- Develop a process for involving and supporting ACC Chapters in addressing issues relating to cost of and access to cardiovascular care at the local level. These might include exploration of more efficient uses of resources at the local level to avoid costly duplication of highly technical services.
- Provide a forum for the critical analysis of the components involved in the increasing volume of cardiovascular services and their cost.
- Encourage innovation and creativity in clinical practice and technology with safeguards to prevent proliferation of technology until appropriate controlled studies have demonstrated the desirability of widespread utilization.
- Continue education of cardiovascular specialists on their responsibility to provide access in a cost-effective manner. This includes the avoidance of utilization of duplicative technical procedures. The ACC should encourage regionalization of underutilized, high cost, technical procedures.
- Emphasize ethical standards of practice as outlined in Bethesda Conference 21: "Ethics in Cardiovascular Medicine."

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Task Force 4: Influence of Private Sector Parties on Access to Cardiovascular Care

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Introduction

Any discussion of health policy, particularly a consideration of access to health care, tends to focus on the actions of government. However, health-related groups in the private sector also play an important role in influencing access to cardiovascular care. Employer groups are of major importance, because employment is the major source of health insurance in the United States. Insurance companies and the insurance industry in general may profoundly influence health care, because insurance is the vehicle by which the majority of health care coverage in the U.S. is provided. Medical industries, particularly companies involved with pharmaceutical agents and medical instrumentation, are a prominent private sector force capable of influencing health care delivery. Finally, organizations involved in liability and malpractice litigation can also have a substantial impact on the accessibility of health care. The purpose of this task force is to consider factors affecting or produced by private sector health-related groups that can influence access to cardiovascular care. This task force will also attempt to

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identify measures that these private sector groups can take to improve access to cardiovascular care.

Access to cardiovascular care may be viewed in several ways. First and foremost, of course, attention is drawn to the more than 30 million uninsured Americans for whom reduced access to health care is so palpably present. However, issues also exist with regard to persons who are underinsured or who have standard health benefits but whose specific access may be limited by the policies and procedures of the carrier. Clearly, employers, the medical technology industry, insurers and those involved in medical liability all play an important role in determining optimal access for both the uninsured and the insured.

Role of Business

Health insurance in the U.S. has been traditionally obtained through the workplace from employers. This is particularly true for persons employed by major corporations (for example, "Fortune 500" companies) but is much less applicable to workers in small businesses. In fact, the National Medical Expenditure Survey reported that more than 26% of workers in settings with fewer than 10 employees were uninsured (1,2). In addition, both considerable variability in the type of insurance provided by employers and substantial employee discretion as to which program to obtain provide significant opportunity for underinsurance.

Recently, increasing costs for health care have stimulated many businesses to reexamine both their role in and the current method of providing health care benefits to employees. It has been estimated that expenditures for insurance premiums increased by an average of 24% in 1989 and 14% in 1990 (3). Health care is now the most rapidly rising portion of the operating budgets of many corporations, and has been estimated to be equal to after-tax profits. Not surprisingly, evidence exists that the number of businesses providing insurance coverage to their employees is decreasing (4). Obviously, these measures serve to increase the number of uninsured or underinsured persons and thereby worsen access.

In an attempt to achieve maximal return for dollars spent, payers have begun to manage the care provided to their beneficiaries by using techniques to determine the need for and the appropriateness, efficacy and outcome of care. In principle, this process is directed toward paying for (and thus providing access to) care that is of benefit, and denying payment for care that provides no benefit or may even be harmful. The techniques used include second opinion, precertification and utilization review and are implemented under the general rubric of "managed care." By necessity, in the absence of other measures, these techniques are external to the care process that involves an intimate doctor-patient relation.

These efforts to manage the care provided to employees are a change from the historic behavior of employers and insurers, who once simply paid the bills for services provided. Many have argued that the managed care process has reduced the efficiency of the total health care system because it has increased administrative costs and diverted revenue from providing additional access. However, those who have successfully implemented managed care programs state that the increased administration enables better control of medical costs, reduced premiums and greater assurance of quality of care. At the same time, the managed care process has made clearly visible the uncertainty attached to the outcomes achieved by a number of cardiovascular interventions. Indeed, this uncertainty is often highest for procedures that are expensive and frequently utilized. The effect of the management effort may increase access (for example, through preventive measures such as immunization) or may impede access by restricting choice of physician, restricting direct access to specialists or providing certain types of care only in conjunction with patient copayment.

As they attempt to control costs with managed care, many payers are simultaneously implementing continuous quality improvement programs to provide better care to beneficiaries. One approach would assign responsibility for establishing the process by which health care is delivered to professional societies such as the ACC but would delegate the determination of quality to individual cardiovascular specialists at the site of care delivery. System improvement can be addressed by attempting to classify the components of care into degrees of certainty for appropriateness. The generation of guidelines for appropriateness by the ACC would be of great value to this process. At least in theory, an element of care that is always appropriate would not require a second opinion, precertification or utilization review. Unfortunately, payers currently often have a low level of confidence about appropriateness of a particular aspect of care. This leads to questions relating not only to an individual case and its specifics but also to system improvement. Alternative methods could be undertaken to assure quality, such as external audit surveys of the record-keeping accuracy and validity of stated outcomes of a representative sample of a physician's case load. If record keeping were consistent and criteria for appropriateness scientifically valid, the need for medical services under these conditions should be clear and intervention by outsiders minimal. Where appropriateness was less established, payers might depend on patient judgment to supplement physician judgment by requiring an appropriate copayment. Some services not judged by payers to be of value to the individual would not be included in insurance coverage. Statistical data for physician, patient and payer would improve the validity of this process.

Small businesses have unique issues with regard to employer-provided health benefits and access to care. First, the costs of health insurance have been estimated to be 20% greater for small than for large businesses because of higher administrative costs and other factors (5). Second, although the costs for employee insurance are totally tax deductible for large businesses, self-employed persons can deduct only

25% of health insurance costs from their taxes (6). As will be discussed with respect to the insurance industry, small businesses frequently have their coverage restricted or their premiums increased because of the medical condition of one or two persons in the group. Because health care costs for large employee pools are spread among many persons, premiums are lower. It is not surprising, therefore, that two-thirds of employed persons without insurance are drawn from small businesses (6).

Several factors were responsible for the evolution of the central role of employers in the provision of health insurance, and the same mechanisms could be used to enhance access to care. During the Second World War salaries were frozen, and health care benefits were one of the few ways in which employers could adjust the compensation of their work force. Subsequently, classification of health care benefits as tax deductible rendered it preferable to provide employees with health insurance rather than an equivalent salary amount. Some modification of the taxes levied on business for health care benefits could provide a method to improve access to care. Certainly, a reconsideration of the tax deductibility for health insurance of self-employed persons is in order.

Mechanisms to ensure the necessity, appropriateness, efficiency, quality and outcome of care would affect the access to cardiovascular services that payers provide to their beneficiaries. In this regard, it would appear to be of critical importance to define a package of core benefits for cardiovascular patients based on appropriateness; this function could be filled by the ACC. The definition of such core benefits would probably form the basis for the support of the business community for access to health care for its own employees, as well as extension of such access to society in general. Industry will certainly be unwilling to support more generous health care access to a broad public that is unable to pay for such services than it is willing to provide to its own employees.

Role of the Pharmaceutical and Equipment Industry

In the purest sense, access to health care depends on the existence of effective diagnostic and therapeutic modalities, and the pharmaceutical and medical equipment industries thereby provide access to cardiac care by developing and disseminating innovative technology. However, new and expensive technology is invariably cited as an important factor responsible for increasing health care expenditures. Innovative and improved drugs and medical instrumentation beget both the benefits of increased health and the liabilities of increased expenses. Thus, the development of beta-blockers and calcium channel antagonists to supplement nitrates in the treatment of angina pectoris, the development of cholesterol-lowering agents and the implementation of the automatic implantable cardiac defibrillator stand as examples of new cost-effective forms of therapy, made possible by technical innovation, that have also increased the cost of health care.

In addition to providing new modalities of health care where none had previously existed, the development of new pharmaceutical agents and medical equipment can increase access to cardiac care in several other ways. New technology may provide less complex and more cost-effective diagnostic and therapeutic modalities, such as the quantification of mitral stenosis by ultrasound as compared with invasive cardiac catheterization. New drugs and instrumentation may replace or reduce the need for surgical therapy of certain conditions, such as catheter ablation of supraventricular arrhythmias, may enable some patients to be treated as outpatients and may reduce the need for long-term medications and the number of follow-up visits. In each case, resources will be conserved to provide greater access to care.

It is essential that all new technology undergo evaluation to document its accuracy and efficacy in diagnosis or therapy. New drugs, instrumentation and procedures should not be widely used throughout the medical community until such studies are completed. However, it should be recognized that technology may be introduced in phases, and may be initially marketed with a capability that will be expanded or enhanced over time. In addition to medical accuracy, the cost-effectiveness of the new technology should be assessed, particularly in relation to devices capable of similar applications. Accordingly, incremental benefit over that of existing technology should be an important consideration in developing new techniques, so that optimal utilization of limited resources can be ensured and access to care maximized. Unfortunately, physician demand for the maximal technology possible, even when not most cost-effective, often serves as a stimulus for industry to provide excessively costly drugs and devices. In regard to medical technology, medical industry in conjunction with the ACC could take steps to ensure that new technology is presented to both medical and lay audiences in an appropriate context, and not marketed prematurely or excessively to engender unrealistic expectations.

Pharmaceutical agents are somewhat unique in the field of health care in that they have not been included in most prior cost-containment measures. In fact, drug prices increased by 152% in the 1980s, and rose three times as fast as the rate of inflation in the first half of 1991 (7). The increase in drug price has often applied even to long-standing products for which generic drugs are available. The drug industry has been highly profitable; projected revenues during 1991 were $63 billion and profits for the 10 largest pharmaceutical companies were three times that of the average of the Fortune 500 companies (7). Moreover, considerable revenues are directed toward marketing or developing agents that are nearly identical to already available drugs. The foregoing considerations have led to scrutiny of the contribution of the pharmaceutical industry to the existence and

solution of the access problem. It has been suggested that smaller profits or less money spent for marketing might enable greater access for patients to pharmacologic agents.

Clearly, a major issue affecting the ability of pharmaceutical and instrumentation companies to maximize access to health care is the cost of product development. According to the Pharmaceutical Manufacturers Association, only 1 of every 5,000 compounds evaluated becomes a product that can be marketed. In addition, research costs have doubled every 5 years since 1970. Evidence exists that the regulatory review process for the development of a compound from synthesis to market entails an average of 12 years and approximately $200 million in costs (7). It is obvious that considerable financial resources would be available to extend access to health care if this process were shortened and simplified.

Recently, medical industry has increased its efforts to reduce regulatory review times, conduct cost-effectiveness studies and share the results of research studies. For example, CANDA, the Computer-Assisted New Drug Application, has been developed and may save more than 20% of Food and Drug Administration (FDA) review time. Similarly, drug companies are providing staff members whose sole responsibility is to deal one-on-one with FDA reviewers, an approach that ensures that each reviewer's questions are handled promptly. These measures should serve to direct more funds to patient care.

Specific considerations exist with regard to the optimal cost-efficacy of pharmacologic therapy. Two medications may differ dramatically in price but minimally or not at all in benefit. For example, recombinant tissue-type plasminogen activator and streptokinase are two thrombolytic agents that have an approximately 10-fold difference in cost, but have thus far been demonstrated to be of similar benefit in reducing mortality due to myocardial infarction. The potential may thus exist to use a less expensive agent without losing therapeutic benefit and provide additional care with the money saved. From the standpoint of the formulary, substitutions of generic drugs may offer considerable cost savings. In each of the preceding cases, of course, it is of critical importance that the agent selected be of equivalent efficacy to the more expensive product. A less expensive drug or device may be less cost-effective by failing to achieve the desired result, increasing the number of side effects or failing to prevent recurrences. With respect to instrumentation, it may be desirable to regionalize new expensive technology that may be indicated in only a small proportion of cases, rather than to duplicate partially used facilities at multiple locations.

The pharmaceutical industry could directly and immediately affect access to cardiovascular care by distributing drugs at cost or even without charge to indigent patients. Several companies have begun efforts to provide free medication to the poor. Alternatively, pharmaceutical companies might provide, on a case by case basis, free medication to persons without funds after identification by a physician or pharmacist. Pharmaceutical companies could also enhance access by supporting long-term outcome research on the agents they produce or the disorders for which they are utilized. Although the desirability of such action is obvious, it is also clear that drug companies are for-profit industries and have a fiscal obligation to shareholders. Finally, in the interests of access, drug companies should seek to provide prescription drugs at the lowest price possible and to limit the marketing budget to that which is necessary.

The Medical Liability Problem: Its Impact on Access to Health Care

Medical liability costs were the fastest growing component of physician practice expenses in the 1980s (8). Average premiums tripled during this time, far outpacing any measure of general economic inflation. The frequency of medical claims also increased dramatically. It is now expected that 38% of all physicians will experience a liability claim at some time in their career, a proportion that increases to 50% if the practice includes surgery.

The cost of liability, together with the ubiquitous threat of litigation, affects patient access to care in four ways: 1) it makes it unaffordable to deliver the full range of health care services in some situations; 2) it adds substantially to the cost of all health care services, making them unaffordable for some patients; 3) it deprives physicians of certain drugs and medical devices that could enhance patient care; and 4) it undermines the foundation of trust and cooperation that is fundamental to a successful physician-patient relation.

The Effect of Liability on Availability of Medical Services

Professional liability costs have been directly linked to gaps in access to physician services. The problems appear to cluster in the areas of obstetric care, emergency room and community health care center care and rural health care. The 1987 Department of Health and Human Services Task Force Report on Medical Liability and Malpractice documented such problems in 26 states. Much attention has been focused on the plight of community and migrant health care centers whose federal and state funding has not kept pace with increases in liability premiums. Access problems are created when the liability-related cost to health care professionals and institutions cannot be passed on to patients. This situation provides an economic incentive to physicians to restrict practice in fields that carry a higher risk of litigation in exchange for obtaining a lower premium.

Emergency rooms and community health care centers are perceived to be settings that carry a higher risk of litigation. Many physicians believe that more adverse outcomes occur in such settings because 1) the patients receive poorer preventive medical care and are on average less healthy than other groups; 2) the quality of care is frequently hampered by insufficient staff and resources; and 3) the patients are

harder to treat after discharge. Rural health care settings are problematic because as the patient volume may not be sufficient to allow a physician to reasonably spread high practice costs through fees for medical service. Accordingly, physicians often choose not to practice in these settings, thereby diminishing patient access to care.

Many physicians who are retired or have discretionary time available would like to provide free care to those for whom it is unaffordable or unavailable. However, medical liability carriers often refuse to cover such activities. This practice reduces access to care, and a decision to cover these services would represent a tangible measure that could be taken by liability insurers to enhance access.

The Cost Impact of Medical Liability

Even when liability-related costs do not directly cause the unavailability of health care services, they contribute to the escalation in the costs of such services, making them unaffordable for some patients. As previously mentioned, liability premiums were the fastest growing component of physician practice expenses in the 1980s, increasing at an average annualized rate of 15.1% (8). In 1989, such premiums added $5.6 billion to the nationwide bill for health care services.

A less apparent liability-related cost is the phenomenon of "defensive" medicine: those procedures and tests performed by health care providers primarily to enhance defensibility of a medical record. On the basis of annual surveys of practicing physicians, the American Medical Association (AMA) estimates that the cost of defensive medicine was $15.1 billion in 1989 (9). When added to premium expenses, the sum of 1989 physician liability costs was $20.7 billion or 20% of the estimated cost of physician services in that year.

Our nation's poorly functioning system for resolving medical liability disputes generates broader social costs that are borne initially by government, health and disability insurers, the business community and, ultimately, by consumers and taxpayers. The U.S. civil justice system is the most expensive dispute resolution system in the world. Studies by the RAND Corporation (10) suggest that less than half of every liability premium dollar spent by health care providers ever reaches an injured patient. The remainder is absorbed primarily in the costs of resolving disputes, most of which comprise plaintiff and defense attorney fees. Among the factors that produce these high litigation costs are 1) long delays in litigation; 2) excessive discovery procedures; 3) the almost lotterylike possibility of a huge windfall recovery for the plaintiff in a sympathetic case; 4) the absence of any standards regarding the value of noneconomic elements of damage (e.g., pain and suffering, loss of consortium, loss of enjoyment of life). The U.S. practice of using a jury with wide latitude in assessing fault and awarding damages has been cited by several commentators as a fundamental cause of high litigation expense.

Although our litigation costs are high, they do not buy consistent or efficient decision making. Separate studies conducted in California in 1975 (11) and New York in 1989 (12) indicated that as few as 1 in 12 patients who are injured by medical malpractice are ever compensated through the civil justice system. These patients must seek compensation and medical care from other sources. At the same time, U.S. courts appear to be replete with litigation that has no merit. The New York study (12) indicated that 80% of lawsuits alleging medical malpractice failed to yield any evidence of negligence. The U.S. General Accounting Office estimates that 43% of insurer defense costs are spent on cases that are eventually closed without a finding of negligence.

The Impact of Product Liability on Access to Medical Care

The broader social cost implications just examined are not peculiar to medical liability litigation. However, medical liability litigation is the type of "high stakes" litigation so troublesome to policymakers concerned with the effect of legal costs on American productivity and competitiveness. Product liability costs also affect access to health care, by increasing the cost or inhibiting the availability to doctors, or both, of effective drugs and medical devices.

The Effect of Liability Risk on Physician-Patient Relations

A final aspect of the effect of the problem of liability on access to care is its impact on the physician-patient relation. The New York study (12) previously discussed confirmed that the threat of lawsuits does not seem to correlate with negligent care. Rather, the distribution of liability claims appears to signal that every patient is a potential litigant, whether or not the physician renders quality care. In addition to promoting defensive medicine, this phenomenon can foster an attitude of distrust of patients toward the physician community. In fact, physicians often cite an increased risk of liability claims as a reason for their reluctance to treat indigent patients, although studies suggest that poor people are less likely to file a liability claim.

Emerging Trends: Liability Versus Cost Containment

In an effort to improve access to health care, policymakers and third-party payers are engaged in a manifold attempt to contain the escalating cost of health care services. This process appears to be on a collision course with an emerging trend in the courts to expand the patient's legal right to an increased array of health care services. Two significant cases illustrate this tension. In *Helling vs. Carey* (1974), the Washington Supreme Court found for a plaintiff under age 40 who was not screened for glaucoma, despite a low incidence of glaucoma and the fact that screening was not the standard of care. In so doing, it effectively elevated both the standard and the cost of ophthalmologic care for all patients in the

state, in exchange for very marginal improvement in patient safety. In *Wickline vs. State of California* (1986), an insurer refused to pay for extended hospital stay to ensure that resolved complications did not reemerge. The court recognized a potential cause of action "when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms." As these cases well illustrate, in medical liability cases courts tend to apply a patient-oriented standard of care in hindsight that does not easily accommodate the social goal of cost containment.

Liability Reform Proposals

Medical liability tort reform may ameliorate problems of access to care in various ways. Many different reform proposals have been made. Once almost exclusively within the province of state legislation, medical liability reform increasingly is the focus of federal reform legislation.

Reforms that help to contain the cost of physician liability premiums are likely to slow the escalating cost of health care services. In California, for example, physician liability premiums have stabilized at about one-third less than the cost of premiums in states without meaningful reform. The core of the California reform model consists of 1) a ceiling on noneconomic damages; 2) sliding scale regulation of attorney contingency fees (the fee as a percentage of the awarded damages decreases as the size of the award increases); 3) mandatory periodic payment of future elements of damage; and 4) an offset from the award for reimbursement from "collateral sources" such as health insurance and disability insurance. On the basis of California's experience, several federal medical liability bills have been introduced that would extend this reform package nationwide, an extension that the ACC should aggressively support.

Reforms that shorten the time or improve the cost-effectiveness, or both, of the dispute resolution process have the potential to help stabilize medical liability costs. Several alternative dispute resolution models have been proposed, such as binding arbitration and no-fault compensation systems. Proponents of these models argue that resolving claims more expeditiously with less transaction cost will funnel more net compensation to victims of malpractice, thereby reducing the impact of liability on the broader social concerns of productivity and competitiveness. Few of these models have actually been implemented.

Some reform proposals, including two federal bills, are based on practice guidelines. These proposals advocate that such guidelines, developed by organized medicine or government, be made equivalent to the legal standard of care applied in medical liability cases. Proponents argue that this action would eliminate defensive medicine costs and assert that because substantive guidelines would be available for opposing parties and the jury, the result might be a shorter period of litigation and lower transaction costs. The generation of guidelines is an area in which ACC can make a substantial contribution to access.

Efforts to reform medical liability must be accompanied by equivalent efforts to identify and reduce the amount of actual malpractice. The College should study or support studies concerning the relation between malpractice and unnecessary or inappropriate procedures. In addition, the College should take an active role in the medical community to identify physicians who are impaired or incompetent and develop mechanisms for intervention and education, or for censure if these measures have failed.

As the various proposals to achieve health care access and reimbursement reform go forward, attention to reform of the medical liability system must be part of the deliberation. Although liability reform is not the single answer to the multitude of access to health care problems, it must be part of any solution that hopes to be successful.

The Role of Health Insurance

Since its inception, private health insurance has grown to cover more than 80% of the population or almost 200 million Americans today (5). During the first 45 years, the growth was primarily in traditional indemnity type insurance contracts. However, with the passage of the Federal Health Maintenance Organization (HMO) Act, in the mid 1970s, there has been a dramatic growth in HMO membership, from fewer than 6 million persons in 1975 to more than 35 million by 1990. Thus, the insurance industry is of fundamental importance in determining access to health care in the U.S.

Over the course of 50 years, the expectations from insurance have changed. In 1940, when national health expenditures stood at $4 billion or 4% of the gross national product, health insurance was simply a convenient prepayment mechanism. During the war years and through the 1950s and 1960s, health insurance became an important fringe benefit, a means of compensation to attract, motivate and retain good employees. Full payment of medical bills and hassle-free claims service were the marks of a good insurer. In the last 3 years as national health expenditures crept past $600 billion and 12% of the gross national product, management of health care costs (cost containment) has become the dominant consumer demand.

Benefit Provisions

Almost from the beginning, health insurance policies covered the cost of hospital and physician services. Most deductibles and coinsurance were subsequently introduced as a way to limit administrative expenses, reduce employer costs and foster cost consciousness on the part of employees. As the health care delivery system expanded, a series of ancillary services and providers were mandated by legislation to be included in insurance contracts. Today in various states there are some 800 separate mandated coverages that add substantially (estimates range to 15%) to the cost of coverage. The proliferation of benefits and the inconsistency among state requirements have complicated the administra-

tion of plans for both insurers and providers, increased administrative costs and diminished access by resulting in increased prices for coverage.

Benefit Limitations

Three provisions in insurance contracts that limit health benefits have been the focus of considerable debate. These relate to 1) preexisting conditions, 2) medical necessity, and 3) experimental procedures. Limitations on preexisting conditions typically deny enrollment or require that a person have been insured for 6 or 12 months before payment is made for medical conditions that exist at the time that insurance is activated. Although initially intended to prevent the acquisition of insurance only after the onset of illness, this provision has excluded many persons from coverage, even some with problems such as mild hypertension. Moreover, the provisions may also prevent persons who have had an illness, or whose dependents have had an illness, from changing jobs or reacquiring insurance after losing a job. The ACC should vigorously support guaranteed availability and renewability of health care coverage for all Americans. The goal of the College should be to eliminate financial barriers to health care coverage and to create a sense of security in Americans that their health care needs will be met.

Medical necessity is the criterion that insurers initially employed to discourage frivolous use of the health care system. Today, it has been used by insurers to question the appropriateness of certain treatments and thereby deny payment. The development of more precise diagnostic and treatment guidelines will help to eliminate the controversy that surrounds the application of the criterion of medical necessity. The limitation on experimental procedures (such as bone marrow transplantation) is also controversial. The issue is whether insurers, in contracting with individual patients or employers, assume a social or moral responsibility for paying for any and all services that might benefit the patient, or whether the law of contracts allow insurers to limit payment to those services specifically identified in the contract itself. These three limitations greatly affect the cost of health insurance policies and should be addressed in an attempt to maximize access to care.

Both medical necessity and experimental treatment limitations have a significant impact on cardiac care. Most insurance policies cover a wide range of common cardiac procedures. For insurers, the issue is not whether the technology is proved and effective, but whether it is appropriate for a particular patient. Cardiologic care tends to be more procedure oriented and invasive than the care provided by many specialties. The morbidity and mortality risks associated with this care are higher than those of many other specialties and as a result receive more than the usual attention from insurance company and managed care medical directors and claims reviewers. The importance of developing practice guidelines and developing ongoing working relations between the profession and the industry cannot be overemphasized as a way of avoiding confusion and disputes about coverage.

As the managed care movement expanded, the use of centers of excellence increased. Heart transplantation is frequently performed in these centers, and transplant patients are typically referred to one of the centers for surgery. Most of the larger companies employ a rather exhaustive screening process to identify centers of excellence. Individual facilities seeking to perform transplantation will be evaluated in terms of total volume, survival rates, retransplantation rates as well as the presence of good social service systems to accommodate the needs of family members.

Managed Care

As indicated previously, the health care reimbursement systems are rapidly moving away from indemnity fee for service toward a managed care environment. As recently as 1982, 95% of all reimbursement was handled on a fee for service basis. In this setting the patient had freedom of choice of physician, who in turn had nearly unrestricted freedom to perform diagnostic and therapeutic procedures. By 1989, less than 30% of reimbursement remained in a pure fee for service mode. Most health care economists are predicting that by 1994 70% of the market will be represented by network-based plans that require either an annual contract with designated providers or point of service choice, and that less than 10% of the market will be unmonitored fee for service reimbursed programs. A major concern in this transition is to ensure that negative incentives to provide service in any such programs do not reduce access to necessary and beneficial cardiac care.

Managed care is not a well understood term. Utilization review, preadmission certification, second opinion for surgical procedures and procedure review are all techniques that are used in managed care programs. However, true managed care programs are network based and have the following characteristics: arrangements with selected providers to furnish a comprehensive set of health care services to members; explicit standards for the selection of health care providers; formal programs for ongoing quality assurance and utilization review, and significant financial incentives for members to use providers and procedures associated with the plan.

In determining the provisions of a health care program, employers want to contain costs and still provide employee satisfaction. Containing costs usually means managing an individual patient's use of the health care system, whereas the greatest employee satisfaction usually means complete freedom of choice. Many employers are opting for something between the two extremes but are clearly moving toward a more structured system. A common compromise is a point of service choice program. The employee who stays within the network will have virtually all of these costs reimbursed, whereas the employee who opts for treatment outside the network must pay a significant deductible and a

higher level of coinsurance. Although freedom of choice remains a clear option, the incentives to stay within the network are very strong. Again, it is crucial that such incentives do not deny beneficial care to patients.

Several specific issues are prominent with regard to the insurance process and the more than 30 million Americans who are uninsured. As discussed previously, insurance coverage for small businesses is both limited and expensive. Employees of small businesses are subject to more medical testing of applicants, exclusions and denials of coverage (4). These problems are accentuated for those seeking individual insurance, who often are perceived as persons at high risk requiring large administrative costs. Clearly these are important issues to address in assuring optimal access to health care. The ACC should vigorously support the implementation of a system of health care coverage that is seamless, portable and affordable for all Americans.

The configuration of the insurance industry is another important issue relating to access. At present there are approximately 1,500 insurance companies in the U.S., accounting for a multiplicity of policies, procedures and forms (13). This configuration imposes an enormous expense and is burdensome and costly for both patients and physicians. It would appear that access to health care could be substantially increased if there were greater uniformity, and perhaps consolidation, among insurance companies.

Recommendations

The ACC should take a number of direct and indirect actions to assist the private sector in achieving optimal access to care. It should:

- Continue, as recommended in Task Force 3, to develop guidelines for the appropriate practice of cardiology, thereby defining for employers those aspects of cardiovascular practice that are appropriate, necessary and of high quality. Such guidelines should serve to reduce actions related to defensive medicine, diminish unwarranted medical liability claims and reduce the likelihood of nonpayment for medical services based on the medical necessity criterion.
- Be cognizant of the guideline development process of both the AMA (14) and the Institute of Medicine (15) and conduct its procedures appropriately. The ACC should interface with the Agency for Health Care Policy and Research (AHCPR) in guideline development, as they are charged by Congress under the Omnibus Budget Reconciliation Act of 1989 to "arrange for the development and periodic review and updating of clinically relevant guidelines . . . ."
- Take steps to ensure that persons representing a broad spectrum of interests are available for the generation of guidelines, and that the guidelines are widely used and result in improved patient outcomes. Demonstration of this process will enhance patient and payer trust.
- Augment its activities with regard to technology assessment. This will enable available resources to be devoted only to technology of proved efficacy, will be of value to employers and insurers in determining benefits packages and will assist the medical instrumentation industry in the process of technology development.
- Consider approaches by which individual physicians could assist drug distribution to indigent persons to enhance access to pharmaceutical agents.
- Take an active role in helping the pharmaceutical industry to pursue cost-effective marketing.
- Assume a leadership position in ensuring that the true medical liability risk for caring for low income patients in emergency rooms and community health care clinics is understood by cardiovascular specialists.
- In conjunction with the overall medical community and all of its members, support a process by which impaired or incompetent physicians are identified and receive appropriate intervention.
- Continue interaction with the insurance industry in projects such as the definition of the insurability and employability of patients with cardiovascular disease.

The ACC can facilitate access to health care by fostering certain practices. It can

- Foster cost-effective cardiovascular behavior among its members and exhort its members to use the least expensive equivalent diagnostic or therapeutic modalities.
- Assume a leadership position in ensuring that appropriate new medical advances are communicated to the public in a responsible fashion.
- As the professional society for cardiovascular specialists, exert its considerable influence in restraining excessive enthusiasm for, and therefore inappropriate expectations from, new technologic developments.
- Urge the regionalization of experimental or complicated, high cost, infrequently used technologies.

The College can also seek to increase access to health care by serving as advocate to governmental and private sector agencies on behalf of certain health care policies. It should:

- Be a vigorous spokesman on behalf of the concept of rationalization of taxes on businesses for health care benefits.
- Actively support a streamlined process for drug development and evaluation on the part of the FDA.
- Continue its substantial activities on behalf of medical liability reform. The College should vigorously endorse 1) a ceiling on noneconomic damages; 2) sliding scale regulation of attorney contingency fees; 3) mandatory periodic payment of future elements of damages, and 4) an offset from awards for collateral sources.
- Explore with the legal community alternative ways of resolving medical liability.
- Advocate insurance reform by measures to decrease administrative costs and eliminate denial of insurance to high risk persons.

- Vigorously advocate the implementation of a health care system that is universal, portable, and renewable.
- Urge liability insurance carriers or state legislators through good samaritan laws to cover physicians who are willing to provide care to those for whom it is unavailable.

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Task Force 5: Access to Cardiovascular Care: An International Comparison

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Introduction

Wennberg and Gittelsohn (1) have demonstrated variability in clinical practice patterns, resulting in variable access to, or rates of, a variety of medical services and procedures. There is also variation in access to and numbers of services and procedures among countries, presumably related to the health delivery system, average per capita income and the cultural, political and social attitudes of different countries (2).

This report briefly outlines the health delivery systems and access to cardiovascular services in eight countries (Australia, Belgium, Canada, Germany, Japan, the Netherlands, Sweden and the United Kingdom) and compares the data obtained from these countries with that available for the United States. As a July 1991 article (3) in "The Economist" pointed out, "There are lessons to be learned from looking at different ways of paying for and delivering the goods. Instead of each country trying out its own experiments, they should be studying each other's for ideas and pitfalls."

The comparison of data among countries is difficult at best, and impossible at worst, because of the variability of accuracy of the data, and the difficulty in controlling for social, medical, cultural, demographic, economic, and policy differences among countries (4). In this Task Force report we have attempted to collect data directly from cardiovascular specialists. Whenever possible, these data have been substantiated through government, the Organization for Economic Cooperation and Development (OECD), or World Health Organization (WHO) data collections. We have not included outcome data; there have been no studies to date that have demonstrated a relation between quality of life and expenditures on cardiovascular services. We have not attempted to pass judgment, nor to determine the medical appropriateness or effectiveness, or cost-effectiveness of the data or the systems generating them.

A brief description of the country and health delivery systems, with specific reference to the cardiovascular services available, is listed for the eight countries in alphabetical order. Comparisons of collected data are expressed in Tables 1 and 2 and Figures 1 to 11, which follow the descriptions of the countries.