Editorials

Some Realities in Cost Containment

It is generally recognized that this nation has the best health care system in the world and also that it is the most expensive. Understandably, those who pay the bills are the most concerned about the costs, and those who receive the benefits, less so—whether they be patients or providers of care. Government and more recently business and labor, have begun to give high priority to the containment of costs in health care, and this is not likely to change in the foreseeable future. So far the efforts to contain these costs through regulation and in other ways have frequently been relatively ineffectual, have only scratched the surface of the problem, and have too often been shown by experience to have increased rather than reduced costs. It seems time that some realities be taken more into account in the approaches to cost containment.

Three Seminal Realities

Three realities seem to be of seminal importance. First, science and technology will continue to advance and this will inevitably generate higher costs. What has happened in the last few years in the care of myocardial infarction and coronary heart disease attests to this. And science and technology are probably only at the threshold of what can and will be done not only for this but for many other conditions as well.

Second, the people of this nation place a high value on human life, a high value on health and on access to health care. For instance, we cannot even seem to bring ourselves to execute convicted criminals who have been fairly tried and sentenced to die because of their heinous and often hideous crimes against their fellow man. Another illustration is the strong sentiment in high places for preserving the lives of hopelessly deformed or impaired newborn infants without regard to the quality of life they may expect or the emotional or fiscal cost to others that might result. Also, the many programs to bring better health care to medically underserved areas and populations are examples. The social value we place on life, health and access to care is surely a seminal force that clearly drives the cost of health care higher, and this is not likely to be reversed very soon.

Third, there must eventually be some limit to the amount of public, personal or community resources that people are willing to devote to health and health care. It has just recently been reported that the national expenditures for health have exceeded 10% of the gross national product for the first time. It is obvious that at some point and in some way there will need to be some cap or ceiling on expenditures for health.

Some Artificial Inflatants of Health Care Costs

There is another set of realities that has produced artificial inflation in health care costs. Some of these are at least potentially reversible, but to reverse them will require some basic changes.

1. The earliest health insurance programs provided better coverage for hospital care and for surgical and other procedures in patient care. This emphasis has continued to the present and the fiscal incentives persist for both provider and patient to make use of the benefits for which the coverage is good. Efforts are being made to provide better coverage for less expensive and often cost-saving modalities of treatment such as cognitive services and out-of-hospital care, but progress has been slow.

2. It is by no means certain that many generally accepted methods of treatment are truly effective. The long accepted but now largely discredited Halsted operation for cancer of the breast is a case in point. It seems more than likely that many health care dollars are being spent for care that is believed to be effective but actually may not be.

3. Failure to realize economies of scale also artificially inflates the cost of health care. When procedures, surgical or otherwise, are done frequently in a centralized location, the true costs are usually less and the quality often greater. The reality is that the charges are seldom lowered as experience and efficiency improve.

4. Defensive medicine adds enormously to the cost of health care. This is an artificial added cost that has very little to do with patient care other than to make it more costly for patients and for the public. The costs of this are substantial. One can only speculate on the extent to which some kind of no-fault insurance would lower the cost of health care.

5. Increasing administrative paper work and bureaucratic hassles have come to add substantially to the cost of care wherever it is rendered. This added cost is necessary for compliance with the myriads of laws and regulations that have been imposed upon the health care system in efforts to regulate it and to control the dollars spent. Some of this added administration and its attendant costs is needed and useful, but certainly not all.

One can only guess at what the total impact of realities such as those just mentioned above might be on the cost of health care. Many costs could be substantially reduced if we as a nation were to change some of our ways of doing things. Clearly these are examples of realities that won't go away unless someone does something about them. The medical profes-

sion can help by calling attention to artificial inflatants of the cost of care such as these, and can begin to document the extent of their impact.

A Final Reality

A final reality is that no matter how much "fat" is trimmed from health care costs by reducing the artificial inflators or by any other means, the three seminal realities stated at the outset will ultimately prevail. Somewhere, somehow people will have to decide what they are willing to have available and what they are willing to pay for in health care. It seems to this writer that the more locally these decisions can be made the better. There is considerable experience to suggest that a centralized federal or even a statewide approach (in the larger states at least) is unlikely to work. Some sort of local or regional confederation or alliance may be needed where people in the public and private sectors can make the hard decisions together in terms of local needs, local customs, and the local and regional resources that the people themselves are willing to allocate to their health care. This is not exactly the pro-competition approach now being espoused, but it would surely stimulate competition and also cost containment in health care.

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Advances in Oncology

ELSEWHERE IN THIS ISSUE, Morton and his colleagues have focused on three areas of current therapeutic research interest in clinical oncology. These include the use of doxorubicin hydrochloride (Adriamycin)-based adjuvant chemotherapy for extremity sarcoma, regional hyperthermia as a new treatment modality and the in vitro human tumor stem cell or clonogenic assay for assessing effects of anticancer drugs as a "culture and sensitivity" test. These topics are not uniquely "surgical"; in various centers, they are being pursued by oncologists with a variety of disciplinary (or, more appropriately, interdisciplinary) interests.

Therapy for extremity sarcoma has been difficult, and the use of only surgical intervention in the past had largely mandated an aggressive approach, with amputation a virtual certainty. The innovative approach taken by the University of California, Los Angeles (UCLA), group, using a combination of preoperative intraarterial chemotherapy followed by radiotherapy, limb salvage surgical procedure and postoperative adjuvant chemotherapy, has had very encouraging results and may well be a major contribution to the management of these uncommon neoplasms. Their results in extremity recovery indicate that this procedure, while not totally uncomplicated, can provide satisfactory local control of extremity sarcoma similar to that which can be achieved with amputation. A recent report by Rosenberg and co-workers at the National Cancer Institute[1] of a prospective randomized trial that addressed the issue of amputation versus saving a limb for patients with locally resectable extremity sarcoma has confirmed the validity of the approach espoused by the UCLA group. In the exploratory studies of the UCLA group, they used a combined modality approach for all patients, and it is difficult to dissect the relative contribution of each component. While the results of Rosenberg's study appear comparable, they did not use preoperative chemoradiotherapy, but rather relied on postoperative adjuvant chemotherapy.[1] They clearly established that the addition of chemotherapy improved disease-free survival in patients with soft tissue sarcoma of the extremities in whom surgical resection of the primary lesion was done. It seems reasonable to suspect that more patients may have been rendered locally resectable with preoperative therapy, as used at UCLA. This approach would appear to warrant more widespread application, as it could significantly reduce the need for amputation in patients with extremity sarcoma. This approach should become even more applicable if more effective drugs are identified that synergize with doxorubicin.

The application of regional or local hyperthermia as a treatment for cancer may be age-old, but the scientific foundations for this approach have been developed more recently. Major clinical research applications of hyperthermia appear to be primarily directed towards therapy for large tumors, which show enhanced susceptibility to hyperthermia, particularly in concert with radiotherapy.[2] A variety of regional heating methods, including propagated wave and inductive techniques, are now being studied in many centers.[3] No one technique appears clearly superior for all sites at this time for the various applications of hyperthermia. Rather, ultrasonic and electromagnetic techniques for producing local and regional hyperthermia have specific advantages and disadvantages, such that they may be used more profitably in the near future in a complementary manner.[3] Despite advances in instrumentation, there are still major limitations in the approaches available to heat deep-seated tumors and specific regional sites. Whereas Storm and his colleagues at UCLA have claimed that their approach using magnetic-loop induction hyperthermia provides an effective means of heating visceral organs, this claim is viewed as controversial. Other groups have observed nonuniformity of regional heating, specifically an inability to raise temperatures of deep-seated tumors to therapeutic (42°C or higher) temperatures and in other cases, associated systemic heating, with this technique.[4,5] Part of the problem in assessing hyperthermic fields has been the lack of techniques suitable for noninvasive thermometry. A number of investigators are hopeful that hyperthermia will prove to be a useful adjunct to the management of tumors at specific sites; however, controlled clinical trials are needed to clearly define the efficacy of hyperthermia and to determine its role in cancer management.

With respect to the human tumor stem cell or clonogenic assay, the results obtained and the perspectives espoused by Kern of UCLA are consonant with those recently put forth in several articles.[6,7] Other groups