



WHAT'S HAPPENING IN

AMWA

Special
Issue: Health
Care Reform

Volume XIV, Number 1/February/March 1994

President's Column

by Kathryn C. Bemmann, MD

This issue of *What's Happening in AMWA* is dedicated to health care reform. Women physicians are concerned about continuity of care for their patients, about how women's health care needs will be met, and about the placement of women physicians in leadership in the coming period of change. In this issue, we will tell you about AMWA's priorities for health care reform and how the bills before Congress address them.

Three years ago, a membership survey in this newsletter revealed our members' greatest concerns about our health care system: lack of universal access, administrative burden and third party interference with physician's clinical decision making. This issue provides another opportunity to let us know how you feel about health care reform. Please complete the survey on page 7 and mail it to AMWA, 801 N. Fairfax St., Alexandria, VA 22314 or fax: 703/549-3864.

In November, the AMWA House of Delegates voted to support the single-payer plan as the best way to
continued on p. 2



Kathryn C. Bemmann, MD, AMWA President, and President Clinton confer in the Oval Office during the December White House briefing on health care reform.

AMWA'S President's Retreat

More than 60 AMWA leaders braved the winter elements to attend the President's Retreat, January 21-24.

The retreat focused on health care reform and included several seminars by Janet E. Freedman, MD, and Susan C. Stewart, MD, Co-Chairs of AMWA's Ad Hoc Committee on Health Care Reform.

A highlight of the retreat was a two-hour White House briefing by Judith Feder, Ph.D., of the Department of Health and Human Services, which focused on President Clinton's Health Security Act. Several AMWA members had an opportunity to ask questions.

In addition to health care reform, strategic planning sessions were led by Kathleen H. Kueht of Proact, Inc.

Joyce Newman, President of The Newman Group, presented a media training session to assist AMWA leaders in formulating messages and working with reporters.

On the final day of the retreat, about 20 AMWA leaders visited the Hill to discuss women's health issues, and specifically health care reform, with their congressional representatives.

Is There a Health Care Crisis?

You may have heard the rumors that there is no health care crisis and that we should leave well enough alone. Is there a health care crisis? You decide:

- Thirty-eight and one half million Americans (17.4% of the population) have no health insurance, compared to 25 million uninsured in 1980. 40% of the uninsured are employed, and 33% are children.
- Six percent of Americans are refused coverage because they are ill or have been ill, i.e., have **pre-existing medical conditions**.
- Employers who give insurance as a benefit to employees are paying for those who do not, because money from private insurance is shifted to pay for the uninsured.
- **Experience** rating rather than **community rating** enables insurance companies to increase rates or cancel plans for businesses who have employees with health problems.
- In 1991, US infant mortality was greater than that of Canada, Sweden, Japan, Singapore, Italy and Turkey.
- Men in Harlem have a shorter life expectancy than men in Bangladesh. 85% of the premature deaths in Harlem

continued on p. 2

President's Column *continued from p. 1*

achieve our goals of universal access, administrative simplification and autonomy of clinical decision making. One month later, we joined nine other physician groups at The White House to support the Health Security Act. Our support for both proposals is not mutually exclusive; and though neither is perfect, both go far to achieve AMWA's three identified objectives.

AMWA has been making important contributions to the debate on health care reform. In May 1993, our model benefits package for women was reviewed by The White House. In December 1993, as part of the Health Care Reform Project, we participated in a press conference to support the employer mandate as an acceptable method of funding health care reform. In February 1994, AMWA was one of 10 organizations to testify before Congressman Waxman's Subcommittee on Health on the merits of a single payer system.

In November and December, AMWA leaders were invited to White House briefings on the Health Security Act. During the AMWA President's retreat in late January, about 60 AMWA leaders spent the weekend studying health care reform and were briefed by Judith Feder, Ph.D., of the Department of Health and Human Services.

This is an exciting time to serve as AMWA's President. It is clear that AMWA is perceived as a credible and important voice in health care reform. People are listening to AMWA's leaders and now is the time to make our voices heard.



Janet E. Freedman, MD, Co-chair of AMWA's Ad Hoc Committee on Health Care Reform, pauses during her testimony on single-payer health care reform to take a photo with bill sponsor, Rep. Jim McDermott (D-WA), MD, a psychiatrist.

Crisis *continued from p. 1*

were due to cardiovascular disease, cancer, diabetes and other medical conditions.

- The United States spends a greater percentage its GNP on health care than any other industrialized country - all of which provide universal health care coverage.
- Over 60% of uninsured women have not had a clinical breast exam in the last three years; 45% of uninsured women have not had a Pap smear.
- USA child vaccination rates lag behind every country in North and South America except Haiti.
- Twenty-four percent of health spending is on administrative expenses that have nothing to do with patient care, at a cost of \$106 per capita (1991).
- In 1990, all newly established HMOs were for-profit corporations.
- Over \$700 of the cost of an American made car was due to health insurance; the figure for Germany was \$337, Japan \$246, Canada \$323 (1988).

What AMWA Thinks About Health Care Reform

Health care reform presents a tremendous challenge. How can we extend care to 1/5 of the population and slow the growth of expenses for health care at the same time? What kind of care and how much care can be given?

In this section we will describe how AMWA's Ad Hoc Committee on Health Care Reform gathered information and built consensus on AMWA's opinions about reform. In the next section we will lay out the criteria for judging a health care plan from the AMWA point of view.

In 1990 the ad hoc committee was appointed. Resolutions on improving care for women and children were passed by AMWA's House of Delegates and the delegates voted to support the concept that AMWA take an active role in the reform debate.

In 1991, a survey was printed in the newsletter. The results of the survey can be summarized as follows:

- The issue of greatest concern was the large number of Americans with no health insurance. This was also the issue the respondents felt should be addressed most urgently. Other issues of concern included lack of preventive care and high administrative costs.
- Two negative impacts of change that concerned AMWA members surveyed included decreased physician autonomy in clinical decision making and increased bureaucracy.
- Those surveyed were more willing to compromise practice arrangements and income, and were least willing to compromise autonomy in clinical decision making and somewhat less willing to compromise patient choice of physician.

At the Annual Meeting in 1991, the committee presented a workshop that analyzed the types of delivery systems. In a straw poll, the plan most favored by the participants was single payer.

In 1992, the committee started work on a position paper

AMWA'S KEY CRITERIA IN HEALTH CARE REFORM

Access

Universal access means affordable, available care for **everybody**, including people with low-paying jobs, poor people, and sick people, the classically uninsured. If an insurance-based system is retained, **insurance reform** must be instituted so that coverage cannot be denied because of **pre-existing** health conditions. Insurance reform must also include **community rating** of premiums rather than experience rating, in which individuals and small business owners are charged very high premiums because of high medical costs the previous year. Access means filling gaps in health care in rural and urban communities. It means an increase in primary care providers who can give preventive care and timely intervention at an early stage of an illness.

Administrative Simplification

This function must be looked at on two levels: **MACRO**, referring to the overall structure of the system and the bureaucratic constructions and interactions required for function. Simplification means that the most direct connection, with the smallest number of bureaucratic personnel, should lie between payment for the health plan and payment for services. **MICRO**, referring to the complex interactions among the patients, physicians, and the insurance companies and governmental agencies supplying health care. Simplification means that there should no longer be thousands of different plans with an equal number of different forms, layers of review, return of incorrectly written forms, and endless delays in payment—all requiring physicians to hire extra personnel and increase the cost of practice as well as the aggravation level of all concerned.

Benefits

This means a package of basic benefits, which every plan would be required to cover, for **EVERYBODY**. Most important to AMWA members are primary care, preventive care, the full range of reproductive health care for women (including abortion), and adequate care for mental illness and substance abuse.

Choice

This means that to the greatest extent possible the patient should be able to choose her/his physician. This principle acknowledges that continuity of care is a medical value and contributes to quality.

Decision-Making Autonomy for Physicians

Autonomy in physician decision making is very highly valued by AMWA members. Emphasizing support for autonomy in decision-making does not imply support for outdated, unproven practices or for excessive, unconsidered testing. Incursions on physician autonomy by managed care systems raise the serious problem of inadequate patient care resulting from an overriding interest in saving money. Quality of care has to be the first priority, but physicians have to take responsibility to make cost-conscious decisions.

Economics

How can we extend care to nearly 1/5 of our population and slow the growth of health care expenditures at the same time? The proposed plans contain measures that **PAY** for the **COSTS** of the changed medical system and other measures that are expected to **SLOW** the rate of medical **INFLATION**. Each plan should be examined to see if these measures are present, and whether the measures are realistic and responsible. Hope and wishful thinking are not enough.

Flexibility

It is important that the basic benefits be changed to keep up with scientific advances. This is also true of protocols and practice parameters used in managed care systems. Conducting research on outcomes of care delivery systems and technologies will yield data that will help to improve the system. Changes in benefits, protocols and parameters must be made quickly to keep up with current science, and the decisions made by knowledgeable, respected medical authorities.

What AMWA Thinks

and presented a workshop at the Annual Meeting on important women's health issues that would need attention in health care reform: breast and cervical cancer, reproductive health and tobacco related illness.

In early 1993, at the request of The Campaign for Women's Health coalition we drafted a model benefits package for women. That spring Dr. Janet Freedman participated on one of the provider panels in Hillary Rodham Clinton's Task Force. At the

Interim Meeting the committee presented a workshop to elicit AMWA members' views on increasing the number of primary care providers and on the working relationships with mid-level providers—nurse practitioners and physician assistants. At the Annual Meeting a number of resolutions were presented. Some of those passed dealt with aspects of the Clinton reform plan, and supported nine health care priorities for women; increasing primary care providers; and improving

patient access, physician access and quality in delivery systems. Another resolution, favoring the single payer plan also passed. The "Ask Me About Women and Health Care Reform" campaign was begun.

AMWA is working with other organizations focused on Health Care reform. In addition to The Campaign for Women's Health, AMWA is active in the Health Care Reform Project, a broad-based coalition of about 30 business, labor, consumer and medical organizations.

THE PLANS

(Description of each, analysis according to AMWA's defined criteria.)

Clinton Plan (Health Security Act)

President Clinton's plan provides universal access primarily via employer mandated coverage. Geographically determined Health Alliances regulate and market insurance plans. Federally mandated benefits with community rating are offered by the various health plans. Each alliance must offer at least three plans. Plans compete for enrollees on the basis of price and quality. Physicians can participate in one or more plans. Funding is through employer and individual mandates, increased tobacco excise tax and savings in Medicare/Medicaid.

Access: Universal access is extended to all legal residents with shared employer/employee payment of premiums and some financial assistance for low-income individuals/families and small businesses. The individual or the family, not the employer, chooses the health plan from those available through the Health Alliance. The plans are community rated and provide health care coverage for those with pre-existing conditions. The overall plan is expected to be phased in by 2001. There are provisions to increase the number of primary care physicians.

Administrative simplification: MACRO: The managed competition model with the Health Alliances is an untried model. It places a totally new layer of bureaucracy between the insured and the insurer. Whether it will simplify functions remains to be seen. The mandatory uniform benefits package is likely to reduce the number of variables among plans. MICRO: The plan establishes one billing form and a health security card. The emphasis on managed care plans creates uncertainty about the potential administrative burden for physicians and plans. Physicians collect copayments for the Health Alliance and submit quality survey data.

Benefits: This is the most detailed plan proposed and it includes a schedule of preventive care, reproductive health (abortion not specifically mentioned), some mental health services with phase in to managed care by 2001.

Choice of physician: Individuals select one of the health plans offered by their geographically determined Health Alliance and within that plan, have their choice of primary care physician. Referral to specialists probably will be through primary care providers. A higher cost plan containing a panel of fee for service physicians must be available.

Decision-making autonomy for physicians: To the extent that managed care and capitated plans are offered, they will have an effect on physician autonomy, either by requiring adherence to protocols or limiting spending to stay within a budget. Practice parameters are encouraged.

Economics: PAY COSTS: This plan is funded through employer/individual mandate, paying 80%/20% of premiums for health insurance. Additional money is derived from a \$0.75 per pack increase in the tobacco excise tax, and Medicare/Medicaid savings. SLOW INFLATION: There is hope that managed competition will drive down costs. There are limits on physicians' fees. A global budget is established. Universal access to primary care

may reduce future health care costs.

Flexibility: The National Health Board makes changes in system and benefits.

McDermott/Wellstone Plan

Rep. McDermott (D-WA) and Sen. Wellstone's (D-MN) plan provides for universal access to medical care in a basic benefits package, paid for by a single payer and administered by individual states. The insurance company role is eliminated. Physicians may practice as individuals or in groups at negotiated fees for services. There are no out of pocket payments, funding is through a payroll tax and an individual income tax at a fixed percentage, pooled into a protected fund, similar to Social Security.

Access: The plan provides universal access to care for all legal residents by 1995. There will be no pre-existing conditions, copayments or deductibles. There are provisions that increase the number of primary care physicians.

Administrative simplification: MACRO: There will be no additional bureaucracy to manage the insurance companies. Substantial simplification is achieved because the benefits are uniform. MICRO: The plan will use a standard claim form, electronic billing and an enrollment card. There will be no precertification requirements and no collection of copayments by physicians' offices.

Benefits: The specifically defined national benefits package includes preventive services, reproductive health (abortion not specifically mentioned), and limited mental health benefits. Federal benefits may be increased by states.

Choice of physician: Complete freedom of choice of physician is provided in this plan for both primary and specialty care.

Decision-making autonomy for physicians: There is no precertification required. The plan mentions voluntary participation in managed care organizations. The benefits follow practice guidelines where they exist.

Economics: PAY COSTS: The plan is funded through employer and employee taxes instead of premiums, plus a \$2.00 per pack total in the tobacco excise tax. SLOW INFLATION: There is a global budget. Physician fees are negotiated and major savings are expected through administrative simplification. Universal access to primary care may reduce future health care costs.

Flexibility: The National Health Security Standards Board can make changes in the system and the national benefits. Physician appeal process is established. States may increase benefits or join regional systems that cross state lines.

Cooper/Democrat, House

There is no mandate requiring access for all Americans. A managed competition model, in which plans would become more affordable through community rating and more equal by offering a standard package of benefits, would be put in place. Plans will be regulated by regional health plan purchasing cooperatives, which will receive premiums and pay the insurers. Cost savings are expected from increased competitiveness.

Access: No guarantee for universal access. Retains insurance based system. Employers must make insurance available to employees but are not required to contribute. Premiums are community rated and pre-existing conditions cannot be excluded for more than six months. Subsidies available to low-income uninsured to help them pay for insurance are removed when they get to 200% of poverty level. Some help for underserved areas.

Administrative simplification: MACRO: The managed competition, using the Health Plan Purchasing Cooperatives (HPPC's), is an untried model. It places a totally new layer of bureaucracy between the insured and the insurer. Its function is to make insurance more accessible by regulating local plans. Whether it will simplify functions remains to be seen. MICRO: Claim forms are to be standardized and electronic transmission used. Health care information is to be electronically recorded to be used in evaluating plans. The inputting and maintenance of this information will require workers. With a managed competition model, there will still be multiple types of insurance plans, each under pressure to be cost efficient, so the usual types of managed care techniques will be operative.

Benefits: Coverage is not universal and therefore benefits are not universal. In reforming insurance, the Health Care Standards Commission will determine the benefits that must be offered in the Accountable Health Plans approved to join the Purchasing Cooperative. Preventive services are mentioned for Medicare patients and Medicaid children under 7.

Choice of physician: To the extent than the Accountable Health Plans have closed panels of physicians, patient choice will be limited. Managed care may limit access to physicians.

Decision-making autonomy for physicians: Both managed care plans and capitated plans will have an effect on physician autonomy, either by requiring adherence to protocols or limiting spending to stay within a budget.

Economics: PAY COSTS: No global budgets or price controls. Elements of employer benefit plans that are more generous than the basic package lose tax deductibility. High income Medicare recipients will pay a tax for Part B coverage. SLOW INFLATION: There is a hope that "the market," e.g. managed competition, will drive down costs. Fees for non-primary care physicians will be reduced.

Flexibility: The National Health Board will make recommendations on updating benefits yearly.

Chafee/Senate Republican Task Force Plan

There is a mandate to individuals to purchase health insurance, with vouchers for low-income uninsured people being phased in over five years. Employers are required to provide, but not pay for plans. Small employers can purchase insurance through state-established insurance cooperatives. Plans must offer a standard benefits package (including preventive services), and not discriminate based on health status. A National Benefits Commission will be established and draw up the benefits package.

Access: All individuals are required to purchase insurance, but subsidies to help poor uninsured people will be phased in gradually over five years. Insurance reform will allow small employers to purchase insurance at a group rate. Employers offer insurance and collect premiums, but are not required to pay. Plans must contain a standard benefits package and not discriminate based on health status. There is increased funding for National Health Service Corps and Public Health Service for primary care education.

Administrative simplification: MACRO: No essential change to the present insurance system. An electronic system will be developed to record health information on patients and performance of health care delivery systems. MICRO: Requirements for insurance reform may pressure companies to increase managed care to cut costs, hence no change in doctors' office function.

Benefits: Coverage is not universal, therefore benefits are not universal. A National Benefits Commission will determine the standard benefit package that insurers must offer in a basic plan. It stipulates preventive services and "severe" mental health and substance abuse services. There is no detailed description of benefits.

Choice of physician: To the extent that employers negotiate to offer a closed panel insurance plan, employee choice will be limited to physicians on the panel. Changing jobs may mean changing insurance and possibly physician as well.

Decision-making autonomy for physicians: The establishment of purchasing cooperatives to enable small employers to negotiate lower premiums will maintain the

pressure on insurers to save money, with the consequent continuation of managed care protocols, gatekeepers restricting access to specialists, and capitation plans. Probably no change from existing structures.

Economics: PAY COSTS: No budgets are set. There are decreases in funding of Medicare and Medicaid with no limits on private spending. There are tax caps on deductibility of premiums. SLOW INFLATION: There are hopes for savings from increased competition, administrative simplification and malpractice reform. Increased cost sharing by individuals is encouraged through choice of catastrophic plan or funding Medical Savings Accounts that have tax advantages.

Flexibility: Outcomes research and practice parameters encouraged. The National Benefits Commission updates the standard benefits package annually. It must be passed *en bloc* by Congress with no amendments.

Michel/House Republican Task Force Plan

This plan retains the insurance-based system. Employers are required to offer, but not to pay for insurance. They can join purchasing groups to get a better premium for their employees. Prevention is included in the benefits package insurers offer. Insurers must offer a catastrophic plan and a medical savings account option.

Access: There is no mandate for universal access. Insurance reform allows employers to form groups to negotiate for insurance rates. Employers must offer, but do not have to pay for premiums. Limitations on denial of coverage for pre-existing conditions. Some expansion of community and rural health services.

Administrative simplification: MACRO: No change in present system. Standardized claims and use of electronic data systems. MICRO: Insurance reform will pressure companies to maintain or increase managed care.

Benefits: No universal access to coverage, therefore no universal access to benefits. In insurance reform preventive services are to be included in plans offered by employers. No detailed information on benefits offered. Insurers decide on details of benefits offered in plans. Premiums must meet targets set by insurance commissioners.

Choice of physician: Employers must offer three benefit packages—a standard, a high deductible catastrophic, and catastrophic plus medical savings account. The employee must use the plan chosen by the employer which potentially limits the employee's choice of physician.

Decision-making autonomy by physicians: Medicaid reform will include mandatory managed care. Pressure on insurers to reduce premiums is likely to maintain existing cost-saving efforts in plans that limit physician autonomy.

Economics: PAY COSTS: There are no set budgets. SLOW INFLATION: Savings are expected from decreased administrative costs, malpractice reform, increased competition. Savings also are anticipated from increased cost sharing with patients through the catastrophic and Medical Savings Account plans.

Flexibility: Outcomes research would be done using the electronic database, but it is not clear whether such research would be aimed primarily at controlling quality, or cost. Benefits and utilization protocols are determined by insurers.

Making The Grade

At the President's Retreat, here's how AMWA leaders rated the plans based on the criteria.

	Clinton	McDermott	Cooper	Chafee	Michel
Access Universal Insurance-based Insurance reform	Yes Yes Yes A-	Yes No Not needed A	No Yes Yes D-	No Yes Yes F	No Yes Yes F
Administrative Simplification Macro Micro	No Maybe C	Yes Yes A	No No D	No change No D-	No change No D-
Benefits Basic benefit package for everyone AMWA specific benefits	Yes Yes B+	Yes Maybe B-	No No F	No No F	No No F
Choice of Physician	Some limitation by plans B-	Total A	Limited by plans F	Limited by plans F	Limited by plans F
Decision-Making Autonomy for physicians	Limited by plans D	Total B	Limited by plans D	Limited by plans D	Limited by plans D
Economics Pay costs Slow inflation	Yes Maybe B+	Yes Yes A	No No C-	No No C-	No No C-
Flexibility	Unsure C	Likely B	Doubtful C-	Doubtful C-	Very doubtful C-
Grade Point Average	B-	B+	D+	D-	D-

BULLETIN BOARD

Select Leaders for 1994-95

AMWA's Nominating Committee announces the following vacancies on the 1994-1995 Slate of Officers:

President-Elect
Vice President, Membership
Vice President, Finance
Director of Residents
Resident Representative
House of Delegates Speaker
House of Delegates Vice-Speaker

To learn more about the responsibilities of each office, see AMWA's bylaws or contact AMWA's national office at 703/838-0500 and request that a copy of the office description be mailed to you. To nominate a potential candidate, please contact the AMWA office for a Candidate Questionnaire (CQ) form. Completed CQ's and Curriculum Vitae (CV) for each candidate must be received by **April 1, 1994**. The eligibility of each candidate will be confirmed. Send all completed CQs and CVs to the Chair of AMWA's Nominating Committee (Lila Wallis, MD, 445 E. 68th St. #5A, New York, NY 10021) or to AMWA (801 N. Fairfax St., Suite 400, Alexandria, VA 22314. Attn: Nominating Committee).

Special Note: Nominating Committee members are not eligible to be candidates. 1994 Committee members are Dr. Wallis, Chair; Susan C. Stewart, MD, Vice Chair; Karen A. Anderson, MD; Mary Guinan, MD; Kaaren Nichols, MD; Omega Silva, MD; Ex-Officio with a vote: Leah J. Dickstein, MD; Ex-Officio without a vote: Kathryn C. Bemann, MD.

Local leaders should be considered for national offices. We need your help to ensure the future of AMWA, the future of women in medicine and the future of women's health issues.

AMWA Thanks Members

AMWA wishes to thank the following individuals who have recruited 230 members in the 1993-1994 Leah J. Dickstein, MD, Recruitment Campaign from October 1 to November 30, 1993:

Allison J. Batchelor, MD	Kaaren Nichols, MD
Ellen Berne, MD	Cheri Olson, MD
Brenda Brishetto, MD	Kathryn Parker
Michelle Brochner	Monica Peek
Susan Cauley, MD	Janet Piehl
Audrey Cheung	Vivian Pinn, MD
Deborah J. Coady, MD	Lauren Plawner
Andrea Crane	Luz Racela, MD
Lori Daughters	Pat Redmond, MD
Leah J. Dickstein, MD	Mary K. Rogers, MD
Linda Ferry, MD	Cherrie Rulka
Julie Freischlag, MD	Leila Saxena
Gerrie Gardner, DO	Vicki Seltzer, MD
Catherine Goodstein	Rochelle Shapiro, MD
Dana Grbic	Omega Silva, MD
Joy Huddleston	Karen Singer, MD
Andrea Hutchinson, MD	A.C. Squires
Romeen Kochlar	Susan C. Stewart, MD
Margaret Kotz, DO	Carrie Sylvester, MD
Joan Langston, MD	Gabrielle Taylor, MD
Sharyn A. Lenhart, MD	Kim Tjaden
Kay Nelson, MD	Allison Tonkin
Carol Ness	Beatrix Urbat

Attention Heart Disease Sufferers

The September-October 1994 issue of *JAMWA* will be devoted to women and cardiovascular disease. The guest editor of this issue, Debra R. Judelson, MD, would like to include personal stories of women physicians who have heart disease. If you are a woman physician who has heart disease, or if you know a woman physician who has heart disease and would like to participate, please mail or fax the name,

address and phone number to Debra R. Judelson, MD, 414 N. Camden Dr., Suite 1100, Beverly Hills, CA 90210; Fax: 310/278-1240. (NOTE: These heart disease sufferers must be women physicians, but do not have to be members of AMWA.)

Call for Abstracts - MWIA

The Scientific Session for the First North American Regional Conference of the Medical Women's International Association (MWIA) is calling for abstracts of no more than 500 words related to this year's Annual Meeting theme, *Women Promoting Women's Health: Empowering Our Global Family*. The conference will be held in conjunction with AMWA's Annual Meeting, November 2-6, 1994, Disney's Contemporary Resort, Lake Buena Vista, Florida. The deadline for submissions is **April 1, 1994**. Submit entries to Estherina Shems, MD, 1310 Wyngate Road, Wynnewood, PA 19096; or Marie Glanz, AMWA, 801 N. Fairfax St., Suite 400, Alexandria, VA 22314.

FAMWA: For Friends and Family

If you know someone who is interested in supporting AMWA but is not a woman physician or medical student, then suggest that they join FAMWA!

Friends and family of AMWA members, and interested other parties who support women's health issues and women physicians and medical students are eligible to become members of the Friends of the American Medical Women's Association (FAMWA).

As the auxiliary of AMWA, FAMWA furthers the goals of the organization through volunteer action and support.

FAMWA President Barbara A. Cadwell, JD (daughter of Past President Anne L. Barlow, MD) encourages all to join FAMWA.

FAMWA members receive membership benefits for just \$40. Medical students not eligible for AMWA membership can join FAMWA for \$45.00 (for all their student years).

Contact AMWA's Membership Department at 703/838-0500.

REGIONAL CONFERENCES SCHEDULED

These regional conferences have been scheduled for 1994:

Region I

Date: April 9, 1994
Location: Newton, MA
Topic: *Women Physicians: Issues In Health Care Reform*
Contact: Laura L. McCann, MD
617/332-3293

Region III

Date: April 23-24, 1994
Location: Annapolis, MD
Topic: *Spring Into Fun & Fitness*
Contact: Willa Brown, MD
301/314-8198

Region VII

Date: September 24, 1994
Location: Omaha, NE
Topic: *The Sport of Medicine—The Winning Team*
Contact: Kay Shilling, MD
402/393-4355

Region VIII

Date: April 15-17, 1994
Location: Breckenridge, CO
Topic: *Health Care Reform — Impact*
Contact: Elinor Christiansen, MD
303/756-4156

Please send information about 1994 regional conferences to Sheri Singer, Editor, 801 N. Fairfax St., Alexandria, VA 22314

Changes in Graduate Medical Education: A Comparison of the Plans

Only the Clinton, McDermott and Cooper plans propose changes in graduate medical education.

Increase in Primary Care Physicians

Clinton. This plan establishes the National Council of Graduate Medical Education which will allocate federal funding for residency training programs, with a target of 55% primary care (internal medicine, family practice, pediatrics and obstetrics-gynecology) positions by the graduating class 2002. Hospitals failing to comply with the federal guidelines will forfeit GME funding.

McDermott. This plan establishes a Committee on Graduate Medical Education to recommend methods of reaching a goal of 50% primary care residencies within five years of enactment. Programs failing to comply will get reduced funding.

Cooper. A commission is established to fund and allocate residency positions nationally, with the total number of spots to equal 110% of graduating medical students. The Accreditation Council for Graduate Medical Education (ACGME) recommendations will be considered. In addition, the specialty distribution will be determined by the commission.

Funding for Graduate Medical Education

Clinton. The plan recommends a 1% surcharge on all insurance plans and Medicare. Funds are distributed using a formula based on the cost of training in each geographic area.

McDermott. The funding for graduate medical education is not specified.

Cooper. This plan also suggests a 1% surcharge on health plans with a distribution in favor of primary care residencies.

Transition to the Recommended Changes

Clinton. This program establishes programs to encourage loan forgiveness for primary care practice, practice in underserved areas, encourages programs to hire minority physicians and retrain mid-career physicians in primary care. The plan also expands the National Health Service Corps (NHSC).

McDermott. The proposed plan expands the NHSC.

Cooper. This plan also expands the NHSC.

AMWA's Health Care Reform Questionnaire

Demographics:

Specialty _____ Age _____ State _____

Career Phase:

Student _____ Resident _____ Post Residency _____

Practice Style (please circle one):

Fee for Service _____ Salaried _____ Retired _____

Other (explain) _____

1. If AMWA had to choose to support one of the five health plans described in this issue, which one would you recommend? (Check one.)

- a. _____ **Clinton Health Security Act** - Managed competition, guaranteed access and benefits, employer/employee mandate
- b. _____ **McDermott/Wellstone** - Single payer, guaranteed access and benefits, payment through taxes
- c. _____ **Cooper** - Managed competition, no guaranteed access and benefits, voluntary employer contribution
- d. _____ **Chafee** - Purchasing cooperatives, no guaranteed access and benefits, individual mandate, voluntary employer contribution
- e. _____ **Michel** - Insurance reform, no guaranteed access and benefits, tax incentives.

2. If the following benefit(s) were not included in the basic benefits package of a health care reform proposal, which do you consider so crucial that you would advise AMWA not to support such a plan. (Check one or more answers.)

- In Reproductive Health Care for Women:
- a. _____ Abortion included
 - b. _____ Contraception included
 - c. _____ Infertility treatment included.

In Mental Health and Substance Abuse:

- d. _____ Same copays for outpatient care as for medical disease
- e. _____ Reimbursement for hospital stays same as for medical disease.

In Preventive Care for Women:

- f. _____ Mammograms every 1-2 years for women age 40-49 and every year after age 50. (American Cancer Society)
 - g. _____ Mammograms every year for women over 50 (National Cancer Institute).
3. What potential negative impacts of change in the health care system under health care reform, concern you the most? (Rank your answers, ONE being the most important, choose at least 3.)
- a. _____ "Gatekeeper" role for doctors: Primary care doctor limits patient access to specialists, tests, and procedures
 - b. _____ "Managed care:" Requirement for doctors to manage patients according to insurance company protocols
 - c. _____ Strict Certificate of Need regulations: Government limits availability of technology and centers offering complex procedures
 - d. _____ Decreased remuneration to doctors for tests and procedures
 - e. _____ "Capitation systems:" Doctor gets a per capita payment for a group of patients and has monetary incentives to limit care
 - f. _____ Doctors required to enter patient clinical data into a databank to be used for outcomes studies
 - g. _____ Loss of control over work schedule: Doctors have administrative pressure to limit time with their patients, particularly in salaried setting.

4. Which mechanism(s) to pay for a reformed health care system do you favor? (Choose more than one.)

- a. _____ Employer mandate to offer and partially cover health insurance premiums
- b. _____ Individual mandate: Everyone must buy insurance
- c. _____ Let employer contribution remain

- d. _____ voluntary Combination of payroll tax and income tax
 - e. _____ Decrease payments to government programs—Medicare and Medicaid
 - f. _____ Graduated copayments for services according to income eg: high income Medicare recipients pay for part B
 - g. _____ Graduated copayments according to type of service eg: 100% copay for cosmetic surgery, 0% copay for cancer surgery
 - h. _____ Eliminate tax deductibility (for employers) of plans above the basic benefits package
 - i. _____ Increase taxes on health hazards, e.g.: \$2 per pack total on the tobacco excise tax.
5. Which mechanism(s) to slow the hyperinflation of health care do you favor? (Choose more than one.)
- a. _____ Eliminate monetary incentives to physicians to perform complex procedures and tests
 - b. _____ Alter fee structure to favor primary care
 - c. _____ Require physicians to follow managed care protocols in order to be reimbursed
 - d. _____ Limit access to costly services by physician gatekeepers in HMOs or capitated systems
 - e. _____ Improve detection and elimination of fraud and abuse of medical payment systems
 - f. _____ Put Point of Service (POS) option into managed care plans. (Patient may see a physician not in the plan for a higher copayment.)
 - g. _____ Increase the practice of advance practice nurses and physician assistants in primary care under physician supervision
 - h. _____ Increase the number of physicians entering primary care to 50% of graduates within 5 years.

MARK YOUR CALENDAR

June 24-27, 1994

AMWA's Interim Meeting
*Women's Health in
Health Care Reform*
The Washington Court Hotel
Washington, D.C.

November 2-6, 1994

79th Annual Meeting
*Women Promoting Women's Health:
Empowering Our Global Family*
Disney's Contemporary Resort
Lake Buena Vista, Florida

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Speak Out for Reform

Congress has made the passage of health care reform legislation its top priority. Two coalitions in which AMWA is participating have launched public education projects to maximize physicians speaking out for reform. Like AMWA, these coalitions support the principles in the Clinton and Wellstone plans. The voices of women physicians are especially vital. We urge you to participate.

The National Health Care Campaign (a project of the Democratic National Committee) has designated Monday, March 28, 1994 as Physician Education Day for outreach and dialogue with colleagues and patients about the need for reform. Activities could include appearing at a press conference, or organizing your own briefing. The campaign has informative video tapes, talking points and other materials. To participate, contact Heather Booth, 202/863-7177 or Jennifer Selling, 202/863-7102.

The Health Care Reform Project, a nonpartisan coalition of business, labor, consumer, children's advocates, older Americans and health care providers, will supply health care providers to various local community forums. If you would like to participate as a spokesperson, or need a physician speaker, contact Amy Slemmer, 202/898-3285.

If you have signed up to participate in AMWA's "Ask Me About Women and Health Care Reform" campaign, your name has been forwarded to these coalitions.

WHAT'S HAPPENING IN AMWA



AMWA

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