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Oncology Issues

ISSN: 1046-3356 (Print) 2573-1777 (Online) Journal homepage: https://www.tandfonline.com/loi/uacc20

Hospitals under Health Reform

Robert T. Clarke

To cite this article: Robert T. Clarke (1993) Hospitals under Health Reform, Oncology Issues, 8:1, 4-6, DOI: 10.1080/10463356.1993.11904402

To link to this article: https://doi.org/10.1080/10463356.1993.11904402

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The Journal of the Association of Community Cancer Centers

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PRESIDENT'S CORNER

Hospitals under health reform

Without a doubt, a number of things are going to be altered under health care reform. Under the new proposals, some of which are described in this edition of Oncology Issues, long term changes are likely to dramatically alter the health care delivery system. In fact, they are likely to alter the role of the components of the system in dramatic ways, some of which we can only guess at now.

For example, hospitals are no longer going to be revenue producers, but cost centers. This simple statement belies the multitude of real and attitudinal changes that flow from this radical change in status. As a CEO of a 600-bed teaching hospital and as the current Chairman of the Illinois Hospital Association, it is impossible to ignore the significant changes that will soon take place.

Under the existing system, I find that my hospital Board, composed of community business leaders press me to keep my costs in line, but also make a profit. They see the hospital as a revenue producer. They expect the hospital management team to produce a quality, value-added product at a competitive price and to do what it can to hold the line on costs. After all, these Board members are also the purchasers of care and they want to keep their costs down and their quality high.

But under "managed competition with global budgets", the hospital will be only one component of a fully integrated Provider Organization, including all hospital services, outpatient and physician services. In some cases, the hospital will be the major partner in this structure, but in a large number of cases, the hospital will be only one of a number of hospitals in the Provider Organization (PO). This Provider Organization will be competitively bidding for contracts with other Provider Organizations on the same package of basic services. The value-added component of the program may not have a place in this bidding process.

Instead of seeing the hospital as a revenue producer, the Provider Organization's new corporate board, will now see the hospital as a cost center. Instead of worrying about the hospital generating significant revenues, the incentive will be for the hospital to minimize its costs of providing services.

You can imagine the difference. The revenue producer mentality is much more entrepreneurial. It is an investment mentality. It is a mentality where there are incentives for bringing in additional patients, additional services, unique program features, and where quality and referral to solid clinical services is the byword. Physician influence in the selection of specialized services can be more important than patient satisfaction, which of course has its good and bad points.

The cost center mentality is 180 degrees different. Here cost is likely to prevail as the key evaluation criteria. Specialized services, the high cost, technologically advanced, and value-added services of the hospital are likely to be discouraged. The hospital will work on the minimum reasonable cost basis. With a trim administrative team and integrated services, the hospital and the entire PO structure will be looking for ways to deliver quality for the lowest possible cost. The management of the PO will see the hospital as an additional cost burden, with projects and overhead to be slashed as bids are developed.

You might remember the initial shake out of HMOs and PPOs. The first round of battles had a number of organizations providing services below their cost structure, a situation that caused a number of these organizations to go belly up. Without a doubt, this same scenario will repeat itself in cities throughout the nation.

(Continued on page 6)

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Articles submitted to *Oncology Issues* for consideration for publication should be no longer than 8 to 10 double-spaced manuscript pages in length. Submissions should include the original manuscript and two duplicate copies. Author(s)' identification (title and affiliation) should be included. If there are multiple authors, one author should be designated as correspondent.

Review and corrections

Articles will be reviewed by two or more editorial review board members. Authors will be informed of acceptance, rejection, or need for revision within 6 to 8 weeks, but at times longer delays may be unavoidable. All articles are subject to copy editing. Author corrections and revisions should be kept to a minimum and must be received within seven days of receipt; after this time, no further changes may be made by the author.

Articles should be submitted to: Managing Editor, *Oncology Issues*, 11600 Nebel St.,Suite 201, Rockville, MD 20852, 301/984-9496

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Authors are encouraged to submit illustrations, tables, figures, sidebars, etc. that help clarify the text. Tables, figures, and sidebars should be typed on separate pages and their position indicated in the text. Photographs should be unmounted, glossy prints.

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LETTERS TO THE EDITOR

Off-label Drug Use

The letters of Drs. Adamson and Wade in the Fall 1992 issue pinpoint the problem of off-label drug use. As a Medicare Carrier Medical Director, Dr. Adamson has the responsibility to determine the medical necessity of any service that his carrier is billed for. When there is no scientific evidence to justify the treatment, there is no justification for payment.

I hope Dr. Wade does not advocate approval of the use of any drug that any physician wishes to use under any circumstance. This flies in the face of quality health care, as well as cost-effective health care, and should not be acceptable to oncologists or third-party payers. There is a potential solution. In New York, our carrier uses the oncology society as a resource in determinations on off-label chemotherapeutics. This has resulted in a better understanding of the issues by both parties. Our carrier is able to make more accurate coverage decisions and oncologists understand (and often concur!) with our reasons for doing so.

There will never be a universal consensus, but reasonable people have a better chance of resolving a problem. Better communication, understanding the other party's position, and development of criteria for off-label coverage would seem the logical solution to this problem.

—John E. Harding, M.D., Medical Director, Upstate Medicare Division, Blue Shield of Western New York, Binghamton, NY.

James L. Wade, III, MD, Decatur (IL) Memorial Hospital and Chair of ACCC's Governmental Affairs Committee, responds:

I applaud Dr. Harding's suggestion that third-party payers work with state oncology societies to research and make recommendations on coverage decisions. My own state society, the Illinois Medical Oncology Society, has an excellent relationship with our insurers. We maintain an ongoing dialogue on difficult issues and the society is willing to review any issue with which our insurers would like assistance. The ACCC encourages the type of arrangement Dr. Harding describes and has assisted state societies, including all of the current ACCC chapter members, in setting up systems that assure a thorough and timely review. The societies see this as beneficial both to its members and the insurers in the state.

President's Corner

(Continued from page 4)

Will all interest in quality evaporate? No, but it will slide down the ladder for awhile. How else is the new Administration going to cut the budget deficit while it adds access? While the proposed cut in Medicare and Medicaid is $66.5 billion over five years, universal access could add between $30 and $90 billion each year to the federal budget!

What does all of this mean for oncology programs? Here are some initial guesses. First, the PO will attempt to deliver chemotherapy in the lowest cost way, with the maximum feasible control of expenditures. So, there will be significant interest in employing medical oncologists. Second, the PO will be interested in using primary care physicians for patient triage and to manage patient follow-up with guidelines for the follow-up interval and appropriate tests. Third, the PO will be interested in using highly trained nurses to supplement the oncologist in any way possible. POs will consider the shortage of oncologists and attempt to find ways to minimize their use. Freestanding radiation therapy centers will be perceived as an uncontrollable cost and will be replaced or purchased. New technology will be discouraged, unless it is more cost effective. Capital expenditures for any kind of new venture, new technology or upgrades are very likely to be discouraged in the near term when the price competition is going to be at its worst. Fourth, experimental procedures, unless they are fully reimbursed, are unlikely to be allowed. Patient satisfaction is likely to out pace typical physician satisfaction interests. Minimum care is likely to be the byword. Guidelines will be necessary to assure that malpractice is abrogated.

Doesn't sound like the old system at all does it?

As times change, we must change. But we must also hold true to our basic standards for quality cancer patient care.

Robert T. Clarke, M.H.A.