

Cancer Care in the 00s: “Era of Accountability”

The entry of the United States health care system into the “era of accountability” was heralded by Arnold Relman, MD, then editor of *The New England Journal of Medicine*, in 1987. This new era of medicine was envisioned to involve a greater emphasis and reliance on evidence in setting policies and, most especially, a system whereby provider groups or even individual providers could be evaluated on the quality, effectiveness, and efficiency of the care that they delivered. Since that widely acclaimed heralding, health care constituencies have entered this “house of accountability,” but they have not made it much past the front foyer.

Clearly, considerable resources and efforts have been invested in making decision-making in health care based more on evidence. Although all clinical researchers have long lived by the “evidence-based decision-making” credo, one of the two major accomplishments of managed care in the 1990s was enhanced integration of this basis for decision-making into processes for establishing clinical policies, health policies, and coverage policies.

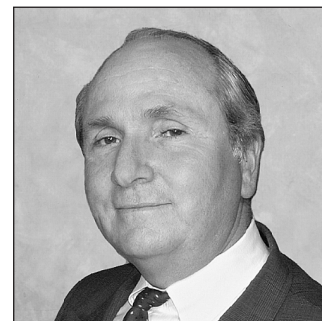
However, the brief era of managed care in the United States did not establish substantial capabilities to evaluate the quality or value of care delivered. Rather, the focus of the managed care environment in the 1990s was on micromanagement rather than on more global analyses and interventions. Managed care companies attempted to improve the value of the care that they managed for patients and employers, as purchasers, through focus on and scrutiny of individual care decisions, often at the point of delivery. Although such attempts at point-of-care management might seem daunting, the strategy actually was less overwhelming than identifying quality measures and setting up a data collection system that would indeed allow evaluation of the quality of care on a national basis. As this commentary shows, the micromanagement route was not a fruitful path.

The rate of rise of health expenditures is again accelerating. The premiums charged for health insurance are increasing as they ride in the wake of health care dollar expenditures. Employers are pressuring health insurance companies, as the vendors of health care benefits, to do something. The provider side, a source of cost-savings in the 1990s, will give back no more, and providers have more clout in the 00s than they did in the 90s (except in the face of legislated federal mandates). The imperative of technologic advancement is strengthening. The population is aging.

So here we are again, needing to do something before total health care expenditures account for 10%, 12%, or even 14% of the gross domestic product. Oh, sorry, we already blew through *those* eras while were talking and writing.

Evaluating the Quality and Value of Cancer Care

Historically, attempts to formally manage and evaluate areas of medical care have focused on the so-called “low-hanging fruit” specialists in the management of asthma, diabetes, and congestive heart failure, among others. Some attempts to manage and “enhance the value proposition” of the clinical interventions for these patient populations have been successful, but in general these successful programs can best be described as large pilot projects. These programs are important, however, because they do show that, with changes in physician



William T. McGivney, PhD

William T. McGivney, PhD, is the Chief Executive Officer of the National Comprehensive Cancer Network and a recognized expert in coverage policy and drug and device regulatory policy. Before joining the NCCN in 1997, Dr. McGivney directed the Division of Health Care Technology at the American Medical Association and worked for Aetna Health Plans as Vice President for Clinical and Coverage Policy. Awarded the FDA Commissioner’s Medal of Appreciation in 1989, Dr. McGivney has served on numerous national boards and committees. He earned his PhD at the University of North Carolina at Chapel Hill and completed a postdoctoral fellowship in the Department of Psychiatry at the Harvard Medical School.

The ideas and viewpoints expressed in this commentary are those of the author and do not necessarily represent any policy, position, or program of the NCCN.

September 2004

decision-making and with enhanced patient communication, collaboration, and participation, patients can have better outcomes and our dollars can be spent more wisely.

Why has cancer care not been an early focus of such industry-driven efforts? The reasons are multiple, and any one reason could be persuasive for any health plan or employer at any one time. Reason number 1 is that cancers are serious and life-threatening illnesses. Also, a number of the historically accepted “standard” interventions are not substantiated by high-level evidence from randomized controlled clinical trials. The management of the disease is often driven by very strong pressures from patients and from physicians to treat aggressively. In the not too distant past, attempts to evaluate and to interpose third-party influence in the selection of clinical interventions were not received well by patients, by physicians, by the public, by the media, or by the courts.

More importantly, the management of a cancer tends to be a more complex endeavor than management of most other diseases, even early stage disease. Multiple subspecialties are involved. Treatment decisions are made collaboratively and, thus, the ability to identify one individual or even group responsible for a treatment may not be possible. Going one step further, in the community, the physical loci of diagnosis and treatment may be significant distances apart, diminishing the likelihood of consistent data collection and reporting. Finally, available treatment options are diverse, complex, and sometimes interdependent.

Notwithstanding those facts, cancer care is now becoming a major focal point for payors and for employers. This attention has been attracted by increasing awareness of the National Cancer Policy Board’s 1999 report identifying deficiencies both in the quality of care delivered and in the cancer community’s ability to identify, measure, and correct those deficiencies. At NCCN Cancer Policy Summits, we have seen a consistent clarion call for nationally recognized groups in cancer care to:

1. Establish and perform a scientific, systematic process for identifying indicators of the quality of cancer care; and
2. Work to establish a mechanism to accomplish user-friendly public reporting of performance data to facilitate selecting the best performing providers of care.

What Employers and Payors Are Looking for

The NCCN initiated a formal process to directly address the call for progress in advancing the state-of-the-art in continuous quality improvement in cancer care with a transparent process and results for the many end-users in the system. This initiative proceeds from the clear acceptance and widespread recognition and application of the NCCN Clinical Practice Guidelines in Oncology as the standard for clinical policy in oncology.

NCCN recently convened a meeting of leaders from the major employer world and from the payor (public and private) community to elicit concepts and requests for a system useful to them and to their employees and beneficiaries. The following 10 points serve as a summary of the general view of what needs to be done:

1. First and foremost, any quality evaluation and reporting process must be a bottom-up analysis. It must be simple, direct, and understandable for employers, payors, and especially for patients.

September 2004

2. The process must encompass performance data on all major provider groups, academic and community.
3. “Process” measures are useful to start, but any system should move to some outcome measures eventually.
4. The use of recommendations from the NCCN Clinical Practice Guidelines as quality indicators would be appropriate, because they have been validated by the process and the experts developing the NCCN Guidelines.
5. We must also to have quality indicators that will serve to decrease inappropriate care and to identify interventions that should not occur.
6. A national benchmark is necessary for high-quality care, and the NCCN could serve that purpose.
7. Small steady steps are needed, but the overall goal is clearly “accountability through transparency.”
8. Strong support for such efforts would be forthcoming from the employer and payor groups with change in benefit design as one contribution they would make.
9. A number of groups are working in this area, and collaboration and cooperation is necessary to avoid a cacophony of quality indicators and processes.
10. The end-product must understandable to and useful and real for patients; educational interventions and tools must be available to patients.

This meeting was the first in a series of meetings with end-users. Multiple meetings with patients are planned to fully understand their needs and concerns. The NCCN is headed down this path based on the success of the NCCN Clinical Practice Guidelines and the proof-of-concept of the NCCN Oncology Outcomes Database. NCCN is open to collaboration with other groups with a shared sense of urgency in developing a comprehensive, useful program in a timely fashion. In the end, our ultimate and most important collaborators will be the patients we serve.