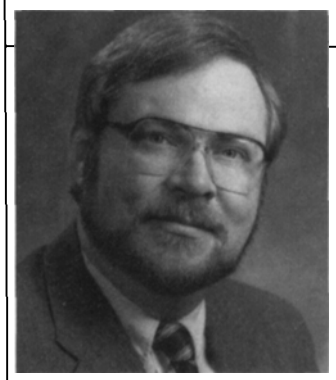
FROM THE EDITOR...

NEW DRUGS FOR OLD



Physicians have always had the prerogative to prescribe an FDA-approved drug for any problem the physician believed could be ameliorated by its use. This concept is still the basic position of the Health Care Financing Administration (HCFA) which says the physician can prescribe any drug and get paid by Medicare as long as the drug has not been specifically classified as dysfunctional for the purpose. This policy has allowed broad latitude to oncologists who, frankly, have used it to try different combinations on patients either informally or on formal clinical trials. Over the years, we have all come to expect that Medicare policies set the pace.

Now, however, things are changing. After a decade or so of relatively small changes in cancer care, we are beginning to see a whole new set of agents and applications emerge. The biologicals, in combination with the existing three modalities, promise a new range of advances. This good news is a result of systematic, prolonged, and sometimes painfully unfruitful research. So much for the good news.

The bad news is that some insurers are unhappy to see this "progress." Simply stated, every new drug or new indication is likely to be more money out of pocket. New drugs and/or new combinations tend to be more costly then conventional treatments. For example, interferon is an "added" cost. And the potential costs of CV rescue with 5-FU will no doubt raise red flags in every insurance computer in the nation. If you were the Blues, losing market share left and right to competitors, HMOs, PPOs, and self-insured companies, wouldn't you try to slow down paying for expensive new drugs? The movement toward quality assessment is a well-timed bandwagon on which to jump for the Blues or HCFA. It provides an opportunity to "assess" all new technologies, perhaps even existing technologies.

Of course, all of this poses a major setback for oncology. Since its development as a specialty, oncologists have lived in times when new innovations have offered improvements in survival and quality of life, when cost was truly a secondary consideration. Which oncologist does not want better treatment options at his disposal? Isn't the desire for hope and innovation one of the major reasons community oncologists sought to participate in formal NCI clinical trials?

With this kind of experience and background, and the new tantalizing promise of the biologicals, you can expect that oncologists will become increasingly frustrated as insurers try and keep cancer care from developing, testing, and adopting new innovations.

Of course there are a number of cogent agreements to be made on both sides. For example, there may be some cancer sites for which we might recommend that several cycles of therapy be attempted with judicious observation of tumor response prior to the use of additional cycles. Indeed, ACCC leaders have been meeting with insurers and others to discuss mechanisms that might allow us to define "trade-offs"; sort of new lamps for old.

In our case, we might trade new drugs for old, more efficacious treatments for a more conservative approach to areas where no standard of care exists. Of course, it would be nice to "have it all," but it's clear that the total costs of all health care are going to be capped and the question is what are we going to lose---the bright, shiny, new lamps that light our future, or the dimmer lamps of the past. If a choice must be made, there is little doubt which selection oncologists will make. Yet, this selection is less attractive to some insurers. They would rather stop payment on the old lamps and delay payment on the new ones. Draconian solutions, like cutting off payment for half of all chemotherapy, simply because the pharmaceutical companies and FDA will not process all the paperwork, puts out the lights, rather than lighting the way.

Lee E. Mortenson, M.S., M.P.A.
Senior Editor, ACCC Executive Director

The Journal of Cancer Program Management

The Journal of the Association of Community Cancer Centers

Senior Editor
Lee E. Mortenson, M.S., M.P.A.
ACCC Executive Director

Managing Editor
Marilyn Mannisto

Production Editor
Carol K. Johnson

The Journal of Cancer Program Management is published quarterly at the Association of Community Cancer Centers' Executive Office, 11600 Nebel Street, Suite 201, Rockville, Maryland 20852. Editorial correspondence, changes of address, manuscripts, and letters to the Editor should be addressed to: Lee E. Mortenson, Senior Editor, *The Journal of Cancer Program Management*, 11600 Nebel Street, Suite 201, Rockville, Maryland 20852.

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