Cost of Cancer Care

ASCO Task Force on the Cost of Cancer Care

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There is a broad and growing consensus that the rising cost of health care in the United States will result in crippling economic effects if this trend is not reversed. Despite per capita expenditures that exceed those in most of the developed world, health outcomes are not better. In some categories, they do not equal outcomes in nations spending far less. Cancer care is one area in which the United States leads the world in outcomes, but its cost is extremely high—and growing rapidly.

New proposals for health reform seem to surface daily, but they all emphasize one clear and immediate need: to control runaway cost. More than one economist has warned that if we do not address this problem, our nation's ability to compete, build a better life for our children, and remain a strong political and economic force will be in serious jeopardy. The term for this in Washington-speak is "bending the curve." How the cost curve bends, along with how we manage cost while sustaining quality patient care, is a top concern among medical professional organizations, including ASCO. Over the past several months, a board-appointed task force has wrestled with just this issue. As task force chair, I must admit there were times when I was not sure we would reach consensus—and I am sure the same story would be told by similar groups throughout the field of medicine. Ultimately, however, our task force—comprising representatives from private practice, academic medicine, research, industry, and the patient advocate community—came together on some key principles, which were published in *Journal of Clinical Oncology*.¹ These include:

- We as a community must confront drivers of cost that we can measure and influence.
- Communication between oncologists and their patients about cost is not only ethical but also an important component of care.
- ASCO has an obligation to help its members understand and deal with the impact of rising cost.
- Patients should be empowered to discuss cost with their oncology healthcare teams and access resources to help with costly therapies.
- More research is needed to understand how to best deliver cost-effective therapies while preserving the high quality of cancer diagnostics and therapy that is the hallmark of US medicine.
- There is room for disagreement regarding the issue of cost. ASCO should provide a forum that allows for constructive dialogue among a diverse community of stakeholders and,

through such dialogue, fosters appropriate solutions to this challenging problem.

In addition to this framework statement, ASCO has produced a patient brochure that helps patients with cancer organize care, access financial assistance, and ask the right questions. The 2009 annual meeting included several sessions exploring various aspects of cost and how we can begin to address it. In the coming weeks and months, the ASCO Cost of Care Task Force will build on these initiatives with development of member resources and continuing dialogue. Efforts now under consideration include:

Physician Tools and Resources

The task force is committed to helping oncologists evaluate treatment regimens in a way that factors in overall benefit, toxicity, and cost. One idea is for ASCO to begin providing available cost data to oncologists on various clinically effective treatment options, thereby arming oncologists with the information necessary to make comparisons. To develop this tool, ASCO could use its current guidelines process as a model by adding cost effectiveness to its guideline analysis, when appropriate cost effectiveness data are available. A special workgroup is guiding ASCO's input on the many initiatives surrounding cost-effectiveness research.

Patient Resources

The task force also is assessing what resources are needed to help patients calculate their out-of-pocket cancer care costs. The first step will be to explore existing tools, assess who is using these tools (and who is not), and determine what oncologists believe to be most useful to their patients.

Streamlining patient assistance programs is another potential focus. Although a number of individual companies and foundations provide such help, accessing these programs can be confusing for patients and represents a significant expense for physician practices. Universal patient assistance applications and consolidated access points could reduce administrative burden and speed up delivery of important support to patients in need.

Policy Initiatives

Payment reform. There is no question that today's reimbursement environment makes it increasingly difficult to sus-

tain clinical excellence with optimal cost effectiveness. Successful change will only grow from a thorough understanding of the many drivers of rising cost. The task force will explore possible approaches to payment reform that promote unimpeded access, excellence in care delivery, efficiency, and social responsibility.

Research needs. The task force is fully behind expansion of research into the cost effectiveness of various experimental therapies. The cooperative group mechanism is one ideal setting in which to accomplish this goal. Much remains to be learned about how to encourage improvements in clinical decision making and how oncologists and their patients value various clinical benefits associated with therapeutic interventions. Although not a funding agency, ASCO is in a favorable position to stimulate such research. For example, the society could include the topic of cost in its list of high-priority research areas when calling for research proposals. Furthermore, in its regular meetings with the leadership of the National Cancer Institute, cost effectiveness and comparative effectiveness of treatment

regimens and techniques must be emphasized as essential goals of funded clinical research.

We will be communicating about these and other aspects of the work of the task force in the weeks ahead. I hope you will participate in this important conversation, with the task force, with your colleagues, and with your patients. Our future depends on it.

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Reference

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Three Changes for Affordable Care: One Payer's Wish List

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Any oncologist's first reaction to the issue of cost is likely to be: "Haven't I heard all of this before, and haven't we always found a way to fund more care? What is different this time?" Ever since the discovery of mechlorethamine, vincristine, procarbazine, and prednisone (MOPP) chemotherapy, payers have paid oncologists directly for cancer chemotherapy.

This time, we have reached a tipping point. When MOPP was discovered in the 1970s, a minimum-wage worker in California could provide coverage for his or her family of four with a standard Blue Cross/Blue Shield health plan for 15% of his or her annual income. In 2005, the same worker would have had to spend 101% of his or her annual income for such coverage.¹ The cost of medical care has been accelerating far faster than the growth of wages for decades, and the impact is now stunning. Workers at the low end of the pay scale face the choice of forgoing food, shelter, and clothing to afford health care coverage. The current economic crisis is driving that same choice into the middle class as well. The debate is much larger than the cost

of an individual drug; society is struggling to keep employees insured. If readers have any doubt about this statement, their business managers can confirm dramatic changes in the numbers of insured and underinsured.

Oncology has taken center stage in this debate. The cost trend in oncology is approximately two times higher than the overall medical cost trend. Patients with cancer had previously received amnesty in the debate on cost because of their desperate situation, but the new economic reality has forced policymakers to look at every branch of medicine to cut cost. How can we accomplish that while still serving patients with quality care?

Adhering to existing evidence is the starting point. UnitedHealthcare (Minnetonka, MN) studies on claims have shown that 35% of all erythropoietins were administered to patients whose hemoglobin levels were in excess of the 12 g/dL maximum recommended by the US Food and Drug Administration and ASCO.² Of women receiving trastuzumab ther-