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Cancer Care In 1990 And Beyond: ACCC's Challenges And Priorities

An interview with ACCC President Lloyd K. Everson, M.D.

The new president of ACCC, Lloyd K. Everson, M.D., has a number of concerns about national health care policy, clinical research, and the directions the Association should consider taking during the next year and beyond. The cancer care background of Dr. Everson comprises a unique blend of academic medicine, clinical medicine, and both rural- and city-based practices. He has been involved in clinical research, cancer patient care, cancer program administration, and consulting for cancer programs, hospitals, and physician group practices. Dr. Everson is currently Medical Director of the Indiana Regional Cancer Center of Community Hospitals of Indianapolis, a three-hospital system in Indiana.

What is your view of the state of national health care policy?

The fact that we do not have a national health care strategy is of pressing importance to all of us concerned with delivering the highest quality of medical care possible to our patients and their families. That includes the diverse interests of physicians, hospitals, Congress, the President, and, certainly, the U.S. Public.

In many respects, health care is analogous to a train. In health care's case—a train without a goal. Although there are many proposals before the U.S. Congress and the American public that aim at utilizing the current health care system and "filling in the gaps," as of yet, we do not have a clear vision of where the U.S. health care "train" is going. The train track keeps changing direction and all of the signposts along the way (RBRVS, Medicare, Hill-Burton, etc.) are nothing but bandaids for the problems of the moment.

We're getting tactics mixed up with strategies. Any successful organization that I know of in the United States that doesn't reflect upon its current position and plan definitively for the future and determine, "Here's where we're at," and "This is where we want to go," is doomed, ultimately, to mediocrity or, at the worst, failure. Only after those two questions are addressed can any organization then develop a plan that will determine, "Here's how we get there."

What impact is national health care policy having on cancer care?

Cancer is one facet of a large, multifaceted health care challenge. Unfortunately, the incidence of cancer and AIDS is growing rapidly. And the new technologies (gene therapy, bone marrow transplantation, growth factors, cytokines) do not come cheaply. The problems of expanding cost and increasing incidence of cancer that we're facing are focusing the question of how to prioritize scarce resources. I agree with those who have voiced the opinion that we have squeezed much of the last bit of cost containment out of the health care system. The cost containment efforts of the 1980s have, in large part, been optimized. Further cost containment efforts will result in a deterioration in the quality of care in our country.

If cost containment efforts have run their course, what new strategies must be employed?

The American public, Congress, and the administrative branch of government must now grapple with the very difficult issues of prioritizing federal expenditures for multiple, competing national programs. We now face the most difficult task of re-evaluating our priorities and, in particular, looking at ways that health care expenditures can become a larger part of the GNP, not a diminishing part.

As unpleasant as this may sound, many have positioned the argument with this question: "Is health care a privilege or a right for people in the United States?" Or, in other words, "Where does the right to equal health care access end, and privilege begin?"

These are enormously difficult and challenging issues. On the one hand, if our families, friends, or associates are diagnosed with any of the chronic diseases, and certainly that includes cancer, we want them to have access to state-of-the-art care. Even if there's only a 1 in 10 chance of being cured by available therapy, or only a marginal change of being helped, people want access to that care. Indeed, when this access is denied, it opens up an entirely new arena of legal and ethical issues.

But who pays the bill? What is our strategy as a nation? The recent Gulf war is a vivid example that if we are to maintain our free society and free enterprise system, it is essential that we have a strong defense. On the other hand, if a wealthy nation like the United States cannot take care of the health care of its people, it definitely needs to review its priorities.

Do you believe the United States can maintain its world leadership in health care research?

America's position as the world leader in biotechnology and health care may be threatened. Clinical research requires adequate funding to support the complete spectrum of research, including basic research scientists and clinical investigators in the community. The technology and infrastructure required to train superior scientists in all of the health-related fields is a rapidly evolving and expensive area. Scientists require a market competitive salary. Young men and women will not pursue careers in science and education without a reasonable chance to pay off their educational debts and to earn a competitive standard of living.

ACCC's Priorities in 1990 And Beyond

Dr. Everson has targeted the following areas as priorities for the Association during the coming year and beyond:

Reimbursement. Reimbursement issues, as they present barriers to access to quality health care must continue to be addressed. We must ensure that there is a check and balance approach to the policies and procedures of third-party payors in our country. This will necessarily require multiple, parallel tracks of local and regional input and coordination; legislative efforts; and liaisons with other cancer organizations.

ACCC Chapters. Cancer specialists have regional and local concerns that must reach the national forum. These societies have a unique perspective and, even though they are embryonic, their concerns require attention and action by health care policymakers. ACCC has been at the leading edge of fostering the growth of these societies. The Association must continue to provide leadership and a forum for the expression and input of these evolving local and regional societies. I believe that providing that forum and exchange of ideas will lead to an expanded vision of state and regional issues that will impact the Association's national perspective.

CCOP and CGOP Support. CCOPs and CGOPs, cooperative groups, and NCI-designated cancer centers are testimony to NCI's success. Those proven quantities need continued support, both political and financial. Methods and strategies that ACCC can use to strengthen the role of CCOPs, CGOPs, cooperative groups, and cancer centers must continue to be a pivotal focus for the Association.

Clinical Research. ACCC has only recently begun to address the need for its members' direct involvement in access to clinical research trials sponsored by pharmaceutical and biotechnology companies. Direct access to research and development budgets in interaction with industry and private foundations will become increasingly important in our efforts to ensure continued access to state-of-the-art research in our communities. ACCC, with the strength of its membership in clinical research, will be expanding the role of the Collaborative Research Group, and arranging more direct relationships between membership and private industry and, perhaps, other sources of funding support and research interests, such as foundations. This is, indeed, fertile ground for cultivation by ACCC.

Hospital Cancer Program/Physician Relations. ACCC has always provided a forum for addressing the complex issues of hospital cancer program and physician interactions. Indeed, these issues are critical to the delivery of quality cancer care in our communities. We need to pursue initiatives that will foster that area of primary importance for the organization's growth. We need input from the membership as to how ACCC can continue to address issues that, indeed, are changing, but nevertheless affect relations between institutions, physicians, cancer programs, and their leadership.

Cancer Organization Liaisons. The ACCC needs to maintain and strengthen its liaison relationships with other major cancer organizations, including the American Society of Clinical Oncology, the Oncology Nursing Society, the American Cancer Society, the National Coalition of Cancer Survivorship, the National Cancer Institute, the American College of Surgeons, and others in a more institutionalized manner. I think the "cross-fertilization" that occurs is mandatory for building a coalition that will help frame our role in national health care strategy debates.

Professional Education. Finally, ACCC has, and must continue, its principal role in providing educational forums for cancer program development. This obviously includes input from multiple multidisciplinary sources, including physicians, cancer program administrators, nurses, radiation oncologists, surgeons, and hospital administrators. ACCC must continue to improve its educational programs for for membership on state-of-the-art approaches to cancer care, diagnosis, and treatment.

The NIH and the NCI are two of the leading forces in the world dedicated to the promotion and funding of research strategies. The NIH and, specifically, the NCI, face even tighter budget restrictions. For example, CCOPs, cooperative clinical trial groups, and cancer centers are probably the leading examples of the success of the NCI. Yet those key examples of success have seen their budgets continue to shrink or, at the least, remain static, at the same time that they are asked to do more and more. From a federal perspective, this is a real threat to the cancer research infrastructure of our country that is, and has been, responsible for state-of-the-art cancer research. The future of continued, adequate funding for research in our country will demand that private foundations, private industry, the pharmaceutical industry, biotechnology companies, and others, shoulder more of the responsibility for funding our research efforts.

What about the future of community-based clinical research?

From a community perspective, most of the CCOP investigators that I know are committed to clinical research, because they believe it represents state-of-the-art care. There is, however, a limit to how much cancer research those individuals and their cancer programs can persuade their colleagues and organizations to fund if those research efforts don't pay their own way, or indeed, subtract from other budgets with higher priorities.

Many of the people who provide the "glue" for quality cancer programs—social workers, medical technicians, nurses, oncologists, palliative care specialists, medical subspecialists, etc.—are not supported by direct, patient care-derived revenues. They are supported by the hospital, which embraces a comprehensive state-of-the-art care philosophy for its community. These real expenses, then, are borne by cost shifting within the organization. However, as reimbursement for services declines, whether for research or patient care, the question must be asked, "How is the institution to stay afloat?" Obviously, the choice is either to increase revenues or to cut services.

In terms of cancer and AIDS, chronic diseases that are rapidly increasing in cost and incidence, that is a very frightening perspective, indeed. ■