

## Oncology's Perfect Storm: The Next Decade

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In this supplement to *The American Journal of Managed Care*, William T. McGivney, PhD, provides a masterful summary of the forces producing the perfect storm for oncology services in the next decade: an explosion of new treatments that are effective but costly; a cresting wave of baby boomers whose age increases their risk for cancer; and a payment system that is already making US businesses noncompetitive within the world marketplace. Infamous lawsuits surrounding bone marrow transplants for breast cancer and superb lobbying by the oncology community have shielded cancer services from managed care and government interventions in the past. Today, healthcare managers can predict cancer costs rising at rates exceeding 20% annually, and they must find ways to curtail spending and improve care. The following 5 major responses are possible in the next decade.

### Transparent Measurement and Enforcement of Adherence to Known Standards

Surgeons performing colorectal resections should remove 12 lymph glands for proper staging, but the literature documents an adequate surgery rate of only 46% of US patients.<sup>1</sup> Reporting each surgeon's performance data for this operation to promote adherence and to inform consumers about their choice of physicians is inevitable—it will be one of many measures.

### Financial Constraints for Cancer Coverage

Dr McGivney mentions coinsurance as a method for patients to participate in the cost of care. Total lifetime maximum coverage may be applied to oncology services, or

copayments may be increased for specific drugs. Payors are reluctant to confront appropriateness issues after the battles of the 1990s, and it is easier to shift the burden of those decisions to patients. Financial constraints will cause patients and physicians to have frank discussions about cost effectiveness.

### Emergence of National Protocols and Registries

Adult oncology is infamous for rapid diffusion of drug use beyond US Food and Drug Administration indications with almost no capture of the results of these renegade treatments. A recent review documented 30% of Medicare beneficiaries receive adjuvant chemotherapy for stage II colon cancer despite American Society of Clinical Oncology expert panel conclusions that adjuvant chemotherapy should not be routinely recommended for colon cancer.<sup>2</sup> Adopting the pediatric oncology community's approach to large national trials or using the Centers for Medicare & Medicaid Services' approach with specific treatment registries can harvest information about new indications much more efficiently than current approaches.

### Managing End of Life

As a plan medical director, I discussed fourth-line treatment for metastatic colorectal cancer to the liver with a patient. He was receiving chemotherapy while on an infusion of dopamine and albumin to maintain blood pressure. It was the oncologist—not

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the patient—who insisted on continuing therapy. It's an anecdote, but a common one. We need to seriously study oncologists' behavior at the end of life and have frank discussions about the appropriate time to end therapy.

**Ending Oncologists' Dependence on Drugs**

A significant portion of oncologists' income comes from chemotherapy, and it is hardly surprising that their behavior is influenced by that fact. This is not to suggest that oncologists should not be paid at present levels, but they should be paid for providing an unbiased view of treatment options and for being an important source of information for patients. All of the changes listed

above will only be incrementally successful unless the reimbursement systems for oncologists are changed.

The previous 5 changes are radical. However, it would be a mistake to assume that the forces coming together will not cause substantial changes in the field of cancer medicine. The protection of the 1990s will not be sufficient for the next storm.

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2. **Meyerhardt JA, Mayer RJ.** Systemic therapy for colorectal cancer. *N Engl J Med.* 2005;325:476-487.