

# NUCLEAR MEDICINE PRACTITIONERS TURN CRITICAL EYE ON MANAGED CARE

**Concern is aired about capitation's effects on diagnostic procedures, while the Society makes first moves toward formally addressing the issue**

**D**ESPITE THE INTENSE DISCUSSIONS about national health care reform, changes in the structure of medical practice have been slowly accruing for years at the state level, both through legislation and natural marketplace evolution. A major alteration in medical practice that has gradually come about in several parts of the country is managed health care, and several nuclear medicine practitioners are concerned about how such changes may affect quality of care and practice. California and Minnesota have experienced particularly extensive changes toward managed care, both states having about ninety percent of health care done through some kind of managed care organization, according to Howard J. Dworkin, MD, chair of SNM's Commission on Health Care Policy (CHCP). Several nuclear medicine physicians in these states have become active in educating the public and politicians about the effects of managed care on practice.

"We have a pretty strong belief," said Malcolm Powell, MD, a nuclear medicine physician and endocrinologist in California's Bay Area, "that managed care in the type we see in California has ethical compromises we cannot abide by." Dr. Powell wrote a resolution passed by the California Medical Society and by the American College of Physicians saying it was unethical for a physician to contract with a managed care organization without discussing with the patient that some diagnostic procedures may not be allowed under the contract. His concern has not been so much with managed care organizations per se as with the way physician are expected to operate within particular managed care systems. "Some managed care organizations don't want physicians to discuss [the fact] that some care is withheld because of insurance. This is unethical," Dr. Powell said.

## Getting a Handle on Managed Care

Robert Boudreau, MD, a Minnesota physician

and president of SNM's Central Chapter, pointed out that under capitated care, radiology and similar services become viewed as expenses. Within Minnesota's Integrated Service Networks (ISN), "patients can't move from provider to provider, so there's a reduction in competition," Dr. Boudreau said. "The end result is that there is competition [among practitioners] for the patients themselves... We compete for contracts [and] we become an expense rather than an asset in the eyes of the companies that must pay for nuclear medicine services. So we provide care that is appropriate but not as full as possible."

Although the Society has not adopted a platform on the issue, the leadership is investigating ways of tackling it. "We're looking into the possibility of creating another committee within the Health Care Policy Commission," said SNM President James J. Conway, MD. However, he pointed out that a number of members have difficulties with such an action concerning such a controversial issue when many committees are already strapped for funds. "It's in the dream stage," he said, adding that the SNM will at least have a course on managed care.

CHCP Chair Dr. Dworkin said the difficulty with managed care is that "it doesn't come from Washington: every managed care organization is a little fiefdom unto itself." Although a managed care system is supposed to keep down costs, the various organizations do not come together in meeting health care needs across the country. Thus, organizations in a given region "pick from a shopping list of what they want" for their services, said Dr. Dworkin.

## Politics of Managed Care

"In the Detroit area, several hospitals got together to form an HMO so a hospital wouldn't close. But in South Dakota, HMOs bought up hospitals and several closed," Dr. Dworkin said. "I have a feeling local politics makes a difference on what kind of HMO you get. Poor areas get one type, rich areas another."

After receiving good press during the early days of Clinton's health care reform plan, which advocated managed competition as a way to control costs and to help achieve universal coverage, managed care as a panacea has come under increasing scrutiny. A September 9, 1994 *New York Times* article related several economists' fears that if most

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of the country were to come under a managed care system, the advantages of such management would start to disappear. Right now, for example, when a care-management company makes a deal with a hospital for lower costs, the hospital compensates for the loss through treating patients with traditional fee-for-services coverage.

While some physicians continue to advocate managed care as a means to help assure efficiency and universality of health care, others remain cautious as to how, in the scramble for efficiency, HMOs and other groups may overlook certain medical specialty services that in the long run are highly efficient. Dr. Powell acknowledges, on the one hand, the advantages of managed care, as in its ability to diminish the number of hospital days. But he

sees other problems arising when nuclear medicine is capitated. For example, with nuclear medicine procedures, "capitation is set up to include both diagnoses and therapy, [with the assumption] therapy is not expensive." But nuclear medicine therapy is usually more expensive than diagnoses, so the patient may end up having to pay for the therapy out of pocket.

### Managed Care within the U.S. Health Care System

Dr. Boudreau described how capitation completely changes the perception of procedures: a procedure "becomes an expense because they give you X dollars to take care of a patient, so anything you do for the patient becomes an expense. If you do a throat swab you make money, but if you do a bunch of MRIs, you lose." However, Minnesota, as in many states, has an added confusion for physicians because "we're just moving into the system; it's still a mixture of fee for service and contract care," and so physicians cannot adopt one across-the-board strategy. "The end result is that we're providing services for fees far less than what we're used to. There's a discount of 40%-50% off the usual bill. The result is that the net revenue in the state for most imaging people is declining—a significant change. I know only one private practitioner group that seems to be bucking the trend. I would say the percent of volume of fee for service is decreasing across the state."

In California, Dr. Powell also observed that managed care within a mixed health care system has had peculiar effects on both the physician and patient. "On a practical basis, surely physician income is affected in California. We see that some patients are paying out of pocket, particularly those from Kaiser. Some [patients] think this is not bad to do since they save so much on the program."

He emphasized that in order to understand just what sort of impact managed care will have in this country, it is important to study our health care system in the international context. "13.1% of the U.S. GNP is going toward purchasing medical care," he said. "No one has done a study to see what the appropriate percentage should be." In Germany, which has the next highest percentage of any country, it's 9.2%. "What's the difference between German and U.S. systems? We have a high liability expense because of malpractice suits. "Also, advertising accounts for 10% of our medical expense. Also, you have money going to shareholders and executive salaries, [which account for] at least 15% of health care dollars. All of these things do not buy health care. Also, our regulatory costs are much higher. So, add all of this up, and it will [account

## Congress Postpones Health Reform

Health care reform, after a year of intense debate, scrutiny and planning (see Newsline, November 1993, p. 32N; May 1994, p. 23N; June 1994, p. 18N; August 1994, p. 26N; and September 1994, p. 15N), officially died in Congress for 1994 when Senate Majority Leader George J. Mitchell (D-ME) announced on September 16 that the legislature would not further pursue the issue this year. Sen. Mitchell cited Republican and insurance company opposition as reasons for the postponement; although the Republican party denied these allegations, it acknowledged that it did threaten to block an international trade pact if the President continued pursuing health care.

The health care proposals in Congress changed considerably from the original Clinton plan made public September 22, 1993. The need for compromise on key issues became apparent immediately from partisan and bipartisan reactions, and two issues in particular became the focus of the most heated discussions: universal coverage effected by mandatory insurance from all employers, and insurance purchasing alliances that would be set up to control costs (see Newsline, September 1994, p. 15N). The Clinton Administration dropped its proposal for insurance alliances, and in the meantime, small businesses attacked mandatory insurance. But major splits in support for the Clinton plan occurred as compromises were made. Proposed Senate bills began slipping back from universal coverage—and thus mandatory insurance—to cover such percentages as 92 percent of the population by a given target date, to gain the vote of some members of the opposition but in the meantime losing the support of universal coverage proponents. Although House Majority Leader Richard A. Gephardt (D-MO) insisted on universal coverage, straw polls showed that such a bill had far from the necessary votes to pass.

Spokespersons for both parties, however, acknowledged that they will take up the issue next year, as polls show a majority of Americans consider the health care system needs overhauling. Already, Daniel P. Moynihan (D-NY), chair of the Senate Finance Committee, has investigated the possibility of a scaled-back bill that would help those employees changing jobs or those with existing medical conditions. Still, with Sen. Mitchell turning his back on reform for the year, November elections on the horizon, and the hard unfinished road toward reform this year, Congressional observers remain skeptical of any immediate rebound of the issue.

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for] Germany's amount or even less." But, in turn, the U.S. has a high technological sophistication in health care that both decreases costs through efficiency yet also increases costs by keeping certain patients alive longer and using health care dollars. He cited, for example, that Canada has only 10% of the U.S. per capita of MRIs. Understanding exactly how U.S. health care dollars are appropriated and

how such appropriation maintains our quality of care can only assist when making health management decisions.

"California is way ahead of the nation in managed care," Dr. Powell said. "Maybe the mistakes made here will modulate what happens in the rest of the country."

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## COMMENTARY

# QUALITY ASSURANCE UNDER HEALTH CARE REFORM



*Henry N. Wagner, Jr., MD*

**A**S IN OTHER SPECIALTIES, we in Nuclear Medicine have a choice: we can survive or not. We also have the opportunity not only to survive but to prosper, if we face up to new problems and solve old problems that have existed for decades. Public and political interest in the health care system have accelerated the changes that are already taking place in the American health care system. A major change is a decrease in fee-for-service practice and growth of managed care and capitation. By the year 2000, half of the American population will be covered by managed care and capitation. What do we face and how should we respond? First, the workforce in nuclear medicine—both physicians and technologists—will continue to diminish as managed care becomes more widespread. The response is to increase expertise and educate physicians, administrators and the public. Second, the focus on cost containment will result in decreased payment for individual medical services. The response is to market nuclear medicine studies and expand volume.

The great strength of nuclear medicine is the quality of its science and technology. Nuclear medicine could be in the forefront of the new molecular medicine, and be a major factor in a "new era of certainty."

Progress depends on problems. The greatest obstacle to progress is satisfaction with the status quo. It is clear that the public and most of the medical profession believe that the status quo is not satisfactory. Regardless of what happens in Washington, DC, this year or next, changes in the American health care system are already being played out in most states and in private industry.

Nuclear medicine procedures are under- rather than over-utilized. Nuclear medicine can benefit greatly from cost-effectiveness research. The quality of nuclear medicine practiced in the United States can be improved if it is practiced by fully

trained expert physicians working with fully trained expert technologists.

Technology assessment is a major opportunity for nuclear medicine. Technical assessment should not be limited to the technical performance of nuclear medicine procedures, but should also include clinical assessment of how the entire encounter of the patient with nuclear medicine benefits the patient. It is essential to document how nuclear medicine helps solve patients' problems. We must begin to assess the effects of nuclear medicine procedures on patient care and clinical outcomes.

Such documentation of efficacy and relevance to patient problems can be carried out locally and nationally, by individual nuclear medicine departments and multi-institutional studies.

Outcomes research must document the value added by nuclear medicine to patient care. When Congress created the Agency for Health Care Policy and Research (AHCPR) in 1989, \$200 million was budgeted to carry out studies which would consist of a review of the available literature, analysis of patient records and the data stored by HCFA and insurance companies. Patient Outcome Research Teams (PORTS) were funded for cost-effectiveness studies of ischemic heart disease, acute myocardial infarction, diabetes mellitus, prostate disease, cataracts and back pain.

Some have criticized outcomes research studies as diverting money from relatively cost-effective trials to uninformative analyses of databases which can do more harm than good. They have criticized this approach, preferring the use of large, multi-institutional randomized clinical trials.

Prospective clinical trials are needed to measure efficacy, to determine whether a procedure can be helpful under controlled conditions of practice. But we need to examine effectiveness as well as efficacy, and such studies could be made in every nuclear medicine department in the country. We need to determine at the local level how helpful procedures are in practice, and after we have documented cost-effectiveness, we need to communicate this information to other physicians, administrators and the public.

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