The Rising Cost of Cancer Care: Physicians Take Charge

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The rising cost of health care has become the focus of a national conversation. Although costs associated with prevention, therapy, and surveillance in patients with cancer after completion of treatment are a relatively small fraction of the total cost of the entire US health care system, the increasing incidence of cancer in the population and greater expense associated with new therapies pose a direct challenge. The impact of physicians' decisions is demonstrated by the substantial regional variations in health care costs that have been documented; there is good reason to believe that physicians in lower cost regions order and provide evidence-based tests and treatments just as often as their colleagues in higher cost regions, but they tend to avoid providing care whose usefulness is not well supported by existing data. It can be concluded that if physicians in higher cost regions ordered tests and treatments in a pattern similar to that followed by physicians in lower cost regions, substantial savings would be realized.¹

Howard Brody, in a recent Perspectives piece in *New England Journal of Medicine*,² emphasizes the overuse of interventions and treatments for which there is no evidence to support their use. The assumption that follows is that curtailment of these practices would be associated with enhancement in the quality of health care in the United States, as well as reduced cost. The Foundation of the American Board of Internal Medicine embraced this concept and developed Choosing Wisely, an educational campaign that is motivated by the importance of conversations between physicians and their patients about the evidence underlying treatment plans. It is anticipated that the consequence of such conversations will be fewer unnecessary interventions, leading to improved patient care and the notable side benefit of lower cost. ASCO and eight other medical specialty organizations joined this initiative. The task was to identify five commonly used practices in each specialty for which there is no evidence to support their use. Through a process that commenced with discussions within the ASCO Task Force on the Cost of Cancer Care, a number of proposals were suggested as elements within an ASCO Top Five list that pertains to oncology. Each had to be supported by published evidence and consistent with practice guidelines developed by ASCO or other reputable organizations. These were whittled down and ultimately shared with the Clinical Practice Committee, leaders of state societies of clinical oncology, and the Executive Committee of the ASCO Board of Directors.

The Top Five that were submitted by ASCO³ to the Choosing Wisely campaign cover a number of important areas of clinical oncology that are supported by evidence. However, they are certain to stimulate discussion about whether omitting certain interven-

tions will compromise care or limit options. Prototypical is the suggestion that cancer-directed therapies give way to palliative care for patients with solid tumors who have far advanced disease, low performance status, and whose disease has not responded favorably to prior therapies. What is clear is that the vast majority of patients in this circumstance will not benefit from cancer-directed treatments, are most susceptible to toxicities that may increase morbidity, and will benefit most from supportive care. The inherent challenge is to guide a patient safely through the transition. Of course there are exceptions, and that is why the ultimate decision for this and each of the Top Five list must be in the hands of the physician and his or her patient. The patient may insist on cancer-directed therapy, or the tumor may harbor a mutation for which there is an extant clinical trial or available approved targeted therapy. Choosing wisely means engaging in this critical discussion and individualizing the management decision.

Similarly, others of the Top Five address overuse (despite well-published guidelines) of either granulocyte colony-stimulating factor or imaging modalities such as positron emission tomography, computed tomography, or radionuclide imaging in patients for whom such studies provide little or no proven value. These include surveillance of patients with early-stage breast cancer after definitive primary therapy and the evaluation of patients presenting with early-stage cancers of the prostate or breast, in whom there are no clinical or biologic features that raise the likelihood of synchronous macrometastases or high probability of late recurrence. In such patients, the literature describes extremely low rates of positivity using sophisticated imaging techniques, and the risk for false positives is substantial. Not to be dismissed lightly are the consequences of false positives, such as repetitive scans and attendant radiation exposure to confirm stability of false-positive lesions, unwarranted biopsies with the small but real chance of resulting morbidity, and the anxiety that accompanies this scenario.

The common thread linking the Top Five is the use of evidence in clinical decision making. ASCO believes that sharing the evidence that guides our recommendations, coupled with respect for the uniqueness of each clinical interaction, will lead to enhancement of the cancer care we deliver and improved stewardship of health care resources.

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