



What about the Patient?

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What About the Patient?

by Albert B. Einstein, Jr., M.D.

As of July 1993, we are still awaiting the national health care reform recommendations from the Clintons. Some states—Hawaii, Washington, Minnesota, Maryland, Vermont, and my new home state of Florida—have already enacted their versions of health care reform.

These plans are already forcing health care providers to consider new relationships, sometimes breaking down age-old political barriers. Reform threatens providers' established economic and political power structures. Physicians, hospitals, and the traditional medical/insurance industry model will no longer have autonomy regarding the cost of care and technology. The traditional paradigm will no longer suffice.

Oncologists are looking at the potential advantages and disadvantages of different models, such as consolidated, multisite oncology group practices, physician-hospital organizations, or insurance-based provider networks. Hospitals are trying to attract medical staff to join hospital-based health plans, develop multihospital networks, and develop cost-efficient, ambulatory-care services. Oncology nurses are trying to define their potential new provider roles in the new health care environment. Academic institutions are struggling with the problems of how to have access to patients and economically support their missions of teaching and research in a highly cost-competitive market place. Who might be the most appropriate gatekeepers for the patients with cancer, the primary care physician or the medical oncologist, also needs to be considered. Everyone is jockeying

for whichever position best serves his or her self-interest.

What about the patient with cancer? Who is looking after his or her welfare when it comes to the availability of and access to quality cancer diagnostic, therapeutic, and support services and clinical research trials?

Those patients without any health care insurance will clearly benefit if universal insurance is mandated. That is good and appropriate. The potential of a uniform national benefits package also has merit. As we have seen over the past several years, the variability in current benefit policies, even among the Medicare carriers, is enormous. We have all heard of the tragedy of workers moving from one corporate office to another in a different state and finding that their ongoing chemotherapy is suddenly denied by the same carrier.

And, without a doubt, the end of pre-existing conditions and the introduction of community ratings will be a real service to cancer patients and their families.

However, those who now have cancer or who will have cancer in the future will not benefit if they do not have access to quality cancer care resources: the cancer care providers of their choice; the full array of cancer diagnostic, therapeutic, and support services provided by multidisciplinary cancer programs; and clinical research trials, which provide access to the newest treatments available when standard treatment is inadequate or has failed.

The government, both federal and state, is primarily concerned with reducing the cost of care for economic and political reasons. Businesses are focused on the bottom line. Given the increasing number and percentage of elderly in the U.S. population, there is no question that the costs of all health care

are going to increase and the number and percentage of individuals in the work force available to support the costs are going to diminish. This same problem has crippled several European countries for some time, so the need to address it over the next three decades has true merit.

Yet, the purchasers of health care may jeopardize the patient's quality of care and outcomes with their overriding concern about cost. Many in government and business remain poorly informed about the issues of cancer care. As we know better than most, cancer programs require a complex, interrelated team of individuals to manage this complex set of diseases with all of their medical, personal, financial and social implications. The potential real losers might be our patients.

The mission of the Association of Community Cancer Centers (ACCC) is to continue to "promote quality, comprehensive multidisciplinary care for patients with cancer." The cancer programs that our membership has worked so hard to create over the past twenty years are taking on new shapes as health care reform evolves. However, each of us in our own way and the ACCC as an organization must work in concert to ensure that our patients continue to have access to quality cancer care that maximizes their outcome and their quality of life. We must work together to inform government and business about patient care issues. The patient's benefit should not be lost as we consider the pressing economic, political, and social issues.

ACCC will continue to represent the patient's welfare as well as the issues of its various professional constituencies. But make no mistake, we will need your help! ❏