

Rationing health care: More heat than light

Posted At : September 1, 2009 10:48 AM | Posted By : Debu Tripathy

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It is hard to avoid blogging about health care reform in the world of cancer at the present moment. It is a bright flashing light on our radar screen.

Cancer care is so complex and typically a long-term process, so it will obviously be affected by any change in health care, let alone massive reform. One of the more contentious aspects of reform is the rationing of health care, particularly in cases where overall outcomes are not good and therapy is often futile. The recent flap about "death panels" has brought up an important point--to what extent should doctors be encouraged (or mandated) to address end-of-life issues and what exactly should their advice and actions be in this regard?

There is no doubt that oncologists in many cases do not adequately discuss issues of curability, probabilities of successful therapy, or prognosis--especially for incurable cancer. This is also true of non-malignant but life-threatening diseases like advanced congestive heart failure or chronic pulmonary disease. At the same time, doctors should not impart their values on the patients' decisions. One potential health plan attempts to level the playing field by providing templates for doctors and allowing multiple constituents (not the government, as rumor has it) to develop and continually improve these templates, which are meant to serve as guides, not absolute mandates.

For this plan to work, the public needs to educate itself and take some responsibility, just as they did with deciphering the complicated Medicare drug coverage plans or changes in the tax code, for that matter. However, at the crux of the argument is whether physicians should primarily advocate for the patient or whether they are also wardens of society-at-large. In our current system, the "have-nots" cannot get even basic care, whereas those with insurance and the means to cover co-payments and other expenses can receive very costly treatment even for questionable or marginal benefits.

Should physicians adopt agreed-upon cost/benefit lines and apply them consistently for all patients? The recent town hall meetings were dominated by those who have something to lose and not those who have something to gain, and the idea of denying care either due to cost-effectiveness or other factors, such as the co-morbidities, age, and likelihood of survival has been roundly criticized in these forums. It appears that, for now, there is an impasse between the need to distribute care resources equitably and the desire by most individuals to keep medical decisions between doctors and their patients. Not the best recipe for cost containment, but perhaps a slight recalibration in everyone's thinking as to how we measure quality health care and innovation.

In the cancer field, this means a continuation of the trend to personalize medicine--that is, to avoid diagnostic and therapeutic treatments that do not

clearly improve outcome (see *CURE's* article on CA125 level measurements for ovarian cancer recurrence, "[CA-125 Monitoring Not Helpful for Ovarian Cancer Survivors](#)"), and to develop more effective therapies for biologically defined subsets of disease.