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Cancer doctors have opportunities to cut costs without risk to patients, experts say

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In a review article published Feb. 14 in *The Lancet Oncology*, Johns Hopkins experts identify three major sources of high cancer costs and argue that cancer doctors can likely reduce them without harm to patients. The cost-cutting proposals call for changes in routine clinical practice involved in end-of-life care, medical imaging and drug pricing.

"We need to find the best ways to manage costs effectively while maintaining the same, if not better, quality of life among our patients," says Thomas Smith, M.D., The Harry J. Duffey Family Professor of Palliative Medicine and professor of oncology at Johns Hopkins.

Smith and co-author Ronan Kelly, M.D., say that rising numbers of new cancer cases among an aging population are inflating total cancer costs, projected to increase by nearly 40 percent in 2020, and that changing practice patterns should be a priority among oncologists to achieve affordable costs.

"Oncology professional societies, such as the American Society of Clinical Oncology, are beginning to guide oncologists on cost-saving opportunities, but change in routine clinical practice is happening slowly," says Kelly, an assistant professor of oncology at the Johns Hopkins Kimmel Cancer Center.

In the article, Smith and Kelly say the biggest opportunities for safe and ethical cost-cutting solutions rest in caring for patients with metastatic cancer, not on new surgical or radiation treatments, clinical trials,

curative care or pediatric care.

For example, the authors suggest that improving end-of-life care with better decision-making and planning could reap large cost savings by reducing hospitalizations in the last month of life. They note that 25 percent of total Medicare costs are spent in the last year of life; 40 percent of which is spent in the last month of life.

"Most people prefer to spend their last days of life at home with family and friends rather than in a hospital, but we still see high rates of hospital utilization in the last month of life," says Smith. Medicare data show that 60 percent of poor-prognosis cancer patients are admitted to a hospital in the last month of life, and 30 percent die there.

The Hopkins team says studies show that hospice care improves symptoms, helps caregivers and costs less, with equal or better survival for patients, yet only half of cancer patients use hospice in their last month of life.

They recommend that patients with poor prognoses have better and earlier discussions with their oncologists about chemotherapy use at the end of life, as well as transitions to hospice. Decision aids spanning these topics have been developed by Smith and colleagues and are endorsed by the American Society of Clinical Oncology.

Unneeded and expensive imaging poses another opportunity to limit costs of care, Smith and Kelly say. PET and other scans, for example, are often used to detect cancer recurrence in patients after initial treatments, but studies show that cure rates are just as good when recurrences are found through other examinations.

"The oncology community needs to have a greater responsibility in evaluating expensive tests, and limit their use to situations where there is

strong evidence for benefit," says Kelly.

Finally, the authors suggest that reducing prices of new cancer drugs could help contain cancer costs.

"There are drugs that cost tens of thousands of dollars with an unbalanced relationship between cost and benefit," says Smith. "We need to determine appropriate prices for drugs and inform patients about their costs of care."

One approach, they say, could be to price drugs according to how well they prolong life.

"We need to include patients, pharmaceutical companies and legislators in our efforts to contain cancer care costs, so that we can afford to provide innovative, quality care to future generations," says Smith.

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