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Cancer Care Benefits

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

Health care reform continues its ponderous evolution at the national, state, and local levels. What is remarkable is the amount of change that is occurring in anticipation of future reforms. The threat of reform has created an avalanche of insurance company, hospital, and physician acquisitions, mergers, and alliances. Columbia Health Care, for example, is purchasing hospitals left and right. Former competitors such as Virginia Mason, the group practice tertiary–care center, in Seattle and the staff model HMO Group Health of Puget Sound have agreed to begin working together to share technology and to create an institute to study health care quality. Consolidation is occurring everywhere.

President Clinton only recently delivered his bill to Congress. The bill allows for payment for routine care during investigational treatment. The comprehensive benefits package appears to be quite inclusive with seemingly appropriate broad allowance for cancer screening, diagnosis, and treatment. However, Congress will obviously make significant changes.

Meanwhile in my state of Florida, the Agency for Health Care Administration (AHCA) through a variety of panels has been busy defining the details of health care reform mandated last April by the legislature. The recommendations for the basic benefits package were released recently after a series of public hearings. Unfortunately, this first version was more cost driven, less comprehensive, and significantly more insurance company-influenced than the Clinton comprehensive package. The proposal does not even provide coverage for patient care costs associated with investigational treatments or reimbursement for off-label use of chemotherapy agents as the federal legislation proposes. The approved indications for bone marrow or stem cell transplants are very narrow and do not include aplastic anemia and chronic myelogenous leukemia, much less the other indications recommended recently by a state-appointed panel. Additional efforts must be made to broaden the coverage for the benefit of our cancer patients.

The Florida legislature also required the AHCA to have fifty clinical guidelines in place by December 31, 1993. The Agency elected to work with the Florida Medical Association and the various specialty societies to identify, review, and approve selected existing national guidelines. In the field of cancer care, two guidelines, one concerning screening mammography and the other concerning treatment of early breast cancer, are being reviewed by the state chapter of the American College of Surgeons and the Florida Society of Clinical Oncology, among others.

While these two guidelines are relatively noncontroversial, the future development and utilization of clinical guidelines remain an enormous problematic and resource–intensive task. Although guidelines offer obvious potential benefits (including standardization of care, reduction of inappropriate physician variability, and reduction of cost), fears continue to surround guidelines. These fears include the potential loss of physician judgment and autonomy in patient management, medical liability if the guidelines are not followed, and too much emphasis on cost at the exclusion of quality. Unfortunately, research regarding guideline development and implementation lags far behind the impetus to create guidelines.

Regardless of these inherent problems, the momentum created by governmental agencies and health care payors to develop and use guidelines is significant. Therefore, the burden on providers of quality cancer care is to get involved in the process. At the H. Lee Moffitt Cancer Center, an institutional objective for the coming year will be for each of our fifteen multidisciplinary, disease–oriented clinical programs to initiate the process of reviewing, developing, and adopting institutional clinical guidelines. Provider involvement in this process is essential if we are to maintain quality cancer care in the face of dramatic change. No matter how much guideline development occurs at the state or national level, each institution or group of health care providers will need to have at the minimum a process of reviewing and adopting or amending guidelines for local use. Institutions must also establish programs to facilitate education of providers, implementation of the guidelines, and measurements of compliance and outcomes. No one can afford to remain insular. ■