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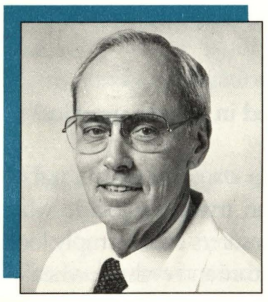
Universal access to health care requires insurance reform, says AMA's Painter

Interview



Joseph T. Painter is vice president for health policy at M. D. Anderson and president-elect of the American Medical Association

JOSEPH T. PAINTER, M.D., IS VICE PRESIDENT FOR HEALTH POLICY AND PROFESSOR OF MEDICINE AT THE UNIVERSITY OF TEXAS M. D. ANDERSON CANCER CENTER; HE WAS VOTED PRESIDENT-ELECT OF THE AMERICAN MEDICAL ASSOCIATION (AMA) IN JUNE 1992. A NATIONALLY RECOGNIZED EXPERT ON CANCER CONTROL, PAINTER HAS TURNED HIS ATTENTION TO A HIGHLY CHARGED POLITICAL AND SOCIAL DEBATE IN THIS COUNTRY: NATIONAL HEALTH POLICY. HE IS AN ENTHUSIASTIC PROPONENT OF THE AMA'S PROPOSAL FOR HEALTH CARE REFORM CALLED HEALTH ACCESS AMERICA. PAINTER SPOKE TO ONCOLOG CONTRIBUTING EDITOR KATHRYN L. HALE ABOUT THAT PLAN AND ABOUT HEALTH POLICY INITIATIVES ON BOTH STATE AND NATIONAL LEVELS.

Q

What is the AMA doing about the current crisis in health care cost and availability?

A

The AMA has been working on a plan for the last three years. Our premise is that the status quo is simply not acceptable, and we want to provide a framework for health care reform. Our view is that we have the best health care system in the world, in terms of the quality, but we need to solve two problems: access and cost.

The access problem is fairly straightforward. Only about 40% of the indigent are now covered by Medicaid; we propose revising the eligibility standards to include 100% of people at or below the federal poverty line. All would be eligible for a basic set of benefits. In this way we believe that we can bring the needy into the system.

Q

Is access limited in any way?

A

The basic benefits would include doctor visits, hospital stays, and a variety of other benefits covered by a standard health insurance policy.

Q

What about the 24 million people who work but don't have insurance?

A

What we're proposing is an expansion of the employer-based system in which both the employer and employee contribute to the premiums.

Q

How are the employers going to pay?

A

They'll be required to provide only a basic set of benefits; this will keep costs down. Built-in tax incentives will encourage smaller businesses to provide this coverage.

Q

Businesses have already indicated displeasure with such a plan.

A

A plan like this one must be accompanied by insurance reform. No longer can we tolerate individual company ratings such that one catastrophic or serious chronic illness drives everyone's premium up by, say, 100%. We need to move to broad, community-based ratings; we need to eliminate exclusion on preexisting conditions. We also need to pool groups of small insurers to spread the risk and lower insurance premiums. Insurance also must be portable so that people can change jobs without losing coverage.

"Doctors don't want to be the rationers; they'd rather provide the best possible care to each patient"

Q

What about people who are unable to get insurance because of medical conditions?

A

State pools could be helpful in providing them insurance at a near-normal rate. Many people should be eligible through their employers if premiums can be kept down.

Q

So the AMA's policy on health care access is...?

A

Very much in favor of universal access by removing the financial barriers that keep people out of the system.

Q

Let's get back to the second problem, cost.

A

That is a much more difficult problem. A big problem in controlling costs is figuring out the cost of providing a particular service to an individual. AMA supports and wants to perfect a relative value scale, which would be used to develop a cost-based payment system. Harvard has developed such a system, which has now been put into effect under Medicare. Like any new system it has a lot of problems, but once it's perfected it will give us a solid base for defining the cost of a service.

Q

Is the goal to develop a uniform cost per service?

A

Yes. Different procedures require different levels of skill, judgment, experience, and time. A relative value scale simply says that if a standard office visit is 1, a coronary bypass might be 100. The relative value is then multiplied by a conversion factor determined through negotation with the payer to establish the fee.

Q

What about the growing volume of care?

A

AMA is also developing "ranges" of appropriate care for given conditions. Once established, ranges can be used to evaluate patterns of care. Care that is outside the range may mean a special circumstance was in effect, it may mean that the physician is using an effective but unnecessary standard of care, or it may be deliberate misuse of the system. Ranges may be a way of getting professional consensus on cases for which there isn't universal agreement on a best approach.

Q

How would it be monitored in private practice?

A

By the insurers. Rather than trying to decide what services will be paid for, the insurers could simply look at the patterns of a physician's care and evaluate whether this physician fell outside the range. If outside, the physician's claims would be examined more closely.

Q

How much cooperation are you getting from the insurance industry?

A

They are very interested. They see that once the relative value scale is perfected and patterns of care are more easily evaluable, claims can be processed much more efficiently. Their approval and review systems would be much simpler. Automation would improve the efficiency even further.

Q

Isn't administration a huge cost?

A

One quarter of all dollars spent on health care go to administration, including filing insurance claims. Insurance companies are interested in any system that would simplify their procedures and reduce their costs.

Q

What other factors contribute to escalating costs?

A

Compliance with regulations is a huge cost in health care. Another is professional liability. Clearly we can't control the volume of care until we have a

"The American people are going to have to deal with the question of how much care we provide to each person"

threat of liability control. Professional liability adds about $20 billion each year to the cost of health care through insurance premiums and defensive medicine.

Finally, we propose that society recognize that the patient has to assume a great deal more of the responsibility for his health. Prevention is the best way to ultimately reduce health care costs. So we're very much pushing prevention as a final component.

Q

What about the costs of the high technology?

A

That is one area in which we have not yet been able to resolve the best way to control costs. And technology is a driving force behind rising costs. Often we have no good way of assessing whether a new technology adds substantially to improvement in health or in the patient's response. At AMA we have a system in place called DATTA, which is an acronym for a technology assessment capability. It's being used more and more by insurers and government groups to decide when a technology is no longer considered experimental and is ready for general use. It's proven to be a quite effective mechanism, but I'm not sure over time whether this method of pulling together a group of experts and having them review the technology and make recommendations will ultimately work. It's a complicated process. Clearly we've got to reduce the demand for high-technology procedures.

Q

This gets to rationing, as in the Oregon initiative.

A

What they've asked in Oregon is, is it better to spend thousands and thousands of dollars on one heart transplant, or to spend the same amount of money and do something that will help a lot of people, like prenatal care? But doctors don't want to be the rationers; they'd rather provide the best possible care to each patient. Consequently, I think the American people are going to have to deal with the question of how much care we provide to each person.

Q

Wasn't the Oregon initiative developed by a broad community-based group of health care professionals, politicians, business leaders, and ordinary citizens? Aren't they representative of "the American people"?

A

The AMA's position on the Oregon proposal is that, if that's what they choose to do, then let's try it. The AMA believes, however, that we can build on the current system, using its strengths and controlling its weaknesses, to give universal access to health care and control its costs. Our costs are already beginning to moderate somewhat compared with those in Canada, Great Britain, and Germany—their costs are growing at steeper rates than ours at the moment. We're beginning to see some slowing, but not as much as we want.

Q

The employer-funded program is a good idea, but the money has to come from somewhere. Tax incentives mean reduced revenue for the federal government. Where might that money come from?

A

We agree that, overall, these incentives reduce revenue, but look at Hawaii. For 20 years the state has required all employers to provide a basic set of benefits, and that's worked very well. Nobody's gone under, and the number of small businesses hasn't suffered. The government has succeeded despite any loss of revenue.

Q

What about the relatively high indigent population in Hawaii? How are they insured?

A

They have a basic set of guaranteed benefits. Everyone is required to have a card that allows them to see a physician or be treated at a hospital. The costs have not gone up astronomically. They've been able to contain them with normal utilization review.

Q

Can that model be transferred to other places?

"Almost all proposals suggest removing control from Congress and establishing an independent commission"

A

I think so, as can other plans. There are some 50 bills now in Congress trying to solve the health care system jproblem. Almost all proposals suggest removing control from Congress and establishing an independent commission to guide health policy, modeled after the federal reserve system. This semi-autonomous body would take over the cost control, benefits regulation, and so on, eliminating the jockeying around of congressional committees and other political groups. AMA favors a market-based system and does not see the advantages of an independent group over Congress.

So that is where we stand on health care reform. Over the last couple of years, AMA has gone to 80 or 90 of the Fortune 500 companies and met with their CEOs. At first they don't like the employer-funded part of our plan. After learning more about it, they begin to see the necessity and admit that it's not a bad plan. They don't agree with the plan's every detail. They want to control costs, but are becoming increasingly disenchanted with the HMOs; even though HMOs are still all the rage, employers say that switching to an HMO gives a one-time 6 to 8% reduction in costs, but then costs start rising again at the same rate. We've met with various groups to attempt to build a consensus that we can then push to get adopted. For example, I think everybody agrees now that liability reform is long overdue.

Q

Why is there a hold-up on liability reform?

A

Reform is slow because tort laws vary from state to state. The trial lawyers are very strong at the state legislature level. For example, in Texas they dominate the state Senate, and until recently they dominated the state Supreme Court. So it's difficult to pass legislation reforming tort law. On the other hand, it is becoming clearer to congressional leaders and the administration that liability adds significantly to health costs and will continue to do so until the liability threat is removed by passage of a uniform national tort reform law.

The AMA has developed an alternative dispute resolution system. We don't believe the tort system really works for resolving health care disputes. It's too costly and too long. Most liability suits are not for real injury, but for lack of result. People expect a perfect result every time, even though every procedure has its risks. An example is the child who has a disability; the parents sue the physician who delivered the child. These are cases that require expert and impartial panels to weigh the evidence. If they decide there was negligence, then restitution would be made directly.

Q

Then you're suggesting a physician- and community-based system rather than a court-based system for resolving these disputes?

A

A court could ultimately be involved if the dispute resolution system was unable to resolve the claim. An interesting model has been adopted in Maine, where to curtail the professional liability problem, the state government asked the Maine Medical Association to develop parameters of care for anesthesia, obstetrics, and one other specialty. If a physician practices within those parameters, he or she cannot be sued for an adverse outcome. In clear cases of negligence, error, or substandard care, the physician may have to make a settlement or be sued. We're interested in how that plays out. It's been in effect about six months.

Q

So the AMA is, in general, very pleased with the state experiments that are going on?

A

I'm not sure any of them are the right way, but they're going to give us lots of information on how to do things and how not to do things. Ultimately, we're going to have to look at a national solution, although I don't think most of us favor a single-payer system in which the federal government takes over.

Q

Such as the Canadian system?

A

I was just in Canada at the meeting of the Canadian

Medical Association. I learned that in this purportedly "federal" system, each province actually has a different health care approach. Basically the federal government has eliminated private health insurance and said that each citizen will get a basic set of benefits. The federal government pays part of the cost, and the provinces pay the rest. Each province manages its own way. A general framework is given, and the province is free to modify it. For example, Newfoundland doesn't have enough money to cover all its health care needs, but it seems to accept the system as is. British Columbia, however, has more money and has chosen to contract with Washington State to provide some of its more complex health care services. In the Yukon, some physicians work only about two weeks out of the month: there's a cap on how much they can be paid under the system. So they may work for a month or two each quarter; when they reach the cap they stop working. If the hospital spends its budget, a section of the hospital closes down. What is disturbing to many physicians is that their system is providing only basic health services, or what we would consider to be basic.

Q

So your position is that a Canadian-style single-payer system limits growth and development?

A

Yes. There's little research being done except in the large medical centers. In Canada, a little over half of the physicians are family physicians; the emphasis is on training more family doctors and limiting the number of specialists. That's probably going to be the subject of the next big fight up there. Of course, there are many outside the medical profession who are concerned about the number of physicians and the specialty distribution in this country. They think this is another component of the health care problem and should be addressed in any long-term solution.

Q

What about the British system? My impression is that they conduct research and still provide low-cost, accessible care.

A

Remember there are two parts to that system. There are the family physicians, who are assigned a certain number of patients and perform general care, and then there are the hospital-based specialists. The family doctor provides only ambulatory care, and only the specialist provides hospital care. But we're seeing the same thing there as everywhere else: the costs are eating them alive. They have a finite budget that is divided among all the local health boards, which then dole the money out to the individual physicians on the basis of the number of patients they see. What they've said implicitly with their system is that, for example, people over 45 years old with renal disease will not receive kidney transplants.

Q

So they've been forced to resort to rationing?

A

They've said that older people with chronic diseases will be made comfortable but not receive treatments such as coronary bypasses and so on. These more expensive, technology-based procedures are not part of the system unless the individual can pay for them. So what is emerging is the private pay insurance system that their public system was designed to eliminate.

I was recently at a World Health Organization meeting in Geneva. We were there to discuss the relationship between private sector and public sector medicine, and particularly what can be done to help nations emerging from communism move from a government-dominated system to a public/private system. All these countries look to the U.S. as a model, recognizing that we do have problems with access and costs; they all want to know how to privatize their system. Clearly, the problems we are having are not unique to the U.S.; costs are a problem all over the world as governments struggle with high demands and limited budgets.

Q

It seems we're moving to a more public system, while others move to a more private system.

A

The public/private mix has served this nation well; we need a variety of delivery systems to suit everyone. Choice continues to be an important consideration: choice of system, choice of doctor, and choice of care. Americans expect and deserve the best medical care. Health care reform must preserve the strengths of our system while correcting the cost and access problems. ■

—Kathryn L. Hale

Physicians who desire additional information may write Dr. Painter at the Office of Vice President for Health Policy, Box 223, The University of Texas M. D. Anderson Cancer Center, 1515 Holcombe Boulevard, Houston, Texas 77030, or call (713) 792-2200.

"Local ... wound complications were seen in only 15% of patients—dramatically less than the rates ... typically reported"

Vulvar Tumors

continued from page 8

and from Dr. Phillip DiSaia of the University of California at Irvine suggested that patients with small vulvar cancers might be equally well managed with more limited resections. Dr. DiSaia recommended limiting conservative resection to patients with tumors having diameters of less than 1.0 cm and invasion of less than 5 mm. He advocated local resection of the primary cancer with a 1- to 2-cm margin. After defining the lymphatic drainage patterns of the vulva, he suggested using the superficial inguinal lymph nodes as the sentinel group for lymphatic metastasis. Perioperative morbidity in patients with conservatively resected tumors was lower than that seen in radically treated patients, and the majority of patients reported acceptable postoperative sexual function.

For the past 10 years, we have used a modified version of his approach and have treated patients with resectable stage I and II vulvar cancers of larger sizes with wide excision of the primary tumor. Our radical wide excision employs a gross lateral resection margin of 2 cm and a deep margin at the level of the perineal fascia (Figure 1). This represents a curative resection effort that is considerably less extensive than the classic radical vulvectomy. Patients with lateral lesions undergo a unilateral superficial inguinal node dissection, while those with midline lesions have bilateral superficial groin dissections. Our therapeutic schema is summarized in Figure 2.

We recently described our experience with 32 patients treated in this manner. This was a mixed group of stage I and II patients with tumors of up to 6.5 cm in diameter and invasion of 1–13 mm. Actuarial 5-year survival was 84%. Local vulvar wound complications were seen in only 15% of patients—dramatically less than the rates of 50% typically reported for radical vulvectomy. Additional review of a second group of patients whose vulvar tumors invaded less than 1 mm has demonstrated that even the superficial groin node dissection can be safely eliminated in this most favorable subgroup.

Figure 1. A 2–cm squamous cancer. Planned resection margins of 2 cm were measured and outlined. For radical wide excision, the dissection is carried to the deep perineal fascia. Primary closure without tension was easily accomplished.

Vulvar reconstructive techniques

We are currently trying to expand the option of function-conserving surgery to patients with larger and more advanced tumors (3–6 cm). We commonly use local rhomboid skin flaps to reconstruct the vulva following removal of mid-sized tumors. This versatile technique can be tailored to cover defects of many sizes and almost any perineal location. Rhomboid flaps have been particularly useful in reconstructing the periclitoral area or posterior perineal body, where primary closure without tension is frequently not possible. Larger gracilis myocutaneous flaps can be employed in the reconstruction of more extensive vulvar defects created when tumor resection requires hemivulvectomy or partial removal the distal vagina. Although originally designed to form a neovagina for patients undergoing pelvic exenteration, gracilis flaps have also proved to be well suited for external perineal reconstruction.

The application of these reconstructive techniques to the vulva has provided a number of benefits. Flaps allow the surgeon access to an adjacent skin source that can be

"Although surgical scars are unavoidable, a reconstruction that is well planned and well executed usually resembles the normal vulva"

mobilized to cover virtually any defect. This option eliminates the need for primary linear wound closure: consequently, the risk of wound breakdown and the tendency of the surgeon to secure suboptimal resection margins are reduced. Reconstructions using rhomboid or gracilis flaps result in soft, pliable, naturally padded repairs that should help maintain comfortable coital function. Although surgical scars are unavoidable, a reconstruction that is well planned and well executed usually resembles the normal vulva.

Current status

Conservative resection is a safe and acceptable option for patients with small vulvar tumors (≤ 2 cm). In most patients surgical cure is achieved, and those who develop recurrences in the retained vulvar skin usually can successfully undergo a second wide excision. Patients with inguinal node metastases or recurrences are at greatest risk of death from disease. We approach these cases by resecting bulky lymph nodes and adding postoperative irradiation. Treatment failures seem to be less frequent when the radiation field includes the lower pelvic nodes and the vulva, as well as the groin.

The role of tissue-conserving surgery is less clear in patients with larger cancers. We believe that control of the vulvar component depends upon an adequate resection of the primary tumor, and that this can often be accomplished with something less than radical vulvectomy. The higher rate of treatment failure observed in these patients is usually attributable to the presence of nodal or distant metastases rather than uncontrolled primary tumor. An accurate lymph node assessment, coupled with an individualized radiotherapy plan, is essential in planning curative treatment for these women. Patients with systemic metastases are usually not curable with currently available cytotoxic therapy.

In patients with large vulvar cancers, tissue conservation and the sexual rehabilitation of the patient should be important considerations. However, additional clinical experience is needed to establish whether less aggressive surgical approaches do not sacrifice the potential for cure. It also should not be assumed that less aggressive techniques necessarily improve posttherapy sexual function and body image. Such issues must be prospectively assessed to confirm clinical impressions. Although cure is the predominant objective of treatment, an individualized, multimodality approach that preserves tissue function warrants a careful, ongoing evaluation. ■

Physicians who desire additional information may write Dr. Burke at the Department of Gynecology, Box 67, The University of Texas M. D. Anderson Cancer Center, 1515 Holcombe Boulevard, Houston, Texas 77030, or call (713) 792-2770.

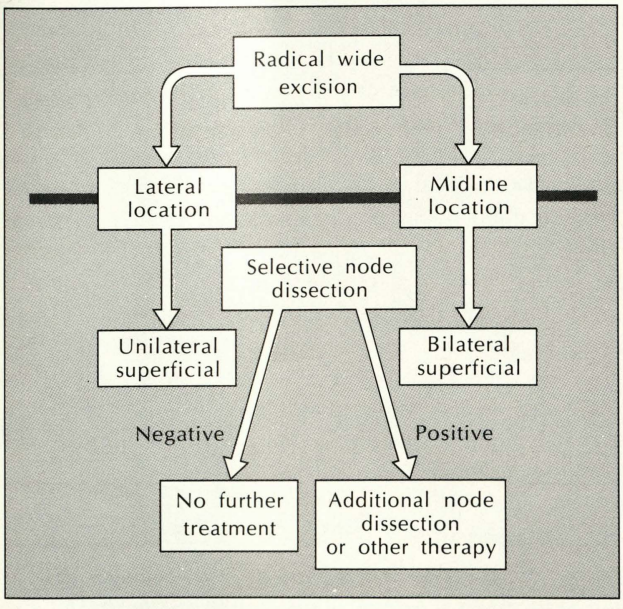


Figure 2. In the conservative management of operable vulvar cancer, resection of the primary tumor is considered separately from evaluation and treatment of the inguinal lymph nodes. The vulvar lesion is removed by radical wide excision. Ipsilateral superficial groin dissection is performed in patients with lateral tumors, whereas bilateral superficial dissections are done for midline lesions. Patients with negative superficial nodes receive no further treatment. Those with positive superficial nodes can be treated with more extensive surgical dissection, irradiation, or both (reprinted with permission from *Current Opinion in Obstetrics and Gynecology* 4:87, 1992).

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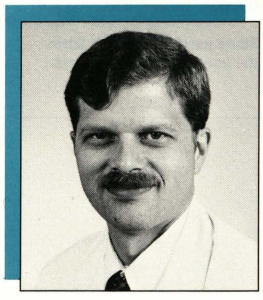
Conservative surgery a safe option for patients with small tumors

Tissue conservation techniques for patients with vulvar cancer

By Thomas W. Burke, M.D.

Treatment Update



Thomas W. Burke is an associate professor of gynecology in the Department of Gynecology

Although radical surgery will always play a role in the management of gynecologic malignancies, recent trends have emphasized modifications of traditional therapy that result in less tissue destruction, fewer operative complications, and better chances for retaining normal function. Certainly this is true for the current management of patients with vulvar cancer. Patients with resectable vulvar cancers have typically been treated by classic radical vulvectomy and bilateral superficial and deep inguinal lymphadenectomy. This is an aggressive operation that removes the primary tumor, all vulvar skin, and regional lymphatics using an en bloc dissection.

Radical vulvectomy was developed and refined during the 1940s through 1960s as a technique to eliminate bulky, bleeding perineal tumors and to prevent groin breakdown and drainage from tumor ulceration in regional lymph nodes. The operation was a significant advance and successfully avoided the morbidity of uncontrolled vulvar cancer. Much of our understanding of prognosis and tumor spread patterns in patients with vulvar cancer is based on Dr. Felix Rutledge's experience at The University of Texas M. D. Anderson Cancer Center. His detailed evaluations of over 400 cases established the prognostic significance of tumor size and inguinal node metastasis. This information has been incorporated into the modern staging classification of vulvar cancer. Dr. Rutledge's work also defined the curative potential of radical vulvectomy. Although producing excellent long-term survival rates of 85–90% in patients with stage I and II disease, the radical operation is associated with substantial morbidity and a significant impairment of the patient's body image and sexual function.

Conservative resection of small cancers

In the late 1970s, preliminary data from the Department of Gynecology at M. D. Anderson Cancer Center

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