Potential of the Patient Protection and Affordable Care Act to Reduce Cancer Care Disparities

By Gina Villani

The Brooklyn Hospital Center, New York, NY

In this month's issue of *Journal of Clinical Oncology*, Moy et al provide an excellent overview of the Patient Protection and Affordable Care Act (PPACA) as it pertains to underserved populations and suggest ways in which the Act can be enhanced to further the elimination of cancer disparities.¹ Ample evidence verifies the existence of disparities in cancer care and outcomes. Reasons for these disparities are complex and myriad. Health care reform hopes to address disparities by expanding coverage, increasing access to care, creating accountability and quality of care, increasing research on health disparities, promoting prevention and wellness and expanding diversity of the health care work force. Although well meaning, some of these initiatives may have unintended consequences, as in Moy's example of expanding coverage in a system such as current-day Medicaid. Moy et al provide recommendations to avoid these potential pitfalls.

However, the oncology community must go further than the provisions provided by the PPACA if it hopes to truly eliminate disparities. In addition to expanded coverage and access to care, the issue of consumption of care must be addressed. According to the National Cancer Institute, the United States spent 228 billion dollars on cancer care in 2008. Spending on cancer now accounts for approximately 5% of all medical spending and approximately 10% of Medicare spending, with 30% of these costs incurred in the last year of life. A recent study published in *Cancer* found significant racial differences in attitudes toward aggressive medical treatments at the end of life.² The study, based on 4,100 patients with lung and colon cancer, found that 80% of blacks were willing to use up all their money to extend their lives, compared with 72% of Asians, 69% of Hispanics and 54% of whites. Physicians caring for cancer patients must be cognizant of both the societal and personal costs of health care and ensure that patients receive evidenced-based treatments and are fully educated about the absolute benefits of treatment. Both doctor and patient must understand that more is not always better. Nationwide only 7.5% of hospice patients are black, and only 4.8% are Hispanic. Reasons for this disparity are complex, but physicians must initiate end-of-life discussions earlier in the care continuum and assist in alleviating fear while setting realistic expectations. ASCO has developed guidelines and educational materials to aid in this process (see text box).

PPACA contains provisions to improve prevention and wellness care requiring all health plans to cover preventive services with an "A" or "B" rating from the United States Preventive Services Task Force. Risk of cancer varies among different

ASCO Statement: Towards Individualized Care for Patients With Advanced Cancer (2011)

As a step toward taking on the issue of value in cancer care, the Task Force partnered with ASCO's Ethics Committee to develop a position paper communication and decision making for patients with advanced cancer. The paper advocates an individualized approach to discussing and providing disease directed and supportive care options for patients with advanced cancer, throughout the continuum of care. Building on ASCO's prior statements on end-of-life care (1998) and palliative care (2009), the paper reviews the evidence for improved patient care in advanced cancer when patients' individual goals and preferences for care are discussed. It outlines the goals for individualized care, barriers that currently limit realization of this vision, and possible strategies to overcome these barriers that can improve care consistent with the wishes of patients and evidence based medical practice.

Advanced Cancer Care Patient Booklet (2011)

Developed in concert with the *ASCO Statement: Towards Individualized Care for Patients With Advanced Cancer*, this booklet is designed to help people with advanced cancer and their family and caregivers understand the diagnosis and treatment options, discuss these options for care throughout the course of the illness, and find support. The booklet is available online on Cancer.net and it is available in English and Spanish.

populations, and preventative and screening services must be tailored to risk. Screening and treatment of hepatitis, screening for hepatocellular carcinoma, human papillomavirus vaccination, HIV screening, and treatment of *Helicobacter pylori* should also be included under PPACA provisions. In addition, the cancer community must participate in efforts to reduce rates of obesity, as it has been shown to influence cancer risk and prognosis.

PPACA expands initiatives to increase diversity in health care professions and, as outlined by Moy et al, ASCO has developed programs with similar goals. As the diversity of the medical workforce increases, ASCO and other oncology organizations must be mindful that for many physicians, English is

not their first language. In addition to cultural competency, training programs must assess English proficiency and provide remediation when necessary. All trainees must learn how to avoid medical jargon and speak with patients in layman's terms. Evaluation of communication skills should be an integral part of all medical training programs.

Moy et al outline the essential components of PPACA and provide guidance on further refining this groundbreaking legislation. Clearly there is much to be done. Broad systemic changes are on the horizon that will have a lasting impact on eliminating health disparities, and ASCO will help to guide these changes. But physicians and hospitals must also do their part. By striving to provide evidenced-based cancer care, optimizing cancer prevention strategies, enhancing the workforce,

and including patients at all levels in the decision-making process, we can begin to close the gap and provide equitable quality care to all in need.

Accepted for publication on July 15, 2011.

Author's Disclosures of Potential Conflicts of Interest

The author indicated no potential conflicts of interest.

Corresponding author: Gina Villani, MD, MPH, The Brooklyn Hospital Center, 121 Dekalb Ave, New York, NY 11201; e-mail: ginavillani35@gmail.com.

DOI: 10.1200/JOP.2011.000400

References

1. Moy B, Polite BN, Halpern MT, et al: American Society of Clinical Oncology policy statement: Opportunities in the Patient Protection and Affordable Care Act to reduce cancer care disparities. *J Clin Oncol* doi: 10.1200/JCO.2011.35.8903
2. National Cancer Institute: Cancer Trends Progress Report—2009/2010 update <http://progressreport.cancer.gov>
3. Martin MY, Pisu M, Oster RA, et al: Racial variation in willingness to trade financial resources for life-prolonging cancer treatment. *Cancer* 117:3476-3484, 2011
4. Haas JS, Earle CC, Orav JE, et al: Lower use of hospice by cancer patients who live in minority versus white areas. *J Gen Intern Med* 22:396-399, 2007

Special Supplement Published by JOP and AJMC on Payer/Provider Relationships in Oncology

To help facilitate understanding of the often divergent perspectives of payers and providers in oncology, *American Journal of Managed Care* and *Journal of Oncology Practice* jointly published a special issue (May 2011) that addresses topics relevant to the payer/provider relationship in oncology. This special issue provides clinical, pharmacoeconomic, and regulatory information that helps inform individual decisions—by providers, payers, and policy makers—with the goal of improving efficiency and outcomes in cancer care.

American Society of Clinical Oncology