

Patients' Rights Legislation: Elusive or Illusion?

By Karen Crimmins, M.A.

In a continuing effort to fulfill his elusive election promise to improve the American healthcare system, President Clinton created a Health Care Advisory Commission in 1997 that would identify problems and submit

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possible solutions. This Commission introduced a healthcare Consumer Bill of Rights in November of that year. From early 1998, pressure on Congress to pass regulatory legislation relating to HMOs continued from the White House and from consumers, spurred on by the medical profession. Finally, as the November elections loomed closer, the urgency to present stricter federal legislation on managed care organizations appeared to encourage productive efforts.

In late July, the House of Representatives defeated by 5 votes the Democratic sponsored Gephardt-Dingell-Ganske Patients’ Bill of Rights Act (H.R. 3605). Instead, the House passed, by a narrow margin of 216 to 210 the Patient Protection Act (H.R. 4250) sponsored by House Speaker Newt Gingrich (R-GA), which President Clinton threatened to veto.

Senate Democrats proposed legislation identical to the House Democratic bill, while Senate Majority Leader Trent Lott presented another GOP plan (S. 2330). Nevertheless, on October 9, the Senate voted to reject a Democratic move to take up a bill to define patients’ rights and regulate managed care organizations.

The accompanying chart with information provided by Families USA compares the proposals of the GOP and Democratic bills as they relate to basic healthcare consumer protections.

Republicans complain that the Democratic legislation, by including so many additional mandates, would create too

strong a Federal Government authority over the insurance industry, and would greatly increase costs and reduce access. They suggest that state laws provide adequate protection for the majority of those insured by HMOs. The Democrats and their defenders argue that state laws are not uniform concerning protections.

They assert that HMOs must be held liable for medical decisions. They also believe that Republican mandates to expand medical savings accounts would segment the insurance market and make it harder for older and sicker consumers to obtain affordable quality medical

care.

While the insurance industry, in concert with business-sponsored organizations, has spent millions of dollars lobbying against restrictive legislation, it supports many of the Republican mandates. The Democratic legislation has backing from the White House as well as from the AMA, the A.F.L.-C.I.O., and health advocacy groups such as Families USA.

Now that Congress has adjourned, what is the future of patients’ rights legislation? Both foe and friend agree that

the issue of basic consumer rights and regulation of HMOs will resurface. In a personal interview, Ron Pollack, Executive Director of Families USA and a member of the President’s Health Care Advisory Commission, stated his belief that public pressure will force the enactment of “significant pieces” of patients’ rights legislation during the next Congress. He considers the “toughest issue” for compromise to be HMO liability. Yet, he also believes that meaningful remedies must be found in order to make HMOs responsible for their decisions. Both Families USA and AARP have publicly insisted on a strong and independent external review process as their major advocacy concern. Mr. Pollack described the external review as the first link of the “whole process” of consumer protection, followed by HMO liability and consumer assistance provided by an advocate or ombudsman.

In answer to the critics of HMO legislation and doomsday predictions, Mr. Pollack pointedly stated that he does not think that such mandates are the beginning of the end for HMOs. These directives would merely establish a greater accountability to the consumer. Once ground rules are in place, it would be expected that managed care will be able

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Basic Consumer Protections: How the Federal Bills Compare

Managed Care Consumer Protection	Gingrich Plan	Kennedy/Daschle Gephardt/Dingell	Lott Plan
Emergency Room Access	W	S	X
Access to Out-of-Network Providers		S	
Specialist Can Be Primary Care Provider		S	
Standing Referrals to Specialists		S	
Direct Access to OB and GYN for Women	W	S	X
Continuity of Care When Physician Leaves Plan		S	X
Access to All Prescription Drugs		S	
Independent External Review of Complaints	W	S	W
Independent Consumer Assistance Program		S	
Disclosure of Treatment Options Required	W	S	X
Prohibit Financial Incentives to Deny Care		S	
Access to Clinical Trials		S	
Right to Sue for Damages		S	

- S Provides strong protections for all consumers with individual or employer-based insurance coverage
- W Provides weak protections to all consumers with employer-based health coverage
- X Provides weak protections in 1 in 3 consumers with employer-based health coverage

Information provided by Families USA

A New Medical Specialty: Good For Patients?

by Patricia Lafferty, R.N.

On my way to interview Dr. Robert Wachter in his office at the University of California San Francisco, I pondered the formation, some twenty-five years ago, of the National Society of Patient Representatives, a new group of health professionals dedicated to patient rights and patient advocacy. Now a new and growing medical specialty, prompted by a concern for patient well-being, has recently formed its own professional organization: the National Association of Inpatient Physicians.

Called a "hospitalist" or "inpatient physician" this specialist takes over the care of patients at the time of their admission to the hospital until discharge home. Dr. Wachter, Associate Chairman of Medicine, describes the implementation of the inpatient physician program at UCSF as a "powerful idea." He is visibly enthusiastic about seeing this idea in action and growing successfully. He emphasizes the importance of communication, and believes it has been the key to the success of the University of California's innovative program.

Dr. Wachter's staff of eight physicians, assisted by residents, cares for ten to twelve patients at a given time, providing their direct patient care. Continuity is ensured by a maximum number of as-

signed days in a row. Effective communication is described as a steady flow of information by computer or fax to the primary-care physician who has referred the patient. An admission note and phone call initiate contact, followed by automatic copies of all progress notes and final discharge summary when the patient is referred back to his primary physician. Phone calls are ad lib and the primary physician often visits during the hospitalization.

Few physicians are reticent to turn over their patients. While some doctors prefer to preserve continuity and want to maintain acute care skills, and primary physicians in community hospitals may wish to continue the traditional role, the number of hospitalists is increasing steadily and there are now more than 2000 across the United States.

Dr. Wachter focused on the concept four years ago. His article "The Emerging Role of Hospitalists in the American Health Care System" was published August 15, 1996, in *The New England Journal of Medicine*. In this article, co-authored with Dr. Lee Goldman, Chairman of Medicine at UCSF, Stanford, he describes the realities of managed care and

its emphasis on efficiency. He anticipated a rapid growth of hospitalists who would manage the care of hospitalized patients the same way the primary physician manages the care of outpatients.

“... a higher premium will be placed on hospital skills, experience and availability.”

Citing the central role of these physicians in Great Britain and Canada, Dr. Wachter feels that the role for this group will grow now both in and out of academia, especially in areas where managed care predominates, such as in San Francisco. Because of cost pressures, managed care organizations will reward professionals who can provide efficient care. In the outpatient setting, the primary physician, no longer responsible for responding physically to condition changes or emergencies, is able to provide care for a larger group promptly and efficiently. Dr. Wachter notes that although many physicians have exceptional hospital skills, he questions whether high-value care can be delivered by physicians who spend only a small fraction of their time in this setting. As hospital stays become shorter and patients sicker, he believes a higher premium will be placed on hospital skills, experience and availability.

As for hospitalists in academia, Dr. Wachter believes that twelve months of increasingly intense care of inpatients is a formula for burnout and a three- to six-month commitment more sustainable. He suggests consulting in or out of this specialty in the off months, and in academia creating a core group of faculty members whose inpatient work is more than a marginal activity and who are thus committed to quality improvement in the hospital. Highly skilled and experienced, they will offer better supervision of house staff and improved patient teaching.

Objections to the hospitalist program,

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to achieve its goal of effective healthcare. In addition, the Congressional Budget Office and independent surveys have demonstrated that the increase in employers' premiums to cover these additional consumer protections would be minimal.

In the quest for this so-far elusive patients' rights legislation, we health advocates also have responsibilities. In this time before the next Congressional face-off we should continue to keep well informed and be willing to actively educate others. In addition to contacting our Congressmen and women, Mr. Pollack suggested sending letters to the editors of regional and national newspapers and publications, and participating in pub-

lic forums such as radio programs or local-level meetings. At the most basic level, we can also assist in the cause by informing our family and friends about the issues and soliciting their help. In other words, we all must contribute to the momentum that has already been initiated in order to prove that the need and the desire for patients' rights and healthcare consumer protections on the national level are not merely an illusion.

Karen Crimmins, M.A., has a special interest in public policy. She is currently the advocate for the disabled for her church parish, enabling people with disabilities and their families to participate in the Parish community.