG system.

Looking further toward the future, the government may regulate outside imaging centers, either through certificates of need or reimbursement limitations.

Under the present system, the  
*(continued on page 340)*