Introduction

Escalating costs in health care are leading to a revolution in health care delivery. The impact of increasing use of health care resources has led to market-based reforms that will change not only the cost of care, but also the model under which that care will be delivered. Since the advent of Medicare, health care has been provided for the most part on a fee-for-service basis, which has led to not only significant increases in technological quality, but also unbridled increases in cost. Because the hospitals and the physicians who prescribed the care directly benefited from its increase in volume, an incentive to decrease the use of health care services did not exist.

In order to remain competitive, American business is now demanding that increases in the cost of insurance premiums no longer exceed the inflation rate. The insurance companies that serve as intermediaries between health care purchasers and providers have developed a process to streamline delivery so that the cost of care will be predictable on a year-to-year basis. The current demand for decreasing premiums comes at a time when there is an oversupply of American specialty physicians. Consequently, insurance companies are beginning to offer contracts for serving patient populations to those providers who bid on the basis of cost as well as quality. Initially, these contracts were determined on a discounted fee-for-service basis. However, such arrangements continue to expose insurance companies to significant future risk. A more recent trend offers contracts on a capitation basis where the risk of increased cost from large numbers of chronically ill patients will be transferred directly to the providers. Under such a capitation system, primary care physicians will serve as gatekeepers to prevent overuse of specialty services. Theoretically, an efficient primary care delivery system will prevent overuse of health care resources and will allow maximal conservation of capitation dollars. It is in such a fully integrated and capitated system that oncologists may have to practice by the year 2000. Since oncologic medicine consumes a large proportion of available medical resources and is inexorably linked with high technology, cost of care may be further escalated. Threatened with the tug of war between a decrease in the use and the impact of technological advances, will oncology care be delivered with the same quality we provide today? Will oncologists be able to control their own practices and experience job satisfaction in the new environment?

The Arbitrariness of Cancer Care

Although clinical research often is mentioned as the centerpiece of the oncology discipline, most cancer care is practiced empirically. Although the majority of our oncologic literature relates to therapeutic intervention, national and local therapeutic practice patterns vary widely. The use of antibiotics, antiemetics, blood products, and cytokines to supplement actual cancer therapy is subject to tremendous variation. Additionally, determining the appropriate number of diagnostic tests, as well as their frequency of use, is controversial and subject to individual clinical judgment.

Determining the circumstances under which expensive treatments, if any, should be offered has become increasingly fraught with controversy. Sophisticated treatments such as high-dose chemotherapy with bone marrow rescue, stereotactic and three-dimensional radiotherapy, and isolated limb perfusion chemotherapy all contribute to the national health care bill without clear evidence of long-term benefit. However, an increasingly educated public demands these types of interventions. Refusal of treatment can lead to loss of referrals and even malpractice liability. The seemingly arbitrary way in which oncologists practice has led to observations by insurance companies that much of what we do has less to do with patient benefit than with patient demand. Consequently, the first round of cost-cutting measures pits oncologists against each other on a cost basis with little emphasis on quality. The purchasers of health care do not see us as differentiated specialists but as consumers of available resources.

Message From the Market

American employers have taken major steps to decrease the cost of premiums. The emergence of mammoth purchasing entities such as the Bay Area Alliance in northern California and the New England Purchasing Coop have led to fierce price competition for their covered lives. For example, the California State Retirement System (CALPERS) has achieved a 2% cost reduction in premiums for the fiscal 1999-2000 year. Managed care providers such as HMOs are seeing their profit margins beginning to erode and therefore would like to decrease the cost of managing care, especially in chronic diseases. Additionally, they want to transfer the financial risk of such care to the provider.

The model for achieving these goals is a fully integrated health care delivery system involving all providers. The system is paid to care for a population of patients on a capitation basis, thereby assuming much of the financial risk for care of complex diseases. Although once perceived as unlikely to occur in American medicine, fully integrated systems now account for much of the clinical care given in San Diego, Sacramento, and Phoenix. The model is rapidly spreading to other parts of the country.

Except for those oncologists who belong to integrated systems such as Kaiser Permanente Medical Care Program or Scott and White Clinic, most have dealt with change only on a discounted fee-for-service basis. Trial capitation systems for medical oncology or radiation oncology have developed in the West and Northeast with varying degrees of patient satisfaction and cost containment. Most health policy analysts feel that discounted fee-for-service contracts or specialty capitation contracts are shortterm solutions that do not address the problem of fully integrating care.

The Cancer "CarveOut"

A recent development in cancer is the emergence of fully capitated specialty contracts. Salick Health Care, Inc. recently contracted to provide complete cancer care on a capitation basis for 100,000 enrollees in Physicians Corporation of America (PCA), an HMO in southern Florida. Based on expected rates of cancer occurrence and the historical cost per patient of delivering care, the Salick network will assume the financial risk for this patient population. This contract was greeted with great interest by both the health care and clinical communities because it represents the first time that a private sector health care company has agreed to provide cancer care for the full range of inpatient, outpatient, and home services.

A key feature of the contract is the implementation of clinical practice guidelines. Over the past two years, Salick Health Care, Inc. and a panel of experts developed a series of guidelines for its practicing physicians including indications for high-dose chemotherapy with autologous bone marrow rescue, the use of antiemetics, chemotherapy, and growth factors, and indications for treatment of metastatic disease. The guidelines, which were developed by incorporating both a clinical data base and an opinion-ranking methodology, are designed to guard against both overuse and underuse of resources by practicing oncologists. Although the Salick Health Care network has long been established as an oncology provider, it has not been tested as an entity with either consistent practice patterns or the ability to deal with the demands for services by an educated, Florida-based patient population. The management of stresses between decreased use and maintenance of patient satisfaction will be challenging to all oncologists.

The Cost of Case Management

The cost of care for the patient with cancer is based on multiple factors, including diagnostic testing, consultation to determine the appropriateness of treatment, therapeutic intervention, and continuing followup. Surprisingly, a tally of expenses reveals that therapeutic intervention actually constitutes a small proportion of the overall cost of care. For example, the frequency and use of diagnostic testing in early breast cancer are largely unstandardized and subject to wide variation. The tests listed below are routinely obtained at some point in the workup of most patients. However, the determination of which tests are necessary for followup and how often they should be administered is subject to personal judgment. At our institution, the frequency of followup laboratory testing ranges from a yearly mammogram to measurements of tumor markers CA 153 and CEA plus other blood tests every three months and a mammogram every six months.

Variability of practice also affects the indications, frequency, cost of treatment, and the continuing ancillary services necessary to support the patient. Insurance carriers note this variability and its effect on year-to-year expense planning.
Development of a Group Practice

Oncology group practice in the past has often consisted of medical, radiation, and surgical oncologists who practice in the same cancer center and participate in standard clinical research programs. Group practice under a capitation contract requires that specialists evaluate goals for the patient at the time of diagnosis and then attempt to achieve those goals in a way that guarantees quality and minimizes cost. Under a capitation contract, profits generated through efficient use of resources would directly affect physician reimbursement, clinical research funds, and the purchase of new technology. The oncology provider group can demonstrate value to a health care purchaser by reducing cost, increasing quality, demonstrating improved outcomes, and providing new services not previously available (e.g., clinical research, psychological counseling, and rehabilitative services). Oncology group practice is even more complex in the academic institution setting where “superspecialists” will have to merge their interests for the cost efficiency benefit of the patient. This philosophy must be implemented at all levels in the health care system, including house staff.

One of the first steps in group practice development is the establishment of uniform practice patterns. The process of developing practice guidelines is resource and labor intensive and involves extensive literature review in which data are clear regarding the value of a treatment or service. When data are inconclusive, a method of standardizing physician opinion needs to be established. The use of guidelines, which offer the greatest opportunity to track objective outcomes, demands adequate datakeeping resources. Finally, the physicians must be comfortable with the guidelines so that they will actually be used in daily practice.

A major obstacle in the effective functioning of an oncology group practice is the difficulty in evaluating the value of each of the oncology specialties within a capitation system. Oncology specialists traditionally have been well reimbursed for treatment of the individual patient on a fee-for-service basis. Under a capitation system, although the group as a whole will benefit from efficient and economical delivery of services, reimbursement to individual members of the group will need to be realigned to reflect the new delivery paradigm.

Conclusions

To prosper under capitation, oncologists will have to recognize and adapt to the economic realities on the medical horizon. The oncologists who will be able to retain control of their practices in the managed care arena are those who can form a functional specialty group practice that streamlines and consolidates their services. They will develop realistic and practical guidelines to provide and evaluate quality oncologic care without unnecessary expenditures and will organize the appropriate use of expensive technology.

We are being challenged to change our previously accepted practice patterns for the sake of treatment quality and efficiency. Rising to this challenge will not be easy and will require a strong commitment from all of us.

References

2. Integrated health care delivery systems. Oncol Iss. 1994;45.