Assuring Access to Academic Cancer Centers

In August, I gave an educational lecture at a large oncology meeting in Los Angeles. The conference was well organized and well orchestrated, and it drew a large and appreciative crowd of several hundred oncologists and oncology nurses. Not surprisingly, the speakers were mostly from NCCN-affiliated organizations. These individuals are acknowledged experts in their fields. They are division chiefs at major cancer centers, recognized investigators who have participated in important clinical trials, and highly regarded commentators who write extensively about the diseases they know well. Most also continue to be busy clinicians, plying their trade with experience and wisdom. Some participate in laboratory research. Most are involved with training oncology fellows and junior faculty. Many serve or have served on expert panels that draft guidelines, review grants, and function as advisory boards. They attend numerous meetings around the world—probably too many—and through those international contacts, keep abreast of important scholarly and personnel developments at leading cancer hospitals.

In sum, the presenters were a familiar collection of those we consider paradigmatic academic oncologists—folks who know a lot about cancer, who know what the important questions are, and who help share those insights with patients, colleagues, and the broader community of people interested in cancer care.

That same weekend, in a front page story, the Los Angeles Times reported that doctors at 2 well-respected Los Angeles area hospitals—UCLA and Cedars-Sinai—would be excluded from all insurance contracts for Los Angeles city employees covered by Blue Cross/Blue Shield. The care at such clinics was deemed, simply, too expensive.

These experiences highlight the dilemma of academic cancer centers. On the one hand, they have been a jewel in the crown of American oncology and serve as a driving force for innovation and care in cancer medicine. The expertise found in these centers is in high demand by both clinicians and patients. On the other hand, they are widely perceived as being costly, perhaps too costly. Limiting access to such centers of expertise is becoming a common strategy for controlling health care spending.

The Affordable Care Act (ACA) provides many important assurances to cancer patients—no coverage denial for preexisting conditions, no doughnut holes for cost, no lifetime dollar limits—and it rewards initiatives in cancer prevention. But it does not guarantee patients will have access to our nation’s leading cancer centers. The ACA does not address the growing fear that patients with cancer will be priced out of access to the comprehensive cancer centers. As insurance programs create tiers of care and coverage, comprehensive cancer centers often find themselves in the most expensive categories. As a result, access to such facilities may become prohibitively expensive for ordinary patients or may simply be denied altogether as long as care is available elsewhere.

Lack of access is problematic for several reasons, and it is critical that Americans with cancer continue to have access to America’s most comprehensive and advanced cancer programs. The success of comprehensive cancer centers reflects taxpayer investment in resources delivered through the NIH; to deny patients coverage for care at such facilities is to keep them away from programs that they built through financial support. It is also to deprive them of access to the emerging technologies and therapeutics that are reshaping cancer care in real time. Finally, making access to academic cancer centers prohibitively expensive is to deny access to many of the most-seasoned clinical experts.

If academic centers wish to retain access to all patients, they must be able to prove their value. These value propositions are not easy to establish, but they surely...
are supportable. The argument begins by rebutting the assumption that academic care is necessarily more expensive.

Second, value propositions rest on the demonstrable quality of care, which may sometimes mean less-intensive care, available at academic centers. Surveys from NCCN Member Institutions reveal tremendously high rates of concordance with guideline-based care, which would be the foundations for high-quality care, much of which may be less resource-intensive.

The third value lies in the unmeasurable domain of hope. Academic cancer programs have been the wellspring of understanding, progress, and innovation in cancer care. Not every new discovery pans out, and not every successful innovation comes from an academic hospital. But the historic record is clear: specialized care in academic centers is the major engine for innovation and improvement in disease treatment.

To deny patients access to such specialists is to steal from them the profound aspiration of hope for progress that can be realized in their own care. That would be a terrible legacy for health care reform and creates a compelling rationale for ensuring that patients can continue to be seen by—and have their treatment guided by—the world’s leading oncologists.