



Responsible Spending in Cancer Care: The Steps That Really Matter

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After surgery and adjuvant therapy, a patient's cancer recurs. A new drug is available, but its benefits are uncertain and its cost is \$100,000. We all know the story; many of us have experienced it. But the cost equation is usually not as dramatic as these high-profile cases involving last-minute, high-stakes decisions.

In fact, all physicians make decisions that affect the cost of care every day, in ways that may not be immediately obvious. Responsible spending in cancer care comes down to a series of continuous, step-by-step decisions throughout the months or years of treatment and follow-up, rather than the impressive, end-of-life gesture. Fortunately, quality care is not the same as expensive care. Many of the daily decisions that have been shown to lead to better outcomes for the patient – in health status, emotional well-being, and quality of life – are the ones that also help control costs.

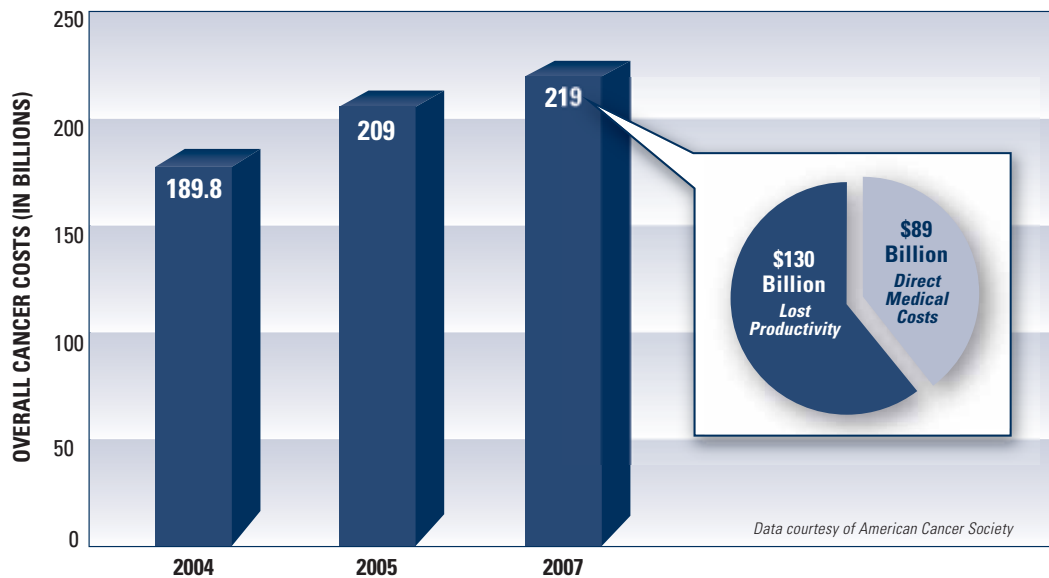
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Rising Costs for Society and Patients

There is no question that the costs associated with cancer treatment have risen rapidly and significantly. Between 1995 and 2004, the overall cost of treating cancer increased by 75 percent, according to the National Cancer Institute. In 2004, the U.S. spent about \$189.8 billion on overall costs for cancer. In 2005, the figure was \$209 billion; in 2007, costs ballooned to \$219 billion, including \$130 billion in lost productivity and \$89 billion in direct medical costs, according to the American Cancer Society.

Although the rate of increase in cancer treatment spending has remained about the same as a percentage of overall health care spending, as the population ages, this percentage is expected to increase as more cases are diagnosed and treatment becomes more expensive relative to other disease categories.

Perspectives



Spending on cancer now accounts for about five percent of all medical treatment in the U.S. and about 10 percent of Medicare spending. However, over 40 percent of Medicare drug expenditures are for oncology/hematology drugs. The disproportionate cost of cancer drugs has been the topic of much discussion as a factor in the increasing cost of care. Cytotoxic and biologic agents are some of the most expensive drugs to develop, with no decrease in sight: according to a recent study, the cost of bringing a new cancer drug to market, including preclinical and clinical testing, is approximately \$1 billion.¹ New imaging and radiation therapy techniques, while groundbreaking in their ability to diagnose, stage, and treat cancer, come with a big price tag as well: a single PET scan for cancer staging can be as high as \$1,800. In this instance, the important thing to consider is if the patient is receiving benefit in proportion to the cost.

Fortunately, as a result of these advancing technologies and new agents, survival rates have increased for patients facing cancer. This good news has its price, too. As patients live longer, the cost of their treatment increases with the length of survival. For example, treating a breast cancer patient for a year vs. that same treatment plus maintenance therapy for eight years represents a six-fold increase in cost.²

Beyond the cost to society of cancer treatment, the cost for individuals is rising to a crippling level. Even when patients have insurance, they may still pay tens of thousands or even hundreds of thousands of dollars for treatment. Those without insurance may delay or forgo treatment, and they may not be able to afford the treatment their physicians would like to offer. (Not surprisingly, those at the low end of the socioeconomic ladder fare the worst – they have more advanced cancers at diagnosis, receive less aggressive treatment, and as a result, have shorter survival times.³)

“Incredible advances in technology and in medication treatment have contributed to the high costs of cancer care,” said Kirsten Anderson, M.D., Ph.D., senior medical director, Aetna Informatics. “Advances in cancer care therapeutics often achieve minimal gains in life expectancy or quality of life, and come with a very high cost,” she continued.

“Advances in cancer care, while beneficial for certain patients, need to be balanced with an evidence-based evaluation of the efficacy of treatments and a better approach to end of life issues,” Dr. Anderson emphasized. “Practicing high quality, evidence-based medicine will result in clinical excellence at a reasonable cost.”

Linking Positive Outcomes and Responsible Spending

The cost repercussions of clinical decisions can be profound for patients and for society at large. In spite of the complexities of health care costs, physicians do have control over many of the aspects of how money is spent. Three pillars of responsible health care spending have emerged from this picture as those that have the most effect on cost, with the best outcomes for patients and their families: evidence-based medicine, appropriate disease management, and compassionate end-of-life planning.

1. Evidence-based medicine (EBM). With EBM, physicians can be sure they are working with the most clinically sound, up-to-date information available in the medical literature reviewed by their peers. Many studies have shown that reducing the variation in care improves its quality and diminishes errors. Although EBM is relatively new in oncology, several organizations have made great strides in creating evidence-based pathways for cancer treatment: the National Comprehensive Cancer Network (NCCN), the American Society of Clinical Oncology (ASCO) and the American Society of Hematology (ASH). By relying on the principles of EBM, physicians can make clinical decisions with evidence of proven treatment regimens, resulting in better outcomes for their patients. Using proven pathways that address the majority of cancers decreases the variability in costs as well, and in several cases offers proof that a less expensive drug is shown to have the same benefit as one that is more expensive.

2. Disease management. Comprehensive, timely disease management (DM) has demonstrated its effectiveness in improving health status, patient quality of life, and financial outcomes. Although previous emphasis has been on chronic diseases such as diabetes and congestive heart failure, cancer has now joined the list of disease states well suited to DM. Implementing DM as soon as a patient begins chemotherapy offers an opportunity to monitor drug reactions; if a patient is vomiting, he or she can report this (usually to a call-center nurse) and receive a prescription for anti-nausea medication. When patients are able to receive medical support and advice as needed, problems are caught earlier and fewer emergencies arise. Trips to the ER – expensive both for patients and health care systems – are thus avoided and the patient's health benefits.

3. End-of-life planning. About 27 percent of Medicare's annual budget goes to care for patients in the final year of life. The 2006 Dartmouth Atlas of Health Care reveals in eye-opening detail that more is not better when it comes to end-of-life care. "There is growing concern... that some chronically ill and dying Americans might be receiving too much care – more than they and their families actually want or benefit from."⁴ And although determining how much is too much is far from easy, it must begin with frank end-of-life conversations. A recent study⁵ showed that despite physicians' concerns that these discussions may cause psychological harm for their patients, in fact they are not associated with depression, sadness, terror, or worry. Instead, patients who had these discussions were more likely to forego aggressive medical treatment, use hospice care, and experience improved quality of life. A compassionate end-of-life discussion is not a single event – it is a series of conversations as the patient's condition evolves. It has been estimated that when a patient first receives a cancer diagnosis, he or she recalls less than half of the conversation. Clearly the end-of-life discussion should be initiated when the patient and family can focus on it, with enough time to make the arrangements that will honor the patient's wishes.

More is Not Better

Although these pillars of responsible spending are not as dramatic as the brand-new, \$100,000 drug with the short-term benefit or the legions of specialists at the bedside, when it comes to making good decisions on the cost of care, they are the ones that matter most. These steps are under the individual physician's control, and they are widely recommended to improve quality of care. Evidence-based pathways for cancer are now commonly available. More and more payers are offering access to disease management for cancer. A compassionate end-of-life conversation can begin as soon as the patient's condition warrants it and the patient and family are ready to talk about it.

"Advances in cancer care, while beneficial for certain patients, need to be balanced with an evidence-based evaluation of the efficacy of treatments and a better approach to end of life issues," Dr. Anderson emphasized. "Practicing high quality, evidence-based medicine will result in clinical excellence at a reasonable cost."

Every physician strives to give his or her patients the best advice. In this new world of expensive technology and drug therapies, that means helping make wise cost decisions as well as wise clinical decisions.

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As the founder and CEO of the Russell Mark Group, a leading verbal branding consultancy, Susan Russell is a specialist in branding, naming, writing, and other language of the marketplace. She has been quoted on branding and language issues in the *San Jose Mercury News*, *Boston Globe*, *Wired*, *California Medicine*, and the *Milwaukee Journal Sentinel*.

In addition to US Oncology, her clients include Carnegie Mellon University, Visa, Procter and Gamble, Hill-Rom, SAS Institute, Kaiser Permanente, and Blue Shield of California.

Before founding the Russell Mark Group, she was an information designer with the international consultancy Fitch, Inc. She has also been director of publications at Princeton University and the Rockefeller Foundation, where she devised and implemented a new communications program.

Susan holds a Master of Arts in English with an emphasis in linguistics from Miami University, Oxford, Ohio.

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