in high-risk and low-risk patients. A change in the medical care of patients which resulted from this monitoring occurred in only 1.4% of patients, raising the question of whether any patients need routine, prolonged ECG monitoring periods in cardiac rehabilitation. Larger studies are needed to assess this and other issues in order to enhance our efforts to continue to provide proven cardiac rehabilitation services less expensively.

Carl J. Lavie, MD, FCCP
Richard V. Milani, MD
New Orleans

Dr. Lavie is Medical Co-Director of Cardiac Rehabilitation and Prevention and Director of Exercise Laboratories; and Dr. Milani is Director, Cardiovascular Health and Wellness, Ochsner Heart and Vascular Institute, Ochsner Medical Institutions.
Reprint requests: Dr. Lavie, Alton Ochsner Medical Foundation, 1516 Jefferson Hwy., Jefferson, LA 70121

REFERENCES
3 Lavie CJ, Milani RV. Effects of cardiac rehabilitation and exercise training on exercise capacity, coronary risk factors, behavioral characteristics, and quality of life in women. Am J Cardiol (in press)
4 Lavie CJ, Milani RV, Boykin C. Marked benefits of cardiac rehabilitation and exercise training in a large elderly cohort [abstract]. J Am Coll Cardiol 1994; 23:439
7 Milani RV, Lavie CJ. Benefits of cardiac rehabilitation and exercise training in depression [abstract]. Circulation 1994; 90:1-472
9 Ades PA, Huang D, Weaver SO. Cardiac rehabilitation participation predicts lower rehospitalization cost. Am Heart J 1992; 123:916-21
13 Ades PA, Meacham CP, Handy MA, et al. The cardiac rehabilitation program of the University of Vermont Medical Center. J Cardiopulmon Rehabil 1986; 5:265-77
16 Lavie CJ, Milani RV. Patients with high baseline exercise capacity benefit from cardiac rehabilitation and exercise training programs. Am Heart J 1994; 128:1105-09

Health-Care Reform and Pulmonary/Critical Care Medicine

A Revolution With or Without Data

The failure of the 103rd Congress to pass a comprehensive federal health-care reform bill and the tension between the White House and 104th Congress on how health-care reform should proceed on a federal level creates an interesting dilemma for pulmonary and critical care physicians. While the massive federal reforms are dead and unlikely to reappear on the horizon, market reform is proceeding rapidly driven by a spoken agenda of improving the efficiency of the system and the less frequently spoken agenda of decreasing the cost of care. The buyers and sellers of health-care services are reorganizing more rapidly than the speed with which a federal plan could have proceeded. Public sector reform is taking place at the state level with virtually every state house having a Medicaid reform proposed at this point in time; the movement of Medicaid patients into managed care programs should prove to create the largest influx of patients into capitated care in the country’s history. Private sector reform is taking place as patients are being moved into novel care plans that provide the full gamut of health-care services, usually with a capitated rather than a fee-for-service financing mechanism. In this kind of environment, the health-care payers may disrupt the doctor-patient relationship and continue to increase their influence in the patient’s treatment. At the level where the clinician is making decisions, the following three forces are going to exert a growing influence on the care that our patients receive: capitation; the systematic exclusion of certain physicians from
certain care provider roles; and the implementation of clinical guidelines within care plans. The trends that we see developing should be disturbing to pulmonary and critical care physicians as new entities become available to make clinical decisions and to provide clinical services. Our concern is that if we do not as a profession pursue an active program of health economics or health services research to document the value (including the economic value) of our specialties and the services we provide to our patients, we could become functionally excluded from the clinical decision-making process for a large number of patients with lung disease. Simply because the federal efforts in health-care reform appear over, this is not a time to pause. Our future is more at risk from market forces driving reform than from the enactment of any specific piece of federal legislation.

Capitated financing of health-care creates disincentives for health-care resource utilization. Nowhere will that be more acutely felt than in the most expensive site of care: the ICU. A recent study suggests that managed care patient admissions to ICUs are 30 to 40% less expensive than those financed through traditional insurance. This apparent advantage may reflect increased efficiency in management of the admitted patients or some selection bias of who enters the ICU. It is largely unexplored whether this effect of capitation results from altered selection of patients who are admitted to ICUs (ie, rationing), or rather a willingness to “throw in the towel” more quickly when treatment begins to appear futile. This is an important distinction for our profession to explore. The current approach of assessing quality within the ICU does not take into account the decision-making process that gets patients into the ICU; rather, it is often limited to a simple comparison of the mortality of those admitted with the mortality predicted by a scoring system. It is necessary for access to intensive care to be part of the evaluation process, and it is incumbent upon us to undertake this research. We need to examine how economic forces will alter the incentives of the gatekeepers to admit patients to ICUs.

As health-care financiers attempt to hold down the total cost of care, they typically see two options: decrease volume and decrease unit cost. As pulmonologists caring for patients with chronic lung diseases such as asthma, we may find ourselves at a disadvantage to primary care physicians because an individual unit of care, an office visit for instance, is often more expensive than a similar service provided by generalists. If the services we provide result in lower chances of expensive hospitalizations or a higher level of patient function and satisfaction with care, then the services we provide are very valuable, indeed. These are the types of questions that need to be explored by our profession so that we can retain long-term access to our patients with chronic lung diseases. In some managed care systems today, patients with chronic lung disease who are recently discharged from the hospital often have a limited number of visits to a specialist. Chronic lung diseases are often viewed by the payers as if they are not long-term management problems, and we risk losing our role as the provider of long-term care to our patients. The data upon which these policies are made need not be made public, and these policies themselves seem to run contrary to findings of the COPD Home Care Study. In this study, patients with severe COPD who have pulmonologists as their regular source of care, do not have higher outpatient cost of care nor total cost of care when compared with patients who have internists or family physicians as the regular source of care. Is access to specialty care in asthma, for instance, related to patient outcomes? That is actually one of the questions being asked in the Managed Health Care Association Outcomes Management System Study. Also, specific health maintenance organizations are performing their own internal studies to use to develop their policies about the care of patients with chronic lung diseases. The Joint Council of Allergy and Immunology did sponsor a study evaluating the cost and outcome differences of patients treated by allergists, when compared with family physicians and pediatricians, had a higher total cost of care and fewer clinical events (eg, emergency room visits and hospitalizations). It is unfortunate that there is not a greater breadth of literature from pulmonary journals for us to cite in this editorial, but that is precisely the issue that we wish to address. As a profession, we need to understand that our access to patients, which may be limited at this point in time, may be further limited or augmented by the results of these and other such studies. There is a need for us to conduct research which compares the outcomes when several specialties including our own treat patients with chronic lung diseases. Without proactively setting in place this research agenda and welcoming the results into our professional literature, one can imagine that pulmonologists will be told that there is no additional value in specialty care of patients with lung disease.

The movement to create and implement clinical guidelines is spreading like a wildfire. In fact, in a recent editorial in Chest, it was stated that, “Like it or not [treatment] algorithms will probably be substantial dictates of practice patterns in the future.” We basically agree with this observation, however hard it is to swallow; but, we must also be willing to ask as a profession the next question: Is a pulmonologist’s implementation of a care guideline for patients with chronic lung diseases better for patients or
for the cost of their care than care by an internist, a family physician, or even a nurse practitioner who is implementing the same guideline? If we do not have the courage to ask these questions, then the distillation of our professional knowledge into a guideline might actually come to replace the need for our services nearly across the board. Many of us could spend the next few years adapting guidelines of care to our local settings only to find that the per unit cost of a physician visit has driven the market away from us and the short-term view is continuing to win.

The market reform in health care is driven largely by the force of short-term cost-reduction. For patients with serious pulmonary and critical care problems, this could be a lethal trend. For our profession, it could be no less so. We need to come to grips with the fact that those who pay for care are systematically evaluating us to an ever greater degree. If we want to remain patient advocates, which is so much a part of our professional identity, we need to insure that our patients retain, in these new systems of care, access to our services. In support of this initiative, we need to have a research agenda underway and hard data so that payers will want to support our continued access to our patients. We need to start a systematic program of health services research to document the unique value that we provide to patients with pulmonary and critical care diseases. The issues which we foresee as having the greatest influence over our practice during the next few years are the following: (1) defining ICU quality in a way that includes access to the ICU in addition to actual survival compared with expected survival rates for those admitted to the units; (2) documenting the change in patient perceived benefits and/or health-care resource utilization when patients are cared for by pulmonologists compared with other types of physicians; and (3) documenting that the implementation of a guideline by one care provider may not be identical to that of another care provider. With these efforts underway, we will be, as a profession, making a strong contribution to the advancement of patient care and simultaneously documenting the large number of roles in which pulmonary and critical care physicians have unique value as health-care providers.

Robert C. McDonald, MD, MBA
William J. Martin, II, MD, FCCP
Indiana University Medical Center, Indianapolis.

References
6 Hunninghake GW. ATS presidential address. ATS News 1994; 20:3-7