Oncology Issues


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

# Cancer Program Development in the 1990s

Lloyd K. Everson

**To cite this article:** Lloyd K. Everson (1993) Cancer Program Development in the 1990s, Oncology Issues, 8:2, 8-10, DOI: 10.1080/10463356.1993.11904417

**To link to this article:** https://doi.org/10.1080/10463356.1993.11904417

Published online: 18 Oct 2017.

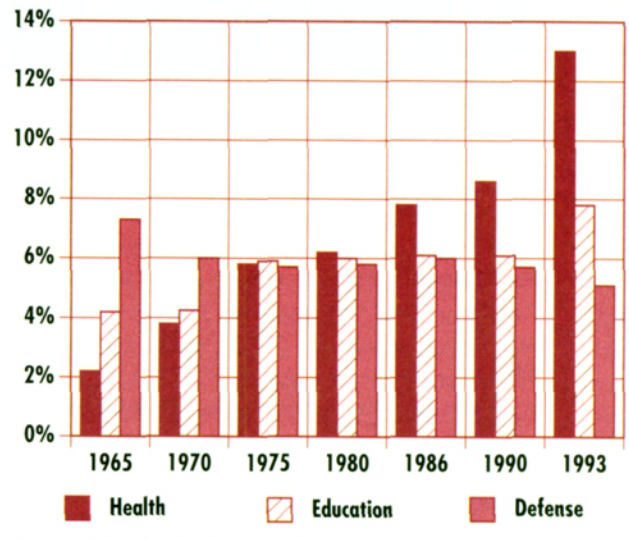
# Cancer Program Development in the 1990s

*The first in a series of six articles that will explore the past, present, and future of multidisciplinary delivery cancer care.*

**by Lloyd K. Everson, M.D.**

This decade offers a multiplicity of systemic challenges to our health care system. We as medical directors, cancer program administrators, oncologists, oncology nurses, and supportive staff will face formidable challenges in continuing delivery of multidisciplinary care to our cancer patients. The triad of concerns—cost-effective care, access for the entire population to health care, and continuing high-quality services—will force our cancer programs to deal forthrightly with these challenges as well as the opportunities that change will bring.

**FIGURE 1. Total U.S. Health Care Expenditures (as % of GNP)**




## Controlling Costs, Assuring Quality

All of us in health care professions must deal effectively with the challenge of cost containment. Rapidly rising costs are placing an increasing burden on the U.S. economy. Per capita health care costs, for example, have increased from $750 in 1970 to $2,500 in 1990. Health care spending, as a percentage of GNP, in 1970 was 7 percent; in 1993 the figure will rise to 13 percent (Figure 1). The 1992 federal budget includes $430 billion for education, $270 billion for defense, and $838 billion for health care. Medicare share, as a percentage of the federal budget, has increased as well. In 1990 it was 7.5 percent. In the year 2010 it is projected to be 15 percent.

**Lloyd K. Everson, M.D.,** *is Medical Director, Community Hospitals Indianapolis Regional Cancer Center in Indianapolis, Ind., and President of LKE Consulting Services.*

If we continue to spend this kind of money, do we really get a better outcome for our buck? There are some data and a developing perspective to suggest not. While the United States spends 13 percent of the GNP on health care, Canada spends just 9 percent; France, 9 percent; Sweden, 8.5 percent; and the United Kingdom, 6 percent. When compared with most other developed countries, the life expectancy in the U.S. ranks number six and infant mortality ranks number seven.

From the 1960s to the 1990s, not only have we experienced a dramatic rise in health care expenditures, we have also seen an explosion in new technology. The next 10 to 20 years may well witness a revolution in science and medicine, a revolution in which we will replace empiric approaches to therapy in many diseases with genetically targeted prevention and treatment strategies. With this proliferation of technology and improvements in treating chronic diseases come increasing cost. Indeed, from the 1960s to the 1990s, medical services' inflation was about 33 percent above the consumer price index (CPI) and is primarily related to new technologies used throughout the health care industry.

Concomitant with the spending boom is the aging of the U.S. population. In 1990 the population older than 50 years was 65 million; by the year 2020 the elderly population is projected to reach 113 million. Cancer incidence continues to increase among the elderly. The older population is more likely to experience increased health care demand and cost, especially for the higher technology services in cancer, cardiac, and neurological diseases.

Curbing overutilization of services is another challenge facing health care professionals. Some studies suggest overutilization is widespread throughout the system with impact on "unnecessary" hospital days, unnecessary preoperative lab screening, and overutilization of major procedures.

Such findings give rise to public consensus now being translated in the Congress and federal government that much spending is unnecessary and misguided. Health care professionals, including hospital administrators, physicians, and insurance industry executives, are just beginning to deal with the problem in an effective manner. With a relative vacuum in place, the federal government is stepping in.

We are all acquainted with the payor initiatives that are pressuring providers to cut costs while maintaining or improving quality. We have all seen price discounting, mandatory use of outpatient services, guaranteed prices, price for volume deals, and, we anticipate, value for volume deals. This pressure to cut costs is giving impetus to many hospitals and cancer programs

to "flatten" their organization, vertically integrate cancer services and providers, and emphasize Centers for Excellence program development.

## Meeting the Challenges

What are the implications? First, there will be an overall broad restructuring of the entire U.S. health care delivery system in the coming years.

Price and value will become the major basis of competition in our health care system. The implication for hospitals and for physicians is that the mastery of outpatient business will become key to survival. Obviously, in this kind of environment, closer integration of physicians and hospitals will be mandatory. Separation of hospital and medical staff will be increasingly unmanageable and counterproductive for physicians, hospitals, and patients.

Already, organizational and systemic restructuring of work design and consolidation of departments are occurring throughout our hospitals. Hospital-to-hospital collaboration and standards of care are being used in clinical pathway decision making. Outpatient services management with increasing inpatient tertiary acute care is taking place. Comprehensive care services are rapidly migrating to the outpatient arena. The old model of hospital/physician relationships in economic joint ventures, under scrutiny by the IRS, Medicare, and the Inspector General, has led many to rethink these models and develop alternative approaches to collaboration and comprehensive services delivery.

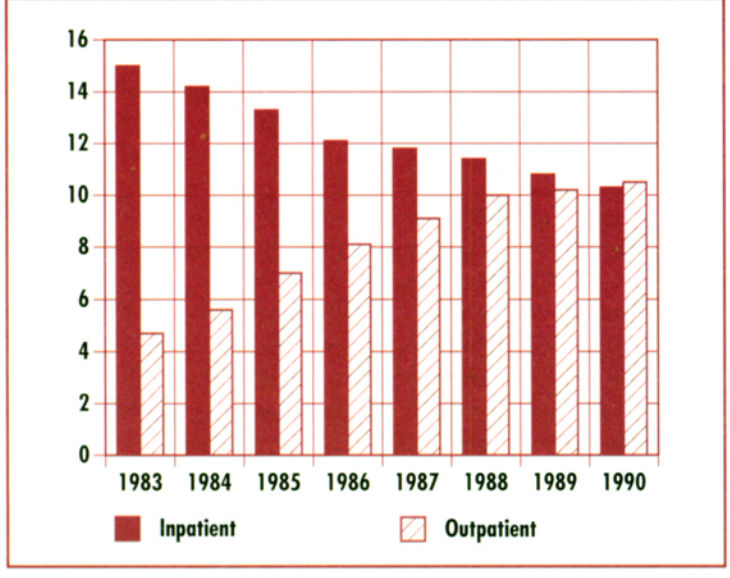
Formal organizational partnerships of hospitals and physicians will continue to evolve. Joint contracting for managed care in the short term (with models such as the "clinic without walls") will become ever more prevalent in the system. However, in the long term hospital and physicians will find that an umbrella organization over both will probably offer the ideal situation in which to increase market share, compete effectively, and cut overhead.

As for outpatient care, the contrast between number of procedures in inpatient and outpatient care shows clearly that outpatient care has surpassed inpatient care (Figure 2). Inpatient care has been the financial foundation of hospitals in the past. Not so in the future. Outpatient care, classically delivered in the physician's office, will become a target of hospital strategic development.

The same global implications and challenges facing the much wider sphere of the health care system will be thrust onto cancer programs. Price and value (i.e., cancer outcomes) will become the major basis of competition between cancer care provider groups and systems. Mastery of outpatient business (radiation oncology, medical oncology, and surgery) will be key to survival for both physicians and hospitals in the future. Separation of hospital and medical staff will be increasingly unmanageable and counterproductive in realizing expectations for integrated comprehensive cancer services, research, and education.

Will slow and incremental changes in health care delivery systems (i.e., physicians, hospitals, payors, and consumers) be adequate to meet these challenges? The answer is no. Rapid and abrupt action is required. In business, incremental changes often are high risk and result in costly outcomes. Although rapid global changes may carry higher risk and be more costly in the short term, they offer the potential for lower risk and less costly outcomes in the long term.

**FIGURE 2. Growth of Outpatient Care (number of procedures, in millions)**




## Past, Present, and Future of Cancer Care

To know where we are going, we must understand the evolution in cancer care over the last 30 years and examine the foundation for multidisciplinary care in our cancer programs. Programs rest on a foundation of cancer clinical care, cancer research, and cancer education.

**Clinical care.** Cancer clinical care in the 1960s was characterized by virtually nonexistent cancer control initiatives. Diagnosis was generally for late disease processes and stages and usually through a surgical biopsy. Primary treatment was usually radical surgical intervention. Chemotherapy and radiation therapy played minimal roles. Site of service for cancer was usually in the hospital inpatient setting, as was continuing care.

In the 1990s cancer control is finally in developmental research and part of the marketing program at cancer programs. Diagnosis is now earlier in the disease process, and many times is done by imaging, physical exam, lab, and education. Although surgery still plays a major role in primary treatment, the primary approach is relying increasingly on chemotherapy and radiation therapy. Replacing the inpatient focus, the site of service is now the physician, clinic, and hospital outpatient care center. Continuing care is in the clinic and home care.

By the year 2020 cancer control will be the main reason for decreased morbidity and mortality as projected by the federal health plan. Diagnosis may be at the predisease processes and stages. Primary treatment will be with chemotherapy, biotherapy, and genetic engineering approaches. Site of service will continue to shift to the outpatient and home care setting.

**Cancer research.** Cancer research, no less, has made a rapid evolution. In the 1960s the scope of cancer research was postdiagnostic treatment oriented. The site for patient accrual to clinical studies for any phase of cancer research was with the university and teaching hospitals. Funding was primarily federal, with support from the National Institutes of

Health (NIH) and the National Cancer Institute (NCI). The scientific rationale was basically empiric testing of drugs, and patient access to these new technologies was a slow transfer with little community involvement.

In the 1990s we are seeing a major change. The scope of cancer research is more focused on adjuvant and chemoprevention focus. From 50 to 70 percent of patients in clinical research trials originates from community-based programs, CCOPs, and CGOPs. Funding is a mixture of federal and industry support. Scientific rationale is slowly moving from empiricism to targeted research and development. Patient access to new technology is faster, with larger community access that is primarily fostered through the clinical trials cooperative group mechanisms with the NCI.

By the year 2020 prevention, screening, and early detection will play integral roles in research. Use of genetic markers, outcomes research, and payor implications research will be behind this change. Patient accrual to research trials will be primarily community based, with increasing university and community hospital and physician collaboration. Funding will be largely through industry; NIH and federal support will gradually diminish. Scientific rationale will continue to evolve toward targeted drug development and genetic engineering. Patients will experience a more rapid access to new technology.

**Cancer education.** In the milieu of cost containment and universal access, the challenge to our society to assure a continued entrance of physicians, nurses, and paramedical support personnel into the profession will be tremendous. Cancer education for professionals in the 1960s was basically at university and teaching hospitals, funded by the federal government, focused on specialty care, and greatly regimented. The source of patients was indigent populations. Public education was physician and hospital oriented, and the focus was on treatment.

Cancer education in the 1990s is undergoing an evolution as well. Physician and nursing education will increasingly entail collaborations at university and community hospitals. Funding will be a continued blend of federal, NIH, and tax bases. There will be an increased emphasis on primary-care development. The source of patients will be a covered population as we deal a death blow to the insurance discriminator of access to health care. The medical school clinical curriculum continues to be introduced earlier and earlier. In the public arena, cancer education is still physician and hospital oriented. The focus will continue to be toward early detection and education.

By 2020 cancer education will be mostly a solid community-university collaborative effort. Funding will be a blend of support from federal, tax base, and community hospitals. The focus will be on primary-care physicians and nursing personnel, and the source of patients will largely be community hospitals. Medical school clinical exposure and genetic-based disease will be integrated early in the curriculum. Cancer public education will be focused on prevention and screening techniques.

## The Cancer Center Vision

The comprehensive cancer center vision continues to be the paradigm for the best multidisciplinary care delivery in our country. However, the dimensions of that comprehensive cancer center have changed dramatically and will continue to evolve. The charge to our university and community-based cancer centers will be in delivering the scope of care that is required for cancer patients and their families. Programs will have to continue to be integrated and comprehensive in the sense of including the entire scope of services—prevention, screening, early detection, treatment, rehabilitation, and palliative care. These comprehensive services must be integrated administratively and clinically with the many clinical services, clinical research efforts, basic research efforts, and education that are required for the entire health care team in cancer.

An obvious question arises. Can we continue to address these expensive, time consuming, and multidisciplinary concerns for our patients as single institutions? With multiple institutions having identical visions for health care, it might be best to look at ways in which collaboration among currently competing institutions can be addressed. That is the major challenge in most of our communities, which have historical animosities among hospitals, hospital systems, hospitals and physicians, and physician to physician groups. Nevertheless, there is a realization that collaboration in partnerships of varying models will become of increasing necessity for the economic and clinical survival of our institutions.

Clinical services that form the backbone of cancer centers include state-of-the-art facilities, equipment, and programs. The comprehensiveness of these programs is critical in dealing with prevention, screening, early detection, treatment, rehabilitation, terminal care, and clinical research. Comprehensive cancer centers succeed especially when they have a loyal, broad base of oncologists and when they have access to clinical research and new technologies.

Basic research, clinical research, and outcomes research will continue to be a necessary part of university- and community-based comprehensive cancer centers. University and medical school ties will become increasingly important to community hospitals and vice versa. Industry relationships with the pharmaceutical industry will also become a major component, especially as federal funding sources decline.

Finally, education is the critical factory for production of health care professionals. Our cancer centers must continue to be involved in professional education for residents and fellows, nurses, and postgraduate physicians. As we develop over the next 30 years a clear understanding of the nature of cancer and other chronic diseases, we will move into the public arena of education in a more focused manner. Clinical services, research, education, and medical school relationships with community hospital systems will become more important.

The same ingredients for a successful program that are critical today will be necessary in the future. There are at least five critical components for cancer program development, whether it be university of community-based. These are: 1) vision, 2) organization with a medical director and administrative director, 3) strong financial foundation, 4) a loyal, dedicated base of physicians, and 5) a strong program that addresses the comprehensive nature of cancer care (prevention, screening, early detection, treatment, rehabilitation, palliative care, and clinical research).

Are we as physicians, institutions, nurses, and other health care professionals involved in cancer care willing to commit to a new vision of cancer care in our communities? That is the question that we will continue to probe and discuss over the next many years as our health care system and our cancer care delivery system undergo changes.