



Cancer Program Development in the 1990s: Survival in a Managed Care Environment

Thomas Vandergrift & Lloyd K. Everson

To cite this article: Thomas Vandergrift & Lloyd K. Everson (1993) Cancer Program Development in the 1990s: Survival in a Managed Care Environment, *Oncology Issues*, 8:4, 14-16, DOI: [10.1080/10463356.1993.11904436](https://doi.org/10.1080/10463356.1993.11904436)

To link to this article: <https://doi.org/10.1080/10463356.1993.11904436>



Published online: 18 Oct 2017.



Submit your article to this journal [↗](#)



Article views: 1



View related articles [↗](#)

Cancer Program Development in the 1990s: Survival in a Managed Care Environment

by Thomas Vandergrift and Lloyd K. Everson, M.D.

The delivery of health care in general, and cancer care specifically, is in transition in the United States. Scientifically, our understanding of disease continues to evolve from an anatomic to a genetic basis. Clinically, our approach to disease continues to evolve from an inpatient and treatment focused strategy to an outpatient and prevention focused approach to health care. From a payor perspective, reimbursement continues to evolve from a seller and fee-for-service basis to a buyer and capitated basis. This rapidly evolving environment has far-reaching implications for cancer program development.

CONFLICTING TRENDS

There are at least two major, potentially conflicting trends underlying the current momentum towards a buyer-dominated payor system. Both have direct impact on cancer care delivery.

Integration of care and the primary care focus. Urged on by health care reform capitation strategies, hospital

systems and physicians are exploring approaches to vertically integrate and consolidate their services by forming multispecialty and specialty groups. An important emerging strategy for many hospital and physician systems is to focus on primary-care-based **integrated health care delivery systems** as the preferred approach to health care delivery. The goal underlying this primary care strategy is to control more effectively and decrease costs by gatekeepers.

Increasing cancer incidence and costs of cancer care. The costs of cancer care continue to rise. This growth in costs is fueled by the development of 1) new technologies, especially in the arena of biotechnology and genetic engineering and 2) the aging of the U.S. population. If current trends continue, cancer is projected to consume 20 percent of all health care dollars by the end of the decade. Indeed, the American Hospital Association estimates that cancer services will comprise the major product line for all hospitals by the year 2000. With these trends, the costs of cancer care are projected to increase.

Can these apparently conflicting trends be reconciled? The answer must be "yes," if we are to continue the delivery of integrated, comprehensive, and multidisciplinary focused cancer care for our patients and their families. How these trends are reconciled and reflected in our institutional and physician strategies

of the future is the responsibility of cancer program leadership today. The clinical and business decisions that arise from these strategies will have a dramatic impact on the future development and structure of community and university-based cancer programs.

INTEGRATED SYSTEMS

Although Congress has yet to pass a final health care reform package, good bets are that reduced health benefits, increased co-payments, increased taxes, reduced provider payments, increased utilization review activities, and incentives to channel patients into contracted care can be expected.

As capitated contracts overtake fee-for-service and discounted fee-for-service arrangements, vertically integrated health care delivery systems are capturing the attention of physicians, hospitals, and insurers. These integrated health care delivery systems offer the potential for delivery of a full continuum of care. They define a geographic region and service continuum that can accept and manage the financial risk for these populations.

Hospitals are redefining their vision of health delivery systems and are rethinking their role within those systems. Many hospitals are moving toward integrated network models in order to achieve the level of physician/hospital collaboration that will allow hospitals and physicians to be successful in this new era. Part of this environment is char-

Thomas Vandergrift is Team Leader of Physician Network Development at Indianapolis Regional Cancer Center in Indianapolis, Ind. Lloyd K. Everson, M.D., is Medical Director at the same institution and President of LKE Consulting Service.

acterized by a shift in focus from disease treatment to disease prevention, intense price competition, and demand for documented value and quality outcomes.

Physicians are more willing to practice in groups. Some forces behind this changing perspective are income protection, diversification of practice revenue sources, minimization of financial risk, reduction in administrative overhead, and maintenance of quality care for patients. Group membership implies, if not requires, using standards of care and performance profiling to remain competitive in the marketplace.

Integrated models and physician group consolidation are increasingly being seen as supportive in developing the clinical and administrative leadership essential for responding to the health needs of local communities. Many hospitals, desiring to solidify their roles in the networks of the future, are prepared to accept diminished control of the network. These hospitals, however, still wish to take an active role as network integrators, and are willing to provide the capital, management expertise, and systems needed to implement and support these networks.

The incentives required to deliver the highest quality of care in a cost-effective manner for hospitals and physicians are becoming increasingly aligned in the support of integrated health care delivery systems. This vertical integration of inpatient and outpatient services envisions the close planning and cooperation of a hospital and physicians or physician groups. The financial incentives are aligned such that all participants have the incentive to ensure care is rendered in the most cost-effective setting. Or, from a different perspective, resources are optimized to preserve or enlarge market share, decrease overhead expenditures, maintain and increase quality, and minimize the discounting exposure in service delivery.

Typically, an integrated health care delivery system focuses on primary care physicians as the control point for service utilization and cost management. The continuing shift from inpatient utilization makes hospitals and specialists increasingly and heavily dependent on primary care physicians. The movement away from inpatient care (i.e., treatment and specialty care focused) to outpatient care (i.e., prevention and

primary care focused) continues to evolve at a rapid rate. This phenomenon, coupled with the shift in performance measures under a capitated payor environment, is expected to transfer the traditional power base from the hospitals and specialists to the primary care physicians and an outpatient focused delivery system.

Does the definition of primary care include any of the specialties involved in cancer care delivery, that is: surgery, radiation oncology, or medical oncology? A good case can be made that medical oncologists are indeed in the primary care delivery field. That premise, however, is more difficult to support for the specialties of surgery and radiation oncology.

As with family practitioners, medical oncologists typically care for patients over a prolonged period (from adjuvant therapy to metastatic disease to terminal care). It is not unusual in this chronic course of care for a medical oncologist also to take on the role of the primary care physician in the other (i.e., cardiovascular, gynecologic, infectious disease, and psychosocial) support and service models. This approach, coupled with the fact that chemotherapy delivery and monitoring is a highly technical and complex area of medicine, should continue to position the medical oncologist as a key member in the cancer care delivery team.

The complexities of leading the construction or expansion of an oncology program in an environment that is focusing more attention and resources on the primary care area are apparent. However, the medical oncologist should be a key gatekeeper for cancer care delivery in this type of emerging managed care environment.

RISING CANCER INCIDENCE AND COSTS

Simultaneous with the movement toward primary care based planning and integrated networks is the reality that cancer is consuming an increasingly large piece of the health care pie. According to the National Cancer Institute (*Cancer Facts & Figures 1993*), overall costs for cancer in 1990 were \$104 billion: \$35 billion for direct medical costs, \$12 billion for morbidity costs, and \$57 billion for mortality costs. If current trends continue, cancer services will consume 29 percent of all health care costs by the end of the decade,

cancer will be the leading cause of death, and medical oncology will overtake cardiology as the dominate medical specialty in this country.

In capitated environments, because of the rising incidence and the cost of the disease, it is essential that the oncology delivery system be efficiently integrated into the system's cost containment and quality assurance programs. If not, the financial integrity of the hospitals and physicians will be jeopardized. Consequently, the ultimate delivery and comprehensive multidisciplinary quality care for the patient will also be jeopardized.

THE CHALLENGE AHEAD

The movement toward primary-care-based, cost-control delivery systems and the increasing costs of cancer are directly competing with each other in cancer programs for scarce organizational attention, priority, and resources. Since most cancer programs, both university- and community-based, have been built in close relationship to hospitals, this move presents critically important challenges to hospital and physician leadership.

There are obviously both risks and opportunities for the integrated systems. Where hospital systems focus on primary care practice and acquisition and integration strategies with such intensity that cancer program investment and focus are diminished, the danger and risk are that already established quality multidisciplinary cancer programs will stagnate and deteriorate. These programs will find it increasingly difficult to recruit and retain top quality oncologists and the myriad of other highly trained and motivated personnel that generally comprise a well-developed cancer program staff today. Without these highly trained personnel, it is unlikely that continued program and new technology growth will be fostered.

Conversely, those systems that capitalize on their competitor's "tilt" to primary care and, instead, continue and even increase support for growth and development of the cancer center or program will be in a position to dominate cancer care in their region. Those hospitals and physicians that have supported cancer program development in the past and that have well-developed cancer programs will be the ones that can most easily position them-

selves in this changing market.

The implications for cancer program planning are varied, depending on the local environment. However, at minimum cancer program leadership must work with both hospitals and oncologists to competitively position the oncology services within the system and within the payor community.

THE NETWORK AND ONCOLOGY SERVICES

The cancer program and its oncologists must be carefully positioned within the integrated health care delivery system. Doing so will require sensitivity to the dynamics between primary care physicians and specialists, especially as they relate to the balance of political power and control within the system. Critical for success are: 1) education and open dialogue with the network developers about the impact of cancer care on the financial performance of the network and 2) the development of a common vision of how oncology services can best be positioned within the network.

Fundamental questions to be answered when positioning the cancer program are: 1) whether the role of medical oncologists as the cancer patient's primary care physician can be formalized within the integrated health care delivery system or 2) whether the medical oncologist will remain the undesignated but de-facto primary care physician for the cancer patient.

Given the complexity of cancer, the chronicity of the disease, and the complexity of the delivery system for oncology service within the integrated health care delivery system, it can be argued reasonably that the medical oncologist is the best positioned physician to ensure appropriate service utilization and to manage the costs of the cancer patient.

Within the structure of an integrated health care delivery system, the medical oncologist will no longer be a specialist, but will be considered a primary care physician. Some key issues that must be addressed in this model include: 1) case management and quality assurance processes, 2) financial incentives and compensation policies, and 3) relationships between medical oncologists, other oncologists, and primary care physicians.

The alternative, of a nonmedical oncologist assuming clinical man-

agement responsibility for cancer patients has potentially profound implications. Oncologic clinical expertise is essential to cost-efficient quality management in the cancer patient population. Additionally, medical oncologists' support of the network may not materialize if they, as the cancer primary care providers, are not included. The exclusion will result in a less integrated, less efficient continuum of service for the cancer patient. Consequently, in the longer term the network's ability to participate in oncology clinical trials, medical and public education, screening, and early detection regardless of cost of efficient care will be jeopardized.

As physician specialty groups become more pervasive, oncology groups will grow and consolidate their positions in their local communities. It is highly likely that oncology groups within the system framework will form a major force for cancer services quality and cost control.

THE PAYOR ENVIRONMENT

In the evolving payor environment, insurers may very well differentiate oncology services from other health services. Direct contracting may occur with cancer programs and cancer groups, thus bypassing the traditional and the evolving delivery structures of integrated health care systems. To be competitive in this contracting process, cancer care providers, groups, and programs must be able to provide objective, quantifiable measures of quality, cost, and outcome.

To do so will require a clinical and administrative management focus on integrating, streamlining, and standardizing the delivery of cancer services. This is true whether the oncologists are in a specialty group, related to an integrated health care delivery system, or part of a system. From a physician's standpoint, this means the development of, and adherence to, disease-specific, practice guidelines. These guidelines should specify the treatment, prevention, and early detection protocol across different outpatient and inpatient delivery environments.

The incentives within the integrated health care delivery system model should allow patients to be cared for and treated in the most cost-effective and highest quality

setting without fear of adverse financial repercussions to the providers. From another perspective, if the paradigm of the best quality of cancer care is that of a multidisciplinary comprehensive integrated team approach, then it follows that the integrated systems must foster that model's growth to then allow for the best position in competition for the managed care contract.

However, surgeons, medical oncologists, and radiation oncologists are required to deliver the cancer care. Without them, there is no cancer care. In our rapidly changing health care environment, oncologists are grouping together at an unprecedented rate. As this phenomenon continues to grow and pervade the managed cancer care scene, integrated health care delivery systems will find it necessary to join or at least negotiate with these large and dominant groups of oncologists.

Payors will continue to look for the highest comprehensive quality of cancer services at the best price. Whether that cancer care is bought from an integrated health care delivery system, a consolidated oncology group, or an oncology specialty group is probably immaterial to the payor's decision-making process.

A key challenge for leadership in hospital-based cancer program planning is that while the cancer services must be an integrated component of the health care delivery system, the wholeness or cancer product identification of the cancer program must be maintained if it is to compete successfully with added value as a cancer program in a managed care environment. Obviously, how the oncologists relate to this integration is of critical importance. The cancer program will also require a maintenance of a specific identity if clinical trials, medical education, and public service are to remain an integral part of the comprehensive cancer program.

The changing health care environment presents many challenges and new opportunities to creative cancer program development and management. Experienced cancer program leadership is essential now more than ever to enable and guide the cancer program. New and creative strategies will be required of hospitals and oncologists to position oncology services within the new, evolving managed care and capitated payor delivery systems. ■