Publications & Reports

Canadian Health Care

*Alternative Payments to Physicians: A Program in Need of Change*, a November 2003 report from the British Columbia auditor general's office, finds that alternative payments to physicians—those that fall outside the government's fee-for-service payment system—are poorly managed and need to be more accountable. Alternative payments account for Can$300 million of Can$2.5 billion spent in British Columbia. They are for service-based contracts, salary arrangements, or time-based agreements for specialized or labor-intensive services or for services carried out in training hospitals or less populous locations. The auditor general's office concluded that alternative payments typically lack strategic direction and are "often used as a fix-it mechanism to deal with ad hoc funding pressures...by physician groups and health authorities for additional funding that is not contemplated within negotiated funding agreements." The report recommends that the government develop clear and achievable program objectives, develop a procedure manual to ensure consistency, and formalize a budgeting process that addresses the program's goals and need for continuing contracts.

Copies are available at www.bcauditor.com.

*Waiting Your Turn: Hospital Waiting Lists in Canada*, an October 2003 publication of the Fraser Institute, finds that the total average waiting time from referral by a general practitioner (GP) to treatment, averaged across twelve specialties and ten provinces, was 17.7 weeks in 2003, up from 16.5 weeks in 2001–2002. The increase in waiting time reflected an increase in the time from first referral by a GP to a consultation with a specialist—8.3 weeks in 2003, up from 7.3 weeks in 2001–2002—and from the consultation to treatment—9.5 weeks in 2003, up from 9.2 weeks. Total waiting time was lowest in Ontario (14.3 weeks) and highest in Saskatchewan (21.1 weeks). Among specialties, the shortest waits were for medical oncology (6.1 weeks), and the longest were for orthopedic surgery (32.2 weeks). The number of people waiting for procedures was 876,584 in 2003, up from 852,308 in 2001–2002.

Copies are available at www.fraserinstitute.ca.

Medicare

*Payment Changes Are Needed for Assistants at Surgery*, a 13 January 2004 report from the U.S. General Accounting Office (GAO), suggests that Congress may want to consolidate within the Medicare hospital prospective payment system (PPS) the compensation for physicians and other health professionals who assist the main surgeon in the operating room. Current policy pays for surgical assistants through both the hospital PPS and the physician fee schedule. When it pays through the physician fee schedule, hospital PPS rates are not adjusted downward, meaning that Medicare may be overpaying for some surgical procedures. In addition, the GAO says that paying under the physician fee schedule does not give incentives to either the physician or the hospital to use a surgical assistant only when medically necessary. Furthermore, there are no clear criteria for which professionals should be paid under the physician fee schedule. Consolidating the payments under the PPS, the GAO says, would give physicians and hospitals an incentive to use the best assistant for the job and only when necessary, because the payment would be the same regardless of whether or not an assistant was used.

Copies of this report are available at www.gao.gov.

Patient Safety

*Patient Safety: Achieving a New Standard for Care*, a 20 November 2003 publication of the Institute of Medicine (IOM), calls for the development of common error-report formats for submitting data to a national patient safety database that addresses near misses and adverse events, as well as errors of
commission and omission. The report recommends the development of information and data systems that allow doctors to immediately access patient records, and that capture information on patient safety to allow the development of safer care delivery systems. The IOM recommends development of a national health information infrastructure through federal financial support and promulgation and maintenance of data standards, as well as through providers’ investment in such systems. The report calls on Congress to provide direction, authority, and financial support for national data standards that support patient safety. The U.S. Department of Health and Human Services (HHS) should take a lead role in the establishing the public-private partnerships required to develop the standards, the report says. The report adds that all health care settings should establish comprehensive patient safety programs that identify and analyze system failures and improve the system to prevent future failures.

Copies are available for $49.95 at www.nap.edu.

Public Health

U.S. Teens in Our World: Understanding the Health of U.S. Youth in Comparison to Youth in Other Countries, a 31 October 2003 publication from the Health Resources and Services Administration’s (HRSA’s) Maternal and Child Health Bureau, finds that U.S. youth ages eleven, thirteen, and fifteen are more likely than their counterparts in twenty-seven other countries to experience stomachaches, backaches, headaches, or difficulty sleeping at least once a week. The U.S. youth also were more likely to feel tired in the morning or feel “low.” The HRSA report says that this may be related to U.S. youths’ general fitness levels (diet and exercise). U.S. fifteen-year-olds are less likely to smoke than youths of similar ages in other countries, but they rank in about the middle range for drinking alcohol at least once a week. Also, U.S. youth rank ninth at ages eleven and fifteen and seventh at age thirteen for students who are bullied at least once a week at school. However, U.S. students are no more likely than students surveyed in other countries to fight or carry weapons.

Copies are available at www.hrsa.gov.

State Health Care Priorities

2004 State Health Care Priorities Survey Report, a 9 December 2003 publication of the National Conference of State Legislatures (NCSL), finds that access to health insurance, Medicaid costs, pharmaceutical purchasing, long term care, and health promotion will be the top issues confronting state legislators in sessions this year. Forty-three states will likely consider access to health insurance, with twenty-nine considering lower-cost plans targeting small employers and twenty-eight looking at medical savings accounts. Forty-two states will likely be trying to control the costs of prescription drugs in Medicaid, and thirty-eight expect to be addressing a Medicaid shortfall. To keep drug prices down, thirty-two will be looking at state bulk purchasing pools, and thirty may consider creating or expanding interstate bulk purchasing pools. Thirty-four states expect to address nursing home quality and safety, and thirty-three may change nursing home reimbursement rates. Also, thirty-four states expect to address nutrition and obesity, the same amount may address childhood diabetes, and twenty-nine expect to restrict school vending machines. The reports are based on a survey of state legislators.

Free copies are available at www.hpts.org/HPTS97/home03.nsf.

Substance Abuse Treatment

The New York State Adult Drug Court Evaluation: Policies, Participants, and Impacts, an October 2003 publication of the Center for Court Innovation, finds reduced recidivism rates among drug-arrest defendants in New York who completed a program of court-supervised drug treatment that allows them to receive reduced or dismissed charges. The center finds that six drug courts—Bronx, Brooklyn, Queens, Rochester, Suffolk, and Syracuse—produced an average 29 percent reduction in recidivism over the three-year postarrest period and an average 32 percent re-
duction in the one-year post-program period, compared with defendants who went through conventional case processing. Although recidivism was lower among drug-court graduates, it was at least as high among those drug-court inductees who failed to graduate. Recidivism rates were lower and graduation rates higher among older defendants. Those with a primary drug charge involving heroin, with prior criminal convictions, and with primary charges involving property also experienced higher recidivism rates.

Copies are available at courtinnovation.org.

The Uninsured

Sources of Health Insurance and Characteristics of the Uninsured: An Analysis of the March 2003 Current Population Survey, a December 2003 issue brief from the Employee Benefit Research Institute (EBRI), finds that health insurance coverage for nonelderly Americans in 2002 fell to the lowest rate since 1987—82.7 percent. Declines in health insurance coverage have been recorded in all but three years since 1987, when 29.5 million nonelderly Americans were uninsured. In 2002, 43.3 million were uninsured. The proportion of the nonelderly population covered by employment-based insurance dropped from 70.1 percent in 1987 to 64.2 percent in 2002. Medicaid covered 11.9 percent of the nonelderly population, above the 8.7 percent level in 1987 but not quite at the 1993 high of 12.9 percent. Public coverage in 2002 was at 13.9 percent of the nonelderly population, above the pre-1990 level low of 13.3 percent. Individually purchased insurance coverage rose only slightly, with 6.7 percent of the nonelderly population relying on such policies in 2002, up slightly from 6.6 percent in 2001. A high of 7.7 percent of the nonelderly population purchased individual policies in 1993. The number of Americans purchasing individual policies grew only slightly during 1987–2002, from 15 million to 16.8 million.

Copies are available at www.ebri.org.

Insuring America’s Health: Principles and Recommendations, a 14 January 2004 report from the IOM Committee on the Consequences of Uninsurance, proposes that President Bush and Congress develop a strategy for universal coverage with a firm schedule to accomplish it by 2010. Until universal coverage is achieved, federal and state governments should provide enough money for Medicaid and the State Children’s Health Insurance Program (SCHIP) to cover all people currently eligible and maintain outreach efforts, eligibility, enrollment, and coverage. The IOM report finds that the number of uninsured people under age sixty-five is large and growing and has persisted even in times of strong economic growth; that uninsured people don’t receive the care they need; that even one uninsured person in a family puts the whole family at economic risk; that a high uninsurance rate affects the overall health status of a community and its health care institutions; and that the value of universal coverage in terms of the number of healthy years “is almost certainly greater than” its additional costs. The report finds that the incremental approach of extending coverage has “made little progress in reducing overall uninsured rates nationally” and that targeted program extensions often help one group of uninsured people at the expense of others. The IOM committee argues that health care coverage should be universal; continuous; affordable to individuals, families, and society at large; and of high quality. The committee outlines four prototypes for accomplishing universal coverage but does not endorse a specific approach. “Each prototype could more nearly achieve each principle than does the current system,” the report says.

Copies are available for $27 at www.nap.edu.

Book Received