NUCLEAR MEDICINE AND HEALTH CARE REFORM

After Clinton plan announcement, Congress and lobbyists gear up for Act II while Nuclear Medicine seeks a part.

EVER SINCE PRESIDENT Clinton announced the health care plan on September 22, physicians, pharmaceutical manufacturers, medical societies, and the average citizen have been examining what this plan means to them. Whatever plan Congress eventually decides on, the consensus is that health care in the United States will be different. Nuclear medicine will thus be affected, and already leaders, practitioners, and researchers in the field are looking to what those effects will be, how they can prepare, and most importantly, whether the plan will be best for the nation's health.

"In general, it appears specialty practice will be de-emphasized and [policy makers] will attempt to convince medical students not to go into specialties, and this includes nuclear medicine," said Richard C. Reba, MD, professor of radiology at the University of Chicago and president of the Society of Nuclear Medicine. Considering nuclear medicine's pro-active response, he said, "We must find other groups with similar interests and work from there, because we cannot have sufficient impact alone."

Competing with Generalists and Specialists

This concern about nuclear medicine as a specialty stems from major alterations in the health care system that the Clinton plan would enact. The plan's central idea is to guarantee health care to every citizen, including the approximately 37 million Americans currently without insurance. While gaining this security and some degree of choice and quality in care, the president wants to inject simplicity into the system and derive savings while demanding greater responsibility of everyone involved. To some, achieving security—while maintaining choice, quality, and savings—means managed competition among health providers, with an emphasis on preventive medicine. Managed competition, with consumers buying insurance plans under large health alliances, will encourage consumers to buy into cheaper health maintenance organization (HMO)-types of plans, with fewer opting for more expensive plans in order to keep seeing individual physicians. Primary care services become the mainstay under managed care; to cut costs, primary care practitioners often act as gatekeepers to specialists. In such a scenario, generalism flourishes.

"Under a gatekeeper system, I'd anticipate the number of nuclear medicine procedures will fall, though not in some areas," said Darrel W. McIndoe, MD, medical director of the Division of Nulcear Medicine, St. Joseph's Hospital (Towson, MD) and chairman of SNM's Socio-Economic Affairs Committee. In cardiology, for example, diagnostic procedures that determine who should undergo a bypass operation will face stronger competition with one another. "If our technique—which is more specific than ultrasound—becomes the national standard, then there will be an increase in our procedures."

In practice, keeping procedures competitive in the medical marketplace often translates into maximizing cost-effectiveness—a need that several nuclear medicine observers echoed. "We must make sure our benefits are defined," said Paul H. Murphy, PhD, former SNM president and assistant chief of nuclear medicine at St. Luke's Episcopal Hospital (Houston, TX). If practitioners can reduce the number of nuclear medicine procedures while increasing the diagnostic information they can glean, they will increase cost-effectiveness—and the greater benefit of the procedures that are done should become evident. "I know we'll lose where physicians offer quasi-essential procedures," Dr. McIndoe said. "Where we are cost-effective, we'll come out on top."

Maintaining Cost-Effectiveness

But some nuclear medicine observers believe the field has a severe, outsider-imposed handicap on its cost-competitiveness with other specialties. Kenneth A. McKusick, MD, associate director of the Division of Nuclear Cardiology at Massachusetts General Hospital, points to the Resource-Based Relative Value Scale (RBRVS), Medicare's physician payment schedule from the Health Care Financing Administration (HCFA), as a major financial strain. "The problem is that nuclear medicine has been undervalued along with subspecialties, with a drop in the relative value for what it does," he said. While procedures have price limits, expenses are increased by other outside forces. Carol S. Marcus, PhD, MD, SNM vice-president-elect and director of the Nuclear Medicine Outpatient Clinic at Harbor UCLA Medical Center (Torrance, CA), cited factors greatly increasing the cost of practice. Burdensome paperwork required by the NRC, redundant regulation among the various federal and state agencies, and lack of regulatory coordination between the agencies (e.g., HCFA decreasing reimbursement while the FDA increases the prices of drugs) puts nuclear medicine at an unfair disadvantage with other specialties that do not have the extra burden of the NRC regulations. "We are in a very precarious position because we are not in control of our costs and they're

much higher than they should be," she said. "I'm very worried about nuclear medicine in the face of [further] reforms."

Whatever the source of nuclear medicine's costs, impending reform has caused practitioners to examine cost-effectiveness with new urgency. "Our goal has always been excellence without regard for cost," said Henry D. Royal, MD, chairman of SNM Committee on Health Care Policy and professor of radiology and associate director of the Division of Nuclear Medicine, Mallinkrodt Institute of Radiology (St. Louis, MO). "Now a new definition of excellence will be to do as good as possible within a certain range of cost." James J. Conway, MD, SNM president-elect and division head of Nuclear Medicine at Children's Memorial Hospital (Chicago, IL), expressed concern that the shifting emphasis toward managed care will bring about changes in more than just cost-effectiveness. "What bothers me is that those who determine what research and care is to be done will be those managers not directly involved in care," he said. He had witnessed managed care [organizations] send children with cancer to institutions that lacked the capability of handling the patients as well as his own. He saw that one good side effect of such reform, though, could be that the public would demand "that practitioners learn more"—for example, about pediatrics, so they would be able to handle a broader spectrum of cases.

Belt-tightening from health care reform inspires worries about other financial concerns than just the cost-effectiveness of practice. "We have to make sure that advances in technology are not impeded—like monoclonal antibodies or instrumentation—just because there are not resources," said Dr. McIndoe. "One of the easiest things to cut is R&D." Dr. Murphy listed three activities of basic scientists that reform may independently affect: quality control of daily operations in radiopharmaceuticals or instrumentation; teaching, of both nuclear medicine and related areas; and funding for medical research, which may not be as high a priority if funds are shifted. To date, the Clinton plan has not addressed the problem of funding research. In the medical community there is some concern about how new emphasis on generalism may affect medical schooling: a de-emphasis on specialties, and specialty training may mean shriveling funds for research and education in those specialties, less continuing education for practitioners, and an erosion in quality care.

From Local to National Levels

Observers are also watching how reform may affect their particular regions. Dr. Conway noted that the Chicago area has been "somewhat retarded" in adopting HMO's, and though there has been some recent stimulus there toward managed care, health care reform will continue this process in his region. Practitioners in the northeast region, Dr. McKusick said, have been restricted in the amount they can charge, as "balance billing"—billing a patient for the costs for a procedure beyond the cost Medicare allows—is illegal in Massachusetts. "The whole U.S. will be like this now, with set fees." Terrence Beven, MD, chairman of SNM Government Relations Committee, past president of the American College of Nuclear Physicians, and director of Nuclear Medicine, Our Lady of the Lake R.M.C. (Baton Rouge, LA) felt that all regions would experience "greater conformity by regional carriers and greater effort by HCFA to establish national standards. So HCFA will attempt to obliterate regional differences."

Though there are obviously many fears and hopes over what reform may do to nuclear medicine and general health, the question remains, *What can nuclear medicine do to ensure that reform safeguards the nation's health?* "Many responses are possible," Dr. Reba said. "Beat our chests and moan we're being hurt, or change our habits." But he conceded that, "Until we talk to other specialty societies, it's difficult to know what we should or can do." Many specialty and umbrella medical societies are already taking action concerning the Clinton plan. On September 29, the American Medical Association (AMA) began a mail campaign to 670,000 doctors and 40,000 medical students, urging them to lobby patients to oppose Clinton's proposal's for cuts in Medicare and Medicaid and for insurance premium regulation. The American College of Radiologists issued a statement lauding Clinton's call for universal health care coverage but expressing concern about Medicare cuts, limits on mammographies, and lack of medical tort reform. For October 22-23, the Council on Medical Specialty Societies has slated meeting on managed competition. In December, in New Orleans, the Section Council on Nuclear Medicine will meet to discuss health care reform .

"They'll ask, 'What is our response?'" said Torry Mark Sansone, executive director of SNM who considers health reform very important to nuclear medicine. "We don't have a response yet. Nuclear medicine should be orchestrating and coordinating its response to health care reform." The Committee on Health Care Policy, he said, is concerned more with the scientific rather than the socio-economic issues behind health care plans. "Currently we have no committee looking at this problem specifically. I'm very concerned about it, and I think our organization should be concerned." He is notifying the chairs of relevant SNM committees about the urgency of the issue and the need to develop a platform. He described the AMA's booklet, *Health Access America*, which gave local AMA chapters criteria for taking political action. Dr. Reba is asking nuclear physicians to operate locally and determine how they may make the health care plan work most effectively in their regions. "We're moving toward a coordinated response, but we're not there yet," said Mr. Sansone. If nuclear medicine does not take a stance, there are hundreds of other interest groups that will decide for it.

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