On December 11, 1991, the Physician Payment Review Commission (PPRC) held hearings that included commentary on the then recently released Medicare fee schedule (1). The College submitted a written statement to the Commission and, in addition, was one of four specialty societies selected to provide verbal testimony. This selection reflects the high regard held in Washington for the members of our Health Policy Division led by Dr. Marie Michnich. We are all indebted to this group for their tireless efforts and recognized commitment to objective and critical analysis of the difficult health policy issues confronting American medicine. Those wishing a copy of the College’s written testimony should contact the Health Policy Division at Heart House (1-800-253-4636, ext. 692).

Let me share a few of my own perceptions of the PPRC hearing on December 11.

1. Unfortunately my first impression is that the Resource-Based Relative Value Scale (RBRVS) has resulted in a serious fractionation of the medical profession. The existing dogma is that the flaw in American medicine is specialty orientation and emphasis on high technology. According to the RBRVS, one solves this by redistributing a portion of the income of specialists to those providing primary care. It is presumed that this stimulus will result in more physicians who will choose a career in primary care rather than a specialty, but the dogma ignores the attractiveness of specialty medicine to many because of noneconomic factors.

2. A second impression is that the RBRVS does not address the fundamental issues of access to care and the cost of care if truly budget neutral and thus represents a diversion from the real issues. My skepticism regarding the value of the RBRVS in improving access to primary care is reflected in the current Medicare fee schedule and its redistribution of income. Of the eight “winners,” the highest percent increases in income occur for optometrists, those in family and general practice, followed by chiropractors and podiatrists. Thus, three of the top four “winners” are not physicians. Internal medicine, otolaryngology and psychiatry are expected to experience small increases. Is the solution to our problem of access to health care in this country to provide more money to optometrists, chiropractors and podiatrists? How does this approach enhance primary care? It is sobering to consider the amount of time and effort that has been invested in the RBRVS to produce the outcome described.

3. My third impression during the hearing is that a serious effort will be made to reduce specialty training positions in general and, specifically, in cardiovascular medicine. This effort appears more likely to address a perceived oversupply of medical subspecialists rather than RBRVS-based reimbursement. Surgeons effectively reduced their training positions several decades ago.

What should be the position of the American College of Cardiology? In recent surveys of College members, 46% of those responding have indicated that the increase in cardiac catheterization laboratories should be restricted and more than 75% stated that they have enough invasive cardiologists in their area. The impact of services provided by cardiologists to the Medicare population is not inconsequential. In fact, recent studies revealed that growth of services provided by cardiologists to these patients significantly exceeds the rate of growth of such services provided by other physicians. This explains in part the pressure to reduce the number of training positions in cardiology.

However, the benefit of such a reduction is not certain. I suspect it is quite possible that an increase in cardiovascular services will continue but be provided by other physicians such as those in family and internal medicine. For many cardiovascular services, these changes may be appropriate, but for others they may be inappropriate. For example, they may lead to the use of expensive noninvasive technologies (echocardiography, for example) by persons who have in-
sufficient training. The ACC Manpower Committee will need
to study this issue carefully. My own bias is that the College
should provide a leadership role in reducing cardiology
positions overall, and in particular in reducing training
positions for invasive cardiologists.

Finally, I commend Dr. Philip Lee, who chairs the
Physician Payment Review Commission and conducted the
hearings in an open and constructive manner. He and the
other commissioners stimulated a candid exchange of views
with provocative questions. It is easy to criticize the efforts
of Congress, the Health Care Financing Administration and
the PPRC to stem the escalation in costs of health care, but
the medical profession itself must come forward with its own
constructive suggestions to reform the system. I am hoping
that “the House of Medicine” will provide leadership in
dealing directly with the problems of access to medical care
and its cost and not be diverted from this focus by redistrib-
uting incomes.

Reference
1. Frye RL. President’s Page: The Medicare fee schedule. J Am Coll Cardiol