

A Framework for Health Care Policy in the United States

THIS POSITION STATEMENT OF THE AMERICAN LUNG ASSOCIATION AND THE AMERICAN THORACIC SOCIETY WAS APPROVED BY THE ATS BOARD OF DIRECTORS, NOVEMBER 1996 AND BY THE ALA BOARD OF DIRECTORS, DECEMBER 1996.

Founded in 1904 to fight tuberculosis, the American Lung Association (ALA) is the oldest nationwide voluntary health agency in the United States. The ALA provides education programs, community service, advocacy, and research to fight respiratory disease and promote lung health. The American Thoracic Society (ATS) is a 12,000-member professional and scientific organization that serves as the medical section of the ALA. The ATS consists of research scientists, physicians, and other health professionals who are dedicated to treating respiratory diseases and disorders that necessitate critical care.

Based on this mission, the ALA and ATS believe that the health care system in the United States must meet the multiple needs of people with respiratory system disorders and critical illness and **access, quality, and cost-effectiveness**. The health care system must provide universal **access to quality** medical care in the most **cost-effective** manner. This includes preventive care and an effective public health infrastructure. Additional goals of health care are the humanistic components of healing and provision of comfort to those suffering from illness. In 1995 there were over 35 million adults in the United States with chronic and debilitating pulmonary disorders, including asthma, tuberculosis, chronic bronchitis, emphysema, lung cancer, pulmonary fibrosis, pulmonary vascular diseases, and environmental lung diseases, and millions more patients had acute pulmonary disorders, including respiratory failure and respiratory infections. Children are also at risk of lung disease with cystic fibrosis, asthma, bronchopulmonary dysplasia, and congenital lung disease. Health care plans that limit access to quality care, treatments, and pharmacologic agents are not likely to meet the needs of people with acute and chronic lung disease. It is widely recognized that far too many people are without access to health care services in our current health care system. In 1995, 39.6 million people, or 15.1% of the U.S. population, were uninsured. Some states have reported nearly 25% of individuals are uninsured. These numbers are increasing.

The ALA and ATS believe that health care consumers and providers must have an effective voice in development of health care systems to fully meet the needs of patients. As advocates for persons with lung disease and for those who require intensive care as well as representing professionals who deliver health care to these individuals, the ALA and ATS call upon federal, state, and local governments, health care insurers, and employers to establish comprehensive health care systems that embody the principles of access, quality, and cost-effectiveness outlined in this document.

During the 1990s, health care delivery systems in many states across the nation entered a period of significant restructuring and downsizing, characterized by increasing competition among managed care plans, a dramatic shift of resources away from hospitalization and use of specialists, and formation of sophisticated health care delivery networks. Although these trends are producing health care systems that are more

focused on reducing costs, their ultimate effect on the quality of care is unclear. Closure, downsizing, and conversion of health care facilities from nonprofit to for-profit status raise concerns that resources historically committed to the local community and the uninsured are being lost.

The ALA and the ATS support the development of a health care system that will meet the health concerns of all individuals. This document is designed to provide a guide for policy makers, health care providers, patients, employers, and health care benefits providers. This statement should be used to influence health care policy and to protect and enhance the patient-physician relationship. Health care systems in the United States should incorporate the important interrelated principles of access, quality, and cost-effectiveness, which are highlighted and which are followed by explanatory text.

ACCESS TO HEALTH CARE

Access is the ability of patients to obtain quality health care. Universal access for all individuals residing in the United States is an essential component for health care. Access to health care is of paramount importance for the patient, and access to the provider is essential to quality medical care. Access to quality and cost-effective health care includes care by specialists serving as consultants, as well as primary care providers.

A. Guarantee of Access to Health Care

ALA/ATS Position: Health care is a right. Health care systems must guarantee access to medically necessary health care services for all individuals residing in the United States.

The ALA and ATS believe that individuals should have the right to medically necessary health care services (see APPENDIX). Access to health care should not be impeded by ability to pay, pre-existing conditions, employment status, or other factors such as, but not limited to, age, gender, sexual orientation, race, and ethnic background. Since absence of health insurance limits access, our nation must seek to achieve universal coverage for health care; that is, to facilitate access and eliminate financial barriers; each individual must have adequate health care benefits.

B. Scope of Health Care Services

ALA/ATS Position: Individuals should have guaranteed access to medically necessary preventive, acute, chronic, and rehabilitative care.

Although all individuals residing in the United States must have access to the health care system, the ALA/ATS recognize that parameters must be set with regard to the breadth of services provided. We recognize that the United States does not have the resources to guarantee unlimited health care coverage to all individuals. However, we support medically necessary health care to which all individuals residing in the United States are entitled and which include medically necessary inpatient, outpatient, rehabilitative, preventive, and long-term

care services. Examples of such medically necessary health care that should be provided are included in the **APPENDIX**.

C. Eliminating Barriers to Access

ALA/ATS Position: Barriers to health care access should be eliminated. This includes, but is not limited to, geographic barriers, educational barriers, cultural and language barriers, barriers for the physically and mentally impaired, and the ability to pay.

The health care system must be easily accessible to patients and easy to use. All societal barriers to access must be eliminated, so all individuals have access to medically necessary health care services. These services should be portable; that is, coverage should not be disrupted when individuals change employment or place of residence. Innovative practice designs should be explored (such as the use of advanced practice nurse managed clinics and physician extenders) as possible solutions to health care strategies in remote or other underserved areas.

In general, individuals should be allowed to enroll in whichever health care organization they choose, not constrained by an employer or by the health care organization itself. Individuals should be allowed to enroll and change health care plans at any time. They should have free choice of a primary care provider within the health care organization and be free to change providers at any time. They should have ready access to specialty care in circumstances where difficult, unusual, or severe disease requires the input of this expertise.

D. Administrative Accountability

ALA/ATS Position: The administration burden to patients and providers should be eliminated so that the provider-patient interaction can focus on patient care.

Excessive time and effort is being expended by health care providers in administrative tasks such as preapproval for routine tests and evaluations. The ALA/ATS believe the administrative processes of the health care system must be simplified so that more of the time of health care providers is spent in the direct provision of health care services.

E. Medical Information Systems

ALA/ATS Position: Development of medical information systems must be supported so that continuity of care is assured, effective preventive strategies can be developed, practice errors are minimized, and populations can be studied to improve clinical outcomes.

Medical informatics will also improve access to clinical data, provide continuity among providers, and establish the database for appropriate medical surveillance and disease prevention. At the very least, computerized physician ordering will reduce adverse drug events and enhance communication among care providers. Furthermore, a centralized database is essential for population-based studies that examine the costs and effectiveness of care. However, confidentiality of medical records is essential, and patient confidentiality should be assured throughout the development and implementation of medical informatics systems.

QUALITY HEALTH CARE

The ALA/ATS concur with the Institute of Medicine definition that quality of health care is "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." For individuals with respiratory system disorders and critical illness, outcomes may variously

include symptoms, functional capacity, health-related quality of life, patient and provider satisfaction, physiologic status, use of health care resources, adverse events, and survival. The quality of health care depends on the perspective of the evaluator (the patient, health care provider, employer, health care benefits provider, and society). It is the position of the ALA/ATS that all residents of the United States are entitled to a health care system that is characterized by:

A. Effective, Appropriate, and Timely Health Care

ALA/ATS Position: Health care services should be effective, appropriate, and timely.

Medical effectiveness is preferably defined by the results of research and clinical investigation. In the absence of such data, effectiveness may also be defined by the consensus of a multidisciplinary panel of experts or by qualified specialists. Appropriateness is determined by the patient, family, and health care team in the context of societal and cultural values. In general, appropriate care includes patient participation in decision making and results in patient satisfaction. Timeliness indicates the provision of health care without delays due to financial or administrative barriers that adversely affect patient outcome.

B. Access to Appropriate Health Care Professionals

ALA/ATS Position: In order to achieve quality, individuals should be provided clinicians who have the appropriate level of knowledge, experience, and skill in the management of the patient's medical condition.

The ALA and ATS acknowledge the current trend toward an increasing utilization of primary care providers. However, in patients with severe, complicated, or unusual respiratory disease, primary and continuing care is optimally provided by respiratory specialists. Additional roles of pulmonary and critical care specialists include consultative services to patients with severe, unusual, or complicated respiratory disorders; primary care of critically ill inpatients, particularly those requiring intensive care; medical direction of respiratory care in health care facilities, including alternate sites of care; and direction of the health care team in patients with complicated respiratory disorders in the home and other health care settings. We advocate that all primary care physician panels include pulmonary and critical care specialists as primary care providers as indicated.

All providers of specialized respiratory health care (physicians, nurses, advanced practice nurses, physician assistants, respiratory therapists, and hospitals) should be reimbursed at a fair rate to ensure continued access to these specialists and services. Compensation should reflect provider cost, skill level, work, time, and risks. Payment for telemedicine consultation, telephone consultation, and additional administration time should be a component of reimbursement for specialists' services.

Patients should have a choice of physician and other health care providers. Tertiary care centers and centers of excellence should be included in all health care systems to meet the needs of patients with complex respiratory system disorders. There should not be financial barriers to the access and provision of such medically necessary care. It is important for all health care plans to provide their beneficiaries with a point-of-service option. Patient access to and patient choice of appropriate care can be enhanced by point of service, out of network, or other mechanisms to assure access to medically appropriate care. Such features are useful if the providers in the plan are unable to meet the needs of the patients with lung disease or if they prove unsatisfactory to the patient.

Due to **changes** in health care, patients with respiratory and critical illnesses may not have access to appropriate numbers of qualified staff to meet their needs. Regulations concerning health facility standards licensing and regulation have not kept pace with changes in health care. These standards should be reviewed and updated to assure safe and adequate staffing levels to provide quality patient care. Staffing levels should be based on severity and complexity of illness.

C. Provider-Patient Relationships

ALA/ATS Position: The integrity of the health care provider-patient relationship must be protected so that medical decisions are not influenced by inappropriate economic considerations or source of health care plan.

An important role for health care providers is not only to provide medically appropriate care but also to act as an advocate for their patient and to assist in obtaining access to quality care. Health plans and other entities should not terminate or otherwise retaliate against licensed health care providers for advocating medically necessary care for their patients. Health care providers should not be penalized for advocating medically necessary health care, for communicating information to a patient in furtherance of medically appropriate care or investigational treatments, referral to sources of out-of-network health care, or for assisting patients in grievances against a health care organization or plan. So called “gag rules” should be eliminated from provider contracts with health care plans.

The unique, trusting nature of the health care provider-patient relationship, which includes advocacy and confidentiality, must not be jeopardized by any other elements of the health plan. Health plans that value this relationship are accountable to their beneficiaries, purchasers, and regulatory agencies and must include an equitable and timely grievance process. Such health plans should include all participants, patients, providers, and administrators in the determination and review of medically necessary health care.

Incentives are increasingly being employed to reduce health care expenditures. Nevertheless, any incentive plan that includes financial or other incentives for delaying, disallowing, or limiting medically necessary health care to patients should be prohibited.

Physicians and other health care providers have a responsibility to respect patient autonomy by withholding and withdrawing life sustaining treatment as requested by informed and competent patients or their surrogate (Withholding and withdrawing life sustaining therapy. *Am. Rev. Respir. Dis.* 1991;144:726–731).

D. Patient Protection and Full Disclosure

ALA/ATS Position: Individuals or their surrogates should become informed and responsible health care consumers, know and exercise their rights to, and responsibilities for, medically necessary care, and become quality as well as cost-conscious purchasers of health care. To provide individuals with the information required to make informed decisions and choose a health care plan that best meets their needs, health insurers must fully disclose coverage, provider financial incentives, and performance.

An informed and empowered patient is the preferred customer in any health care setting. Patients gain the most when they serve as active and skilled partners in managing their own health care. Provision of useful and readily understandable information about coverage, provider financial incentives, and treatment alternatives will increase patient satisfaction and enhance patient health.

All patients have the right to receive treatment with respect, consideration, and dignity, and to discuss and participate in treatment decisions, including refusal of treatment. Health care insurers and providers share a responsibility to protect the interests of children and of incompetent or disadvantaged individuals with respiratory system disorders and those with critical illness.

All individuals, to the extent capable, should have the responsibility to pursue a healthy lifestyle, be knowledgeable about their health insurance coverage and limitations, actively participate in decisions about their health care, and cooperate with the health care team on mutually acceptable courses of treatment.

E. Biomedical Research

ALA/ATS Position: The health care system should place increased emphasis on biomedical research as a tool to improve the health of all individuals. Since all providers and recipients of health care benefit from biomedical research, all participants in the health care system, including health benefits providers, should contribute to its adequate funding.

The most important long-range tool to improve the health of all individuals is the support of biomedical research. Through the support of laboratory research, our understanding of the mechanisms and causes of disease will be expanded and new avenues of early detection, prevention, and treatment will accrue. Equally important is support of clinical investigation, including clinical epidemiology, bioethical, outcomes, and translational research to identify the risks or exposures that cause disease and to optimally develop and apply new approaches to care. The humane use of animals in controlled medical research is essential for the advancement of medical knowledge to improve patient care. Access of pharmaceutical and other new therapies on an expedited basis, when appropriate, can enhance clinical research and patient care.

Research is an important core value of the ALA/ATS. Private health care entities that profit from the advances of biomedical research should support biomedical research.

F. Education of Health Care Professionals

ALA/ATS Position: Training new health care professionals and continuing education of current practitioners is essential to maintaining access and quality of health care. Since all providers and recipients of health care benefit from the education of health care professionals, all participants in the health care system, including health benefits providers, should contribute to its adequate funding.

Quality medical care cannot be achieved without education of future generations of physicians and other health care professionals. There must be an adequate number of health care providers to assure access of all individuals to medically necessary health care. In addition, adequate numbers of health care providers with the particular skills, experience, and knowledge required by patients with respiratory system disorders and critical illnesses must be assured.

Incentives must be created within the medical education system to ensure the availability of a full range of providers in all geographic regions, especially in rural, inner city, and other underserved areas. A strong primary care network must be developed to act as the entrance point for individuals into the health care system. To achieve these goals, we make the following recommendations: provide financial incentives, such as scholarships, loan forgiveness, or tax credits, to health care professionals choosing primary care careers in underserved areas; and revise clinical curricula in medical school to emphasize ambulatory care and provide adequate compensation for

all health care providers. The cost of graduate medical education should be borne by all who participate in health care financing and not exclusively by Medicare and other government programs.

Education is an important core value of the ALA/ATS. All health care benefits providers have the obligation to share in the costs of education of health care professionals.

C. Public Education

ALA/ATS Position: To attain and preserve optimal health care and to capably and fully participate in the patient/health care provider relationship, the public needs to be educated regarding all aspects of health care, prevention, and rehabilitation. All participants in health care financing are responsible for advancing the education of the public.

Education occurs in three areas: public awareness, public policy, and individual patients and families. The ALA/ATS believe that public information should be readily accessible and directed to assist the public in making healthy life choices. Public policy should be based on accurate and current information that is regularly provided to health care policy makers. The goal of patient/family education is to assure health-enhancing behavior and may include information regarding prevention, pathophysiology, treatment options, medications, and other therapies. Further, this education should be individualized for the patient/family involved. Education improves health care and should be a covered benefit in all health care plans and reimbursed accordingly.

COST-EFFECTIVENESS OF HEALTH CARE

Cost effectiveness is the prudent use of resources to assure the accessibility and quality of health care to residents in the United States. Resources for the provision and receipt of health care include technology, facilities, therapies, and the health care team. An important concept in the cost-effectiveness of health care is value, which is defined as the quality of health care divided by the costs required to achieve that outcome. Cost-effectiveness incorporates the dual concepts of improvement in outcomes and reduction of costs. The ALA/ATS recognizes that few data exist to define/determine cost-effectiveness. We encourage research in clinical investigation that will further define cost-effectiveness.

A. Preventive Health Care and Public Health

ALA/ATS Position: Society must recognize the value of prevention of illness and promotion of health and provide mechanisms to incorporate prevention in all aspects of health care.

An important and cost-effective method of assuring the health of the nation is to prevent the development and allay the progression of respiratory system disease. Such methods include, but are not limited to, elimination of risks associated with the development of disease, including smoking prevention and cessation, control and elimination of harmful substances in the environment and workplace, early detection of disease, including screening programs, prenatal care, immunizations, patient education, and rehabilitation.

Strong, comprehensive individual and population-based health education programs are an integral part of preventive health care. Education for health is the responsibility of many sectors of society, including federal, state, and local governments, employers, schools, families, religious institutions, health benefits providers, and voluntary health agencies and professional associations such as the ALA and the ATS. These programs will encourage individuals to maintain healthy

life-styles and responsibility for positive health behaviors. Individual responsibility for health is crucial to an effective health care system. Proper education for both healthy individuals and patients with respiratory system disorders is essential for the promotion of informed, active participation in self-care, assumption of responsibility for positive health behaviors, and maintenance of healthy lifestyles.

The ALA/ATS support the development of methods within all health care systems to achieve these goals. Adequate reimbursement must be assured to allow health care professionals and programs to attain these goals. For example, additional efforts should be made by all health care benefits providers as well as federal, state, and local governments to reduce cigarette smoking and air pollution. Smoking prevention programs for children, smoking cessation programs for children and adults, and other efforts to curtail smoking are necessary to assure lung health. The ALA/ATS support the regulation of tobacco products as nicotine delivery systems and the regulation of air pollutants.

Agencies such as the American Lung Association and the American Thoracic Society are ideally suited to provide leadership in this area. Public education is a primary tool used by the ALA/ATS to fight lung disease and promote lung health. The ALA/ATS urge schools, families, health care benefits providers, religious institutions, community organizations, and others to join the voluntary health community in providing comprehensive health education.

B. Organization of Health Care Delivery and Financing of Health Care

ALA/ATS Position: The delivery and financing of health care should be rational, cost-effective, and integrated.

Health care in the United States is unique because it is a combination of commercial- and employment-based systems with a publicly funded system. The multiple systems involved in health care delivery are evolving and need to be responsive to the changing needs of health care consumers and providers. Employers now finance only about one half of the medical care, while an array of noncontinuous, uncoordinated public programs and personal expenditures make up the other half of the system's financing.

A fundamental review of American health care should be performed to develop a rational delivery system that assures universal access, quality, cost-effectiveness, and community risk-sharing. However, it is likely that health care will continue to be financed through multiple sources, including the government. No one sector or individual should bear an unfair or disproportionate share of the costs of patient care, prevention, education, and research.

Managed care is increasingly influencing the American health care delivery system. The ***ideal*** managed care system encourages many of the values that the ALA/ATS seek, such as access, quality of health care, and cost containment. ***Existing*** managed care systems bring valuable discipline and efficiency to medical care, but they do so through powerful financial incentives to minimize care and avoid treatment. Recent evidence suggests that managed care may jeopardize the access and quality of health care to some populations, such as the elderly and the poor. Exclusive reliance on commercial competition and market mechanisms to regulate medical care threatens both the quality of care and adequate access to specialized care. The ALA/ATS strongly support health care that assures access, quality, cost-effectiveness, and community risk-sharing while enhancing the important features of the provider-patient relationship.

The ALA/ATS believe the needs of the uninsured and underinsured must be addressed. The current quality of care for this population is substandard and is extremely costly due to delayed care and lack of preventive care. Innovative delivery systems and health care practice designs should be developed to meet the needs of these populations.

Cost containment is essential for all health care systems but should not occur at the expense of the quality of health care. Pulmonary and critical care specialists can provide cost-effective care that includes consultative services to patients with severe or complicated respiratory disorders; primary care of acutely ill inpatients, particularly those requiring intensive levels of care and those with severe, complicated, or unusual respiratory disorders; and primary and continuing care of respiratory patients with severe, complicated, or unusual respiratory disorders. The development of clinical practice guidelines by knowledgeable health care professional experts, appropriate use of high-cost technology, and innovative health care practice design may be used to reduce the escalating costs of health care. However, the ALA/ATS support carefully designed outcomes studies to validate the cost-effectiveness of these tools.

APPENDIX

Necessary Health Care Services

Respiratory-specific examples: Including but not limited to the respiratory conditions of asthma, chronic obstructive pulmonary disease (chronic bronchitis, emphysema), lung cancer, tuberculosis, acute and chronic respiratory infections, cystic fibrosis, interstitial lung disease, acute lung injury, bronchopulmonary dysplasia, congenital lung diseases, sleep-related breathing disorders, and occupational lung diseases.

Preventive

Prenatal care
 Childhood immunizations
 Adult immunizations
 Periodic health examinations
 TB prophylaxis
 Well baby/well child
 Patient education
 TB skin test
 Influenza and pneumococcal vaccine
 Effective therapies for at-risk populations
 Smoking cessation/prevention programs
 Screening for occupation- and environment-related pulmonary problems
 Routine and complaint-specific clinical evaluations
 Appropriate testing for hereditary processes (cystic fibrosis, alpha-1-antitrypsin deficiency)
 Diagnostic evaluation: periodic medical history and physical examination

Outpatient

Problem-directed history, physical examination
 Diagnostic evaluation: history, physical examination, testing, procedures, chronic therapy
 Diagnostic testing: pulmonary function, radiologic imaging, sleep testing
 Outpatient procedures: thoracentesis, fiberoptic bronchoscopy
 Outgoing treatment for chronic problems
 Prescription drugs

Inpatient

Extensive diagnostic evaluation
 Complex treatment of acute and chronic conditions
 Follow-up for positive findings on diagnostic evaluation
 Treatment for serious exacerbation of chronic conditions
 Treatment for acute conditions
 Lung transplantation
 Intensive care

Rehabilitation

Pulmonary rehabilitation
 Physical therapy
 Respiratory therapy
 Occupational therapy
 Mental health services: substance abuse, including nicotine

Alternate Site Care

Skilled nursing facilities, home, hospice, respite
 Durable medical equipment, oxygen, chronic ventilator care

Patient/Family Education

Patient and family education is an essential component of all health care practice and is implicit within all of the above services.

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