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Editorial

Early Steps in the Value of Cancer Care—Many Paths Remain Unexplored

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The cost and value of cancer care have recently come under close scrutiny. As section editors of this journal, over the past 2 years we ran a series of invited commentaries to provide different perspectives on this crucial issue [1]. In this article, we draw this series to a close—highlighting the issues raised, as well as proposing worthy future areas of investigation.

There were two commentaries from the payers' perspective. Lee Newcomer of United Healthcare proposed that new regulation is needed [2]. He proposed that both public and private payers should have the right to refuse coverage for a highly expensive therapy that provides only minimal clinical benefit. In addition, he proposed that the profit margin for administering a drug should be capped at 18%. He noted that United Healthcare's average payment for community physicians is average sales price (ASP) + 28%, but the average for hospital-owned cancer clinics is ASP + 152% for exactly the same medications. Michael Kolodziej of Aetna responded to the article by Newcomer [3]. He suggested that, because of political opposition, it was unlikely that future legislative changes would allow payers to deny coverage of a U.S. Food and Drug Administration-approved drug. He also suggested that the hospital lobby would be too strong to enable capping of the profit margin.

Goldstein and Sarfaty highlighted different pricing and reimbursement mechanisms used around the world and suggested lessons that the U.S. could learn from other countries [4]. They highlighted the use of cost-effectiveness in the U.K., payment by real world effectiveness in Italy, and the decision-making process when there is a fixed budget available for new drugs, as is the case in Israel. Jeffrey Peppercorn highlighted societal concerns about the high cost of cancer care [5]. He emphasized the importance of clearly distinguishing between patient costs and societal costs. Essentially these are two separate discussions that are frequently intertwined, with very different financial and ethical considerations.

Wollins and Zafar highlighted the importance of communicating with patients about the cost and benefit of cancer care [6]. They highlighted the fact that there is scant evidence about how cost discussions between patients and providers affect patient care or financial toxicity. Dalal and Bruera highlighted the importance of palliative care [7]. They noted that early referral to palliative care improves not only quality of care but also costs of care. Schnipper and Bastian described the current array of value frameworks that have recently been developed by different organizations [8]. They noted that frameworks can potentially influence treatment decisions to favor the use of higher-value drug regimens. The authors also acknowledged that existing frameworks differ in scope and target audience and that such differences prevent comparisons among them. Although far from perfect, frameworks have provided an important opportunity to start the discussions about value. Eaton et al. discussed specific value-based issues related to lung cancer [9]. They emphasized the wide range of clinical benefits available from the vast array of recently approved drugs for lung cancer. They noted low-value clinical decisions, such as using more than two lines of chemotherapy or using positron emission tomography to evaluate response in the metastatic setting.

The original plan of this series was to incorporate articles from additional individuals and stakeholders. Unfortunately, some articles did not reach us in time, and others did not succeed in passing the peer review process. Now that this value series has been completed, it is important to stop and take stock of what the future direction should be. Discussion of value in oncology has largely focused on discussion of drug costs. However, clearly, drugs are only one component of the high cost of cancer care. We need more research into other drivers of high costs. For example, end-of-life care needs to be carefully examined. Hospital and intensive care unit admissions in the last days and weeks of life occur commonly and substantially contribute to costs but provide uncertain clinical benefits. We need to consider more carefully who should receive such therapy and try to guide patients to hospice care in a timely fashion. We need to improve the coordination of care in the outpatient setting to avoid needless hospitalizations. Furthermore, we need to consider more carefully other cost drivers, such as surgeries, radiation, and imaging diagnostics.

This is a challenging time in the field of the economics of cancer care, but with all challenges come opportunities. Under the pressure to contain costs, stakeholders are implementing strategies to improve value by providing higher-quality care. Examples of such efforts include the development of cancer care pathways and investments in precision oncology and early

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cancer detection. Likewise, policy makers have just started to design new value-based reimbursement models, and government officials are beginning to contemplate legislative reform to address the high prices of oncology drugs. Although these measures will require time and effort to yield meaningful results, we hope that they will fundamentally transform cancer care delivery, improve patient outcomes, and reduce costs. As the oncology field rapidly changes, many uncertainties arise. But one notion remains certain: we need to change cancer care from a high-cost to high-value enterprise.

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Editor's Note: See the full collection of articles in the Value in Cancer Care series:

Value: The Next Frontier in Cancer Care
Bernardo H.L. Goulart ***The Oncologist*** 2016;21:651-653; first published on May 25, 2016; doi:10.1634/theoncologist.2016-0174

New Frameworks to Assess Value of Cancer Care: Strengths and Limitations
Lowell E. Schnipper, Alex Bastian ***The Oncologist*** 2016;21:654-658; first published on May 31, 2016; doi:10.1634/theoncologist.2016-0177

Value-Based Care in Lung Cancer
Keith D. Eaton, Barbara Jagels, Renato G. Martins ***The Oncologist*** 2016;21:903-906; first published on June 2, 2016; doi:10.1634/theoncologist.2016-0116

Getting Past No in Cancer Care
Michael Kolodziej ***The Oncologist*** 2016;21:782-784; first published on June 20, 2016; doi:10.1634/theoncologist.2016-0187.

Those Who Pay Have a Say: A View on Oncology Drug Pricing and Reimbursement
Lee N. Newcomer ***The Oncologist*** 2016;21:779-781; first published on June 20, 2016; doi:10.1634/theoncologist.2016-0119

Cancer Drug Pricing and Reimbursement: Lessons for the United States From Around the World
Daniel A. Goldstein, Michal Sarfaty ***The Oncologist*** 2016;21:907-909; first published on July 6, 2016; doi:10.1634/theoncologist.2016-0106

A Touchy Subject: Can Physicians Improve Value by Discussing Costs and Clinical Benefits With Patients?
Dana S. Wollins, S. Yousuf Zafar ***The Oncologist*** 2016;21:1157-1160; first published on August 22, 2016; doi:10.1634/theoncologist.2016-0207

Financial Toxicity and Societal Costs of Cancer Care: Distinct Problems Require Distinct Solutions
Jeffrey Peppercorn ***The Oncologist*** 2017;22:123-125; first published on February 6, 2017; doi:10.1634/theoncologist.2016-0301

End-of-Life Care Matters: Palliative Cancer Care Results in Better Care and Lower Costs
Shalini Dalal, Eduardo Bruera ***The Oncologist*** 2017;21:361-368; first published on March 17, 2017; doi:10.1634/theoncologist.2016-0277

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