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Health Care Reform: Portrait of Change

by Mary Anne Fleetwood

More than 475 attendees, a record number, participated in ACCC's 19th Annual National Meeting, March 17-20, 1993, in Washington, D.C. For almost four days, oncologists, cancer experts from around the country, congressional leaders, and representatives of the health insurance industry examined the potential impact of health care reform. The content of the Administration's health care package was the subject of much speculation. Conference speakers went straight to core issues: What will the package look like? How will it affect the quality of care? How will it affect oncology in the 1990s?

"President Clinton will not see the train (of health reform) derailed," Lee E. Mortenson, D.P.A., Executive Director of ACCC, told attendees. "President Clinton sees his political future tied to the success of health reform. The President's package is likely to be passed by the Congress without substantive changes." Mortenson set the stage by painting with broad brush strokes the political scenario likely to frame the reform effort. The low-cost providers will be the winners in the new configuration. In addition, there is every indication that research and quality of care could be threatened under the new system, he said. There also will be less reliance on fee-for-service practice—if it exists at all in the future.

Michael M. Hash, a staff member of the House Subcommittee on Health and the Environment, defined the key elements likely to drive reform. Universal coverage for a defined package of benefits is a key component, he said. "We are moving away from voluntary health insurance coverage in this country, Hash noted. But the new package is going to have to be better than or equal to what we have now or it will be a hard sell."

Cost containment will be one of the most controversial features, he said. The legislation's designers will no doubt be looking at cost containment over the short-term while the new reform is being implemented. Without short-term cost containment, health care costs could skyrocket over the next three to five years as providers try to offset conservative pricing associated with the Administration's package.

Everybody into the Pool

Andrea King, from the office of House Majority Leader Richard Gephardt (D–Mo.), addressed other probable components of the package. All employers will be required to pay a set amount for health insurance for all employees, she said. There will also be limits on pre-existing condition clauses, allowing workers to change jobs without fear that pre-existing medical conditions will exclude them from coverage.

Marketing reform, she said, will be driven by mandated purchasing co-ops. These Health Insurance Purchasing Cooperatives (HIPCs) will bid on competing packages of care for the most economical price from Accountable Health Plans (AHPs). AHPs are provider networks or integrated organizations of an insurance administrative structure, which contract with a select group of physicians and a hospital. Several AHPs in each service area will provide employees with options.

The formation of HIPCs and AHPs will constitute radical change in the existing health care infrastructure, King noted. The cost of health care will be determined by the cost of the package that HIPCs select for their constituents. Physicians in a given package must offer care at costs stipulated by AHPs.

Health care reform also will mean a paradigm shift away from specialty care, King observed. At present, about 60 percent of U.S. physicians are specialists. With reform, the pendulum will swing in the opposite direction. There will be a great need to train additional primary-care physicians to serve as gatekeepers to specialty care in the emerging system.

The Administration's concept will be to get everybody in the pool and then share the cost, she said. The government will tell the states who will be in the purchasing co-ops, or HIPCs. There will be federal standards regulating the health care packages offered and the co-ops as well. For consumers, there will be safeguards to ensure a certain standard of care.

Clearly, the President's goal is to get a handle on health care inflation, said King. The driving problem is the increase in the cost of health care for families and businesses. Some employers and families are now forced to drop their health insurance coverage because it is too expensive. Given current trends, health insurance premiums may double in the next five years.

Under the new system, she said, health providers will have to stop doing the unnecessary or be penalized. "Every attempt will be made to create a marketplace dynamic providing the highest quality of services for the lowest cost. This will require the development of the standard benefits package (available to all citizens under universal coverage). Moreover, co-pays and premiums are likely to be standardized."

People who elect expensive plans may suffer the consequences. In contrast, those individuals selecting more reasonably priced plans may receive a consumer incentive. Under the cost containment dynamics of the new system, the government will set the percentage by which health care costs climb annually. "But

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how the plan will be enforced is still an unanswered question," King concluded.

John Hoff, attorney and ACCC Legal Counsel, examined "global budgeting," which he described as a euphemism for cost containment. "Global budgeting is a fascinating and scary process," he told ACCC members. Hoff speculated that price controls could have an adverse impact on how much health care will cost the nation annually. Lowering cost could actually increase the volume of business, thus driving costs up.

Explaining pricing mechanisms further, Hoff stated that the HIPCs would negotiate with AHPs, setting payment levels for health care. Providers would have to stay within the boundaries of the cost guidelines.

An oncologist and Associate Medical Director of Health Net, a California-based HMO, Clifford Ossorio, M.D., described the perils of capping costs without regard for the effects on the quality of patient care. He cited California's experience with HMOs and the practice of oncology. "We are at a crossroads where our national system must also address service," he stated. HMOs are relying increasingly on patient reporting to determine the quality of physician care, outcomes, and health status. The future winners, he projected, will be those providers who can offer quality services and health outcomes that are measurable.

How Will Oncologists Fare?

A. Collier Smyth, M.D., spoke directly to health care reform as it affects oncology. Going straight to a key issue, he said, "We do provide excess care in the United States." But it is hard for a physician to "sell no" on a procedure to a dying patient, who wants every intervention available regardless of expected outcome. At present neither the physician nor the patient is accountable for the cost of the clinical decision made at bedside.

Physicians have had little incentive to contain costs in the fee-for-service system of the past. Consequently, the insurance industry has had to micromanage care, said Smyth, who is President of the Northern New England Clinical Oncology Society and member of the American Society of Clinical Oncology Clinical Practice Committee. Currently, the power structure of the U.S. health care system gives the physician and the patient the lion's share of control in decision making, followed by the insurance industry and the hospital. The employer and employees who finance the current system are at the bottom of the structure.

Under the proposed reform, the oncologist will be in the position of "selling no" to low-yield interventions and expensive new technologies.

That power structure will change under reform, he warned. Under managed competition, the HIPCs will be at the top of the ladder, followed by AHPs. Within each AHP will be positioned an insurance administration, one or more hospitals, and a defined group of physicians (both primary care and specialists). Insurance companies and hospitals are organized. Each speaks with a single voice, and each has data on costs. According to Smyth, physicians are generally disorganized, having multiple interests and a poor understanding of their costs. Capitated primary-care providers may become gatekeepers who control access to specialty services.

Smyth focused on the dynamic between oncologists and their patients as the key interactive process in the delivery of care. At present, the motivating factors for both doctor and patient are to "do more." Under the proposed reform, the oncologist will be in the position of "selling no" to low-yield interventions and expensive new technologies. AHPs prefer a conservative practice style, he said.

Reformers believe a critical problem that contributes to the high cost of medicine is the abundance of specialists who perform expensive procedures. To control expenditures, AHPs will accentuate the role of primary-care physicians and give them financial incentives to limit use of specialists, said Smyth. Oncologists will be forced to offer relatively inexpensive interventions. However, protracted use of low-yield, inexpensive interventions will undoubtedly have an adverse impact on the quality of care, he said.

Physician cost profiling, maintaining a database that documents a physician's pattern of care, may control the oncologist of the future, Smyth conjectured. The low-cost oncologist will be obvious; whereas quality, which is hard to measure, may get left in the dust. Physicians—who have long been comfortable with their role as a patient advocate—will find their additional responsibility as an allocator of resources quite difficult. Attorneys may make a difficult situation untenable.

Addressing the future of oncology under health care reform, William T. McGivey, Ph.D., with Aetna Health Plans, Hartford, Conn., envisioned an alternative scenario. McGivey stated that in the future a National Technology Consortium could surface. Its mandate would be to establish guidelines on utilization procedures and to focus on treatment outcomes and the appropriate use of devices. In McGivey's view there is not sufficient research to show how many procedures impact treatment. More outcome data is needed for review by the National Technology Consortium, he explained. A major shift noted by McGivey is that cost effectiveness analysis will be used as a basis of decision making regarding appropriate treatment for cancer patients.

However, the new reform will probably move away from micromanagement, and doctors will be more in control of treatment decisions than in the past, he said. Further, the medicine of the future is likely to be based on a shared decision-making model. The patient will be involved to a greater extent in decisions about drugs, procedures, devices, and techniques.

Burton F. VanderLaan, M.D., Medical Director with Blue Cross Blue Shield/HMO Illinois in Chicago addressed practice guidelines. "Clinical guidelines are an indicator of quality," he said, "and the development of practice parameters are a current trend." At present, said VanderLaan, the types of treatment offered for the same diagnosis vary considerably. An appropriate approach to a given diagnosis can be defined, and doing so eliminates care that does not contribute to outcome. Practice guidelines are expected to play a role in reform by limiting excesses and trimming costs.

Practice parameters are the domain of professional specialty societies, VanderLaan said. Blue Cross Blue Shield of Illinois developed guidelines for cancer patients, not to be followed slavishly but merely to suggest an appropriate, follow-up protocol. Having devised such a profile, the insurer can use it as a model of what to pay for in a patient with ovarian cancer during the first year of follow-up, for example.

Oncology practices in the future will be increasing developed around the managed care concept, VanderLaan said. Managed care is an organized system of care, a practice style including costs,

Developing Community-Based Breast Centers

Recent studies show that one in every nine or ten women will develop breast cancer during her lifetime. Consequently, early detection and intervention are critical, lifesaving factors. As more women have regular screening for early detection, more institutions have become interested in developing breast centers. Roberta Kale, R.N., Director of Womens' Health at HCA St. Mark's Hospital in Salt Lake City, Utah, conducted a workshop on developing breast centers at ACCC's Annual National Meeting. She defined practical guidelines, based on her experience in the development of womens' health programs, on how to plan, sell, and implement a successful breast center.

Information Gathering

Several questions must be addressed before deciding whether a breast center will be successful in your hospital, Kale said. First, determine whether the concept of the breast center is compatible with the goals of the hospital's strategic plan. If it is not consistent with these goals, then the breast center will rarely gain the support of key hospital staff. Second, find out what women in the community want and what consumers perceive a successful breast center to be. Third, know the competition. Find out their pricing strategy and whether the programs are accredited. To really know competitors, Kale advised, sign up for a mammogram and diagnostic services with them.

In the marketplace of the nineties, physicians in the hospital may be concerned that patterns of self-referral circumvent the primary-care physician. Therefore, it is important to clearly identify early on the referral patterns to be used and to assure physicians that the breast center will generate new dollars and will not compete with existing services.

Creative Planning

In defining the scope of services, Kale advised planners to "be creative" and envision the perfect system. The ideal can be scaled down later. At this stage, you will need to know if comprehensive services will be included and what equipment will be needed. Will there be a surgeon on site? Who will reimburse for services?

Before writing a proposal, Kale advised rethinking key elements. For example, ask yourself if the scope of services makes sense in terms of anticipated need and what variables are critical to the success of the breast center. You also should examine whether the medical staff is genuinely committed to the program and whether the plan meets revenue objectives.

Programmatic Support

Kale underscored the importance of identifying a key physician to champion the breast center. Identifying and recruiting a physician who gets things done will make it easier to circumvent turf battles and administrative gridlock later on. If the right person is recruited, his or her presence on the team should guarantee success. In fact, she said, it is even better to have multiple breast center champions.

Shoring up institutional support through development of the Physicians' Advisory Committee is the next step. Study those physicians who are perceived by their peers as successful. Then, select the physicians who are power brokers in the hospital. They will be invaluable when it is time to sell the idea to the Board of Directors. The Physicians' Advisory Committee will continue to serve in an advisory capacity regarding the policies and protocol of the program, remaining a crucial link between breast center staff and medical staff at the hospital.

Writing the Proposal

All proposals should start with a mission statement, articulating exactly what will be accomplished. The mission statement must be compatible with the mission and philosophy of the hospital.

The next step is to define the scope of services, determining, for example, whether the program will offer mobile screening vans or a full-service program. Defining the target population is normally based on population research, as well as what planners believe consumers will use. You may want to include clients who will be attracted after self-referrals, as well as the anticipated pattern of physician referrals.

When developing protocol, ask how long it takes a patient to complete an appointment for breast imaging from the time of entry to completion. This information helps determine how many patients can be screened in one day. The protocol can show the referral pattern from the initial phone call (from a self-referral client or from a physician) through the summary report to the patient or follow-up sessions.

The institutional capability statement requires a resource assessment. This section presents to the prospective grantor the resources of the institution to plan, sell, and implement the project. Grantors will look at whether the institution has a track record in the services to be offered and at staff capability.

Include an education plan, said Kale. The training program should educate hospital personnel, including volunteers at the front desk, about breast center services. Further, breast center staff needs continuous training in state-of-the-art technology if quality service is a priority.

During implementation, Kale advised administrators to use full-time rather than part-time staff. Employees need to be current with the operation of the Center, and full-time staff can do this better, she said. Once the program is up and running, test it. Be sure the service works and is competitive with similar programs in the area.

For more information on developing breast centers, contact Roberta Kale, R.N., Director of Womens' Health, HCA St. Mark's Hospital, 1200 East 3900 South, Salt Lake City, UT 84124. Telephone: 801-268-7210.

outcomes, prevention services, and quality of care. In the future, oncology practitioners will find themselves competing for pools of patients within managed care organizations. Managed care organizations will use physician profiling as a means of selecting oncologists. Profiles will be generated from clinical databases showing practice styles and fee structures for individual physicians. The activity of profiling will allow managed care organizations to identify and select physicians with practice styles that are compatible with the goals of the managed care organization.

Unanswered Questions

Most presenters voiced concern that reform has too many unanswered questions and too many loose ends. One such presenter was Tom Faletti, Legislative Director to Rep. Richard Durbin (D–Ill.). Faletti articulated a series of unanswered questions that are critical to the impact of reform on the country and its health care system:

- Who will control the various networks that arise within the new infrastructure?
- How will quality assurance reviews be conducted and by whom?
- Who is going to call the shots? Doctors? Insurance companies? The government? Consumers?

Harvie E. Raymond, F.L.M.I., representing the Health Insurance Association of America, Washington, D.C., addressed the question of who will cover patients participating in clinical trials. The insurance industry does not favor coverage of patients participating in clinical trials of experimental procedures and devices that are as yet "unproven", he said. Raymond also stated, however, that insurance companies should pay for procedures or technologies that are proven. Coverage should be based on outcome data, he reiterated. With chances that the federal government will not fund research much beyond its current level, the question of what happens to research under health care reform is poignant indeed.

Developing a variation on this theme, James L. Wade III, M.D., cited preliminary results of a 1993 ACCC-sponsored "Clinical Trial Denial Study." Wade is Director of Medical Oncology for the Decatur Memorial Hospital, Decatur, Ill., and Principal Investigator of the Central Illinois CCOP. He outlined the increasingly

New Technologies, New Drugs

Although blamed for increases in the cost of health care, medical technology continues to hold great promise for cancer treatments. One new technique that combines the old technology of radiation oncology with state-of-the-art, 3-dimensional software is stereotactic radiosurgery. Its applicability is mainly to the limited patient population with small single lesions in the brain. However, stereotactic radiosurgery also has some applicability to other sites such as the prostate, which may have a very small tumor mass.

"There are long-term data on small focal lesions [in the brain] that show results of this type of treatment are equivalent to fractionated standard external beam treatment," said Robert L. White, M.D., of the Washington Hospital Center in Washington, D.C., during a special symposium on new technologies during ACCC's Annual National Meeting.

After the patient has completed a CT scan, the planning team outlines the tumor contour. Powerful software enables a 3-D reconstruction in space of the tumor volume—not only of the tumor, but also of the eyes, the optic nerve, and other critical structures nearby that the treatment must avoid. The planning session allows the team to safely direct the radiation. Within 20 minutes of exposure, the tumor is destroyed.

In stereotactic radiosurgery, small focal beams rotate through various arcs, so the tumor receives less radiation over a larger area of the brain than with the gamma knife. "The bottom line is that the side effects and the cost are less than with the gamma knife," said White. Whereas the gamma knife may cost up to $2 million, the computer package planning software required in stereotactic radiosurgery runs from $250,000 to $750,000. According to White, most institutions are selecting those packages in the $250,000 to $500,000 range. "When you compare it to conventional techniques, the cost is basically no more, and obviously it's a lot more efficient."

The Promise of New Therapies

Will paclitaxel (Taxol) become the anticancer drug of the 1990s? A generally bright picture of the antimicrotubule agent was presented by Eric K. Rowinsky, MD, of the Johns Hopkins Oncology Center in Baltimore, Md. Speaking at ACCC's Annual National Meeting, Rowinsky outlined data from five single agent phase I and II trials in advanced ovarian cancer. Results showed that responses occurred in liver, abdominal, nodal, and subcutaneous sites. The total response rate (n=166) was 35%. Twenty-four percent of patients who were considered platinum-resistant (disease progression during or ≤ 6 months after platinum) responded to Taxol, whereas 40% of those relapsing at a late stage responded.

Recent investigations at both M.D. Anderson and Memorial Sloan Kettering Cancer Center have shown that Taxol has substantial activity in breast cancer. Taxol also shows promise in treating lung cancer (small and nonsmall cell), head and neck cancer, and is undergoing evaluation in a broad range of adult solid tumors. Taxol appears to be inactive against melanomas and colon, renal, prostate, and bladder cancer, said Rowinsky. The compound is marketed by Bristol-Myers Oncology Division.

"It is naive to think that Taxol as a single agent will really make an impact as initial therapy. We need to combine Taxol with other agents," said Rowinsky. Studies evaluating the efficacy of combination chemotherapy are already under way.

A new approach to therapy for non-Hodgkin's lymphoma and chronic lymphocytic leukemia is CAMPATH-1H. This promising monoclonal antibody is now in early phase II trials in the U.S. and Europe. Responses were observed in most subtypes of non-Hodgkin's lymphomas and in chronic lymphocytic leukemia in phase I trials, according to Mary A. Collier, M.S., a senior clinical research scientist with Burroughs Wellcome Company. Circulating malignant lymphoid cells were most responsive to therapy, while bulky nodal disease tended to be less responsive.

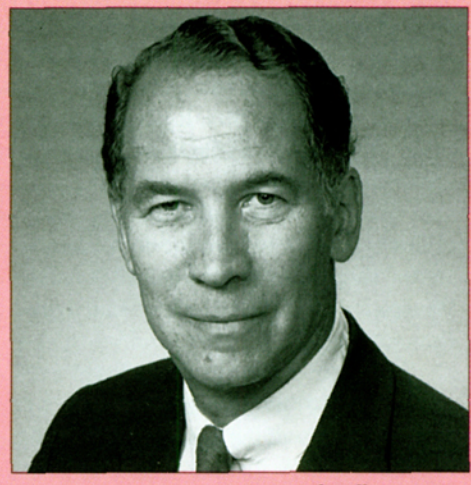
Acute toxicities included fever, hypotension, chills, nausea, and transient decreases in white blood cell counts. The incidence and severity of these reactions decreased with repeated dosing, said Collier. The three times weekly infusion schedule was believed to be the most appropriate for the phase II trials.

An Explosion of Discovery

The biologic revolution offers great potential, but we must be careful to present these advances with moderation and perspective." That was the message delivered by Samuel Hellman, M.D., who received ACCC's National Achievement Award for Outstanding Contributions to Cancer Care. He is Dean and A.N. Pritzker Professor of the Division of the Biological Sciences and the Pritzker School of Medicine and Vice President for the Medical Center, University of Chicago, Chicago, Ill.

"Among the issues most concerning us at present," said Hellman, "are the changes in health care delivery that will be needed to be responsive to changes in health care organization and financing. The government clearly has our attention. While these concerns are timely, I believe that they may divert us from a revolution going on around us. This revolution in biomedical science will have great clinical impact; however, the actual evidence of it, thus far, is quite limited."

Hellman reflected on a similar revolution that occurred at the beginning of this century: the discovery of radium by the Curies. "I believe we can profit greatly by considering how this discovery was accepted by society. It is difficult to exaggerate the profound effect of the findings



Samuel Hellman, M.D.

of a new power and the lionization of its discoverers. This great revolution, with its folk heroes, was accompanied by great expectations and, unfortunately, some subsequent disillusionment."

That revolution, according to Hellman, revealed a profound fear and antipathy to certain areas of scientific research thought to be tampering with essentials of human nature. Although scientific discovery has tremendous power to change the world, it can lead to inflated promises and overuse. "Our time," said Hellman, "with the explosion of discoveries in molecular biology, has great similarity to those early heady days of radioactivity. Today, like at the beginning of the century, new discoveries and their potential medical benefits are found on the front pages of newspapers, and companies are being founded to exploit the potential therapeutic benefits of these discoveries. This happened with radium as well. However, the enthusiasm for radium led to overpromising and overuse and then, with the appreciation of the hazards, came disillusionment. The intended beneficial medical uses of the new biology also have accompanying societal concerns.

"Considerable progress has been made in cancer care from the first wonder medicine, radium, to our current therapeutic armamentarium. Of course, there is much more to do. The biologic revolution offers great potential, but we must be careful to present these advances with moderation and perspective. We must not distort real and important gains by overpromise or by the influence of potential deleterious applications in other areas. We of this Era of the New Biology must learn from the Atomic Age if we are to gain appropriate medical uses while avoiding excessive application and inappropriate condemnation. These new discoveries have great applications, but untoward effects are also possible. We must moderate our rhetoric concerning both. These are the lessons from Madame Curie."

restrictive reimbursement policies for the expenses of patients in clinical trials over the last five months. He then cited examples of insurance policy changes in Michigan, Illinois, Washington, and Alaska, which excluded virtually all NIH treatment protocols. Because of this trend, ACCC and the Illinois Medical Oncology Society performed the "Clinical Trial Denial Study."

This study demonstrated that although the probability of participation in clinical trials is a rare event, it primarily occurs in Phase III cancer control studies. The study also showed the denial patterns of insurance carriers who refused to cover the costs of cancer patients in clinical trials. Almost 70 percent of the subjects denied coverage were participating in breast cancer research. Who will fund research and what will happen to the research agenda under reform are questions still unanswered.

Posing additional questions, Linda Green, M.D., medical oncologist with the Group Health Association of Washington, D.C., a local HMO, asked where and how decisions will be made for the oncology patient of the future. Speculating on possible futures, Green postulated that the addition of a case management specialist to the treatment team under the new reform would benefit the oncology patient. The case management specialist, possibly a nurse, could become a patient advocate, representing the patient's concerns in the complex decision-making process.

Michael A. Friedman, M.D., of the National Cancer Institute told ACCC members that reform will highlight the necessity for recognizing the concerns of all parties in the process. We need a national agenda to set priorities, he said, about what to study and in what order.

Looking to the future, presenters left ACCC members with several messages. All agreed that reform will radically change the infrastructure of the American health care system within the next three to five years. By the year 2000, the majority of people in the United States will be in managed care plans. Physicians will have adopted a more conservative practice style, one based on the use of low-cost interventions and driven by "generic" guidelines for treatment. Prevention will be a standard component of the mainstream health care system. Undoubtedly, a new power base will emerge. At present, however, we do not know who will be empowered and by whom.