The Cost of Cancer Care: There Is More Than One Elephant in the Room

October 23, 2012
By Jonas A. De Souza, MD [1]

The current system rations care in an irrational way. This irrational rationing is going to worsen, for the costs of the current system are simply not sustainable nor are they justifiable by almost any metric used.

In this issue of ONCOLOGY, Dr. Eagle reflects on the cost of cancer care, initially focusing on the magnitude of the problem, followed by a discussion of its causes. Recognizing that the cost of oncology drugs is not the only elephant in the room when addressing the costs of cancer care, Dr. Eagle appropriately points out that “provision of more aggressive care by physicians, the prolongation of the period of treatment and patient survival, and changes in the site of care,” all in an aging population, are important drivers of the rising costs. Within this context, understanding two intertwined aspects of oncology care becomes mandatory: the cost-value dissociation of interventions in oncology; and the misalignment of incentives among payers, providers, patients, and industry.

The Cost-Value Dissociation

When referring to drug costs as the paradigm of cancer interventions, one should also recognize that cancer care involves imaging, radiotherapy, surgical procedures, and so forth. Nevertheless, rising drug costs are in the center of the cost-value discussion. In a recent report from the IMS Institute for Healthcare Informatics, in the United States oncologic drugs led all classes in drug spending in 2011, at $23.2 billion. Spending on targeted agents grew by $1.1 billion, higher than the $0.8 billion spending increase in 2010.[1]

However, some of these drugs have marginal benefits that can be measured in a few weeks (or days) of additional life, with associated toxicities. Thus, an alternative view is that the high prices may not be justified by the value or benefits these drugs provide when seen from the perspective of the healthcare system as a whole. As mentioned by Dr. Eagle, “the pharmaceutical industry retains the capability to unilaterally determine the price of drugs coming to market in the United States.” This certainly contributes to the development of marginally beneficial drugs, and their introduction at high prices to the market. For example, sipuleucel-T (Provenge), a novel immunotherapeutic for metastatic prostate cancer, has been shown to improve median survival by 4 months.[2] Although FDA-approved and currently reimbursed by Medicare, it carries a price tag of $93,000 for the required three doses. If the market consisted of individuals spending their own wealth on marginally beneficial treatments, then that would be acceptable from the viewpoint of an economic purist. However, in the current healthcare market these costs are borne by others in the society, and in Medicare Part B, approximately 70% of the costs are supported by general taxpayer revenues.[3] In this context, discussions related to the value of a life, the benefits that a specific treatment provides, or even the cost of cancer care become a relatively protected sanctuary and another elephant in the room.

The Current Reimbursement Framework—Misalignment of Incentives

The reimbursement system directly relates to the total expenditure on drugs through changes in the manufacturers’ prices and drug utilization. It is based on contracting directly with providers and giving provider incentives. This has resulted in payers abdicating their role as the controllers of cost, shifting this burden to hospitals and physicians. Providers have benefited from this system in several ways. In oncology, based on the current formula that reimburses Medicare Part B drugs at the average sales price plus 6%, prescribing physicians have a perverse incentive to use higher-cost drugs.[4] Although this research study has supported that reimbursement levels did not affect the decision to give chemotherapy or not, once that decision was made, oncologists tended to use drugs...
for which they were reimbursed the most.[5] As costs increased, cost-sharing arrangements (copayments) as a mechanism to decrease utilization became increasingly common, with patients required to pay a fixed share of the cost of the treatment. Out-of-pocket costs for oncology patients have risen at a much greater rate than health plan costs,[6] and “high deductible” plans are becoming more common.[7] This cost shifting to the patients in a nonselective way has resulted in a barrier to accessing care, and data from the US National Health Interview Survey from 2003 to 2006 identified more than 2 million cancer survivors in the US who did not get one or more needed medical services because of financial concerns.[8] Another study has shown that patients with cancer may experience a greater financial burden than patients with other chronic illness, with 13% of cancer patients spending at least a fifth of their income on healthcare and insurance.[9] Still, with this misalignment of incentives, under this system, pharmaceutical companies set the highest possible price for the highly insured majority while offering discounts or patient assistance programs to those who cannot afford the cost-sharing. Patent laws that create monopolies for newly introduced drugs also protect these same manufacturers, allowing them to charge health insurers more than it costs to produce their products.[10] In a true market, a supplier should get whatever price the market will tolerate; however, such a market does not currently exist in healthcare, much less in cancer care. As such, the price charged has little relation to its cost or to its true value as measured from a system-wide perspective. Furthermore, this payment system has also failed to promote evidence-based utilization of drugs. Although there are many evidence-based off-label uses of drugs, there is also an increasing use of off-evidence therapies, as based on extrapolation from limited data,[11,12] and a high demand for therapy by cancer patients. As exemplified by Dr. Eagle’s patient with gastrointestinal stromal tumor who could not receive imatinib (Gleevec), we all face similar discussions in our daily practices. The current system rations care in an irrational way. This irrational rationing is going to worsen, for the costs of the current system are simply not sustainable nor are they justifiable by almost any metric used. In this context, further research and discussion of this topic, such as the one promoted by Dr. Eagle’s article, should always be incentivized.

Financial Disclosure: The author has no significant financial interest or other relationship with the manufacturers of any products or providers of any service mentioned in this article.

References:


Source URL: http://www.physicianspractice.com/practice-policy/cost-cancer-care-there-more-one-elephant-room

Links:
[1] http://www.physicianspractice.com/authors/jonas-de-souza-md