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## A Plan To Fix Cancer Care

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This year, more than 1.6 million Americans — 0.5 percent of the population — will receive a diagnosis of cancer. Their treatment will consume at least 5 percent of the country's health care spending, at a cost that is growing faster than all other areas of medicine. Doctors and patients recognize that this is unsustainable and that we need to change the way we deliver care.

But we need help, and that is why more than 20 prominent members of the oncology community contributed to the drafting of this essay (their names appear below).

Many cancer patients, after getting a diagnosis of a terrifying disease, pursue any potentially promising therapy, regardless of the price. But the main cost driver is the fee-for-service payment system. The more doctors do for patients, the more reimbursement they receive. Surgeons earn more for every procedure. Oncologists typically make more money if they use newly approved drugs and the latest radiation treatments than if they use cheaper, older alternatives that work just as well. (This is because they get paid back the cost of the drug, in addition to an extra 6 percent of that cost — the more expensive the drug, the higher the compensation.)

Some of these new therapies are rightly heralded as substantial advances, but others provide only marginal benefit. Of the 13 anticancer drugs the Food and Drug Administration approved in 2012, only one may extend life by more than a median of six months. Two extended life for only four to six weeks. All cost more than \$5,900 per month of treatment.

Significant costs also come from hospitalizations and emergency room visits that could be prevented with better management of common symptoms. Unfortunately, doctors earn more treating patients for serious problems in the hospital than they do preventing those problems from occurring in the first place.

Five major changes need to occur:

First, over the next few years, the payment system needs to move away from fee-for-service toward a system of bundled payments, in which doctors are paid one fee for all the treatments involved in caring for a cancer patient. This would remove the incentive to prescribe more expensive drugs when older generics are equally effective.

Second, insurers have to give physicians information about where they are spending money.

As crazy as it sounds, most physicians have little ability to track the care they deliver, or how they compare with other physicians who care for similar patients. Costs vary wildly for patients with identical cancers. One study of patients with cancers that had spread throughout their bodies showed that the costs of four months of scans varied from \$1,800 to \$6,400 per patient. Doctors don't have a clear sense of whether the money is going to chemotherapy, hospitalizations or follow-up M.R.I. scans. Armed with better data, physicians can learn how to improve care at lower cost.

Third, any change in payment methods must be accompanied by rigorous quality monitoring to ensure that there is neither under- nor over-utilization of care.

Fourth, we need more "high touch" oncology practices. In these practices, nurses manage common symptoms before they escalate to the point that they require visits to the emergency room, and doctors talk with patients about palliative-care services and end-of-life preferences early on — not in the weeks before death. These services are frequently not paid for by insurers but can improve the quality of care and save significant money by averting repeated tests, hospitalizations and futile, toxic chemotherapy. Insurers need to share the resulting savings, enabling physicians to invest in providing these services.

Fifth, we need better incentives for research. Many expensive tests and treatments are introduced without evidence that they improve survival or reduce side effects, and with poor information about which patients should receive them. For instance, while more than 800,000 robotic surgeries, mostly for cancer, have been performed in the last two years, there is no reliable evidence that the robots either improve survival or reduce side effects — despite the fact that they cost more than traditional surgery. Once interventions are paid for, the incentive for research disappears.

The oncology community cannot make these changes alone. The government is deeply involved and has to help. Today, 60 percent of cancer diagnoses are made in patients who are eligible for Medicare. By 2030, that number will rise to over 70 percent. Medicare and the other payers need to work with oncologists. The secretary of health and human services should organize a working group representing Medicare, private insurers, oncologists, quality experts and patients to figure out how to develop these proposals — with no increase in costs — and start implementing them by the end of 2015. Everyone engaged in cancer care needs to help improve it.

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