The Era of Accountability and Oncology: Carpe Diem

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In 1988, Arnold Relman, MD, then the editor of the *New England Journal of Medicine*, declared that medicine was about to enter an era of assessment and accountability.¹ In the 1990s, medicine clearly entered the assessment portion of the era with a much greater focus on the evaluation of the effectiveness of

the health care technologies (i.e., drugs, devices, procedures, and techniques) that were to be applied clinically. With respect to the accountability side, medicine has taken only a baby step into this realm.

All that is now changing as a second wave of cost pressures and tensions are challenging our nation's health care system. This time, the pressure on the public side (e.g., Medicare) is as substantial if not greater than on the private side due to escalation of the federal budget deficit. Purchasers and payers now are challenging the provider side to demonstrate the value of the health care delivered with its component parts of quality, effectiveness, and cost. The era of accountability has indeed arrived for medicine.

Similar to the late 1980s and early 1990s, purchasers and payers are out in front of the provider community in designing and devising the foundation for the evaluation of the quality of care delivered. The schema calls for

- evidence-based guidelines that delineate appropriate care and the logical progression of such care.
- concise sets of indicators or measures of the quality of care delivered.
- systems that allow for the collection of data on actual practice and its concordance with guideline recommendations and/or its consistency with indicators of high-quality care.
- models/templates for the public reporting of provider performance data

- pay-for-performance models that facilitate different levels of reimbursement for providers based upon evaluations of the relative quality and cost of care.
- information modules on cost, effectiveness, and quality for patients to inform their decisions on the choice of treatment, provider, and setting of care delivery.

The multidisciplinary nature of cancer care complicates the fulfillment of the last three schema requirements. Thus, other specialties that are deemed less complicated, such as cardiology, have been the focus of initial systematic efforts. However, the spotlight has begun to shine on oncology.

Organizations such as the NCCN and ASCO must shift into high gear and achieve leadership positions on behalf of the oncology community. NCCN Clinical Practice Guidelines in Oncology are widely recognized and applied as the standard for oncology practice in the United States. Additionally, they are being used extensively by public and private payers to establish coverage policies that influence the choice of appropriate technologies. The importance of these uses is that it is the oncology community that is establishing the recommendations for what is appropriate care on the basis of scientific evidence and expert judgment. The NCCN Guidelines present the oncology community and its representative organizations the opportunity to establish the guideline recommendations as the basis for the identification of quality indicators; as the elements for public reporting on performance; as sources of drug utilization review, coverage, and reimbursement; and as the intellectual capital for appropriate reimbursement for high-quality care.

The next steps are at once most critical and most difficult for the practicing oncology community as they involve the perceived risk of greater transparency. However, the lessons of sitting on the sidelines as happened in the late 1980s and early 1990s remain. The knowledge, expertise, and experience of practicing oncologists must be the basis for delivery system changes that will inform and improve the cancer care decisions of all constituencies on behalf of patients whom we serve. Organized oncology must seize the day!

Reference

1. Relman AS: Assessment and accountability: The third revolution in medical care. *N Engl J Med* 319:1220-1222, 1988.