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PODCAST

Ethics of Cost Containment for Cancer Therapies

Will the Affordable Care Act bring down costs?

By Arthur Caplan, PhD[1] | August 23, 2012

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Interviewed by Anna Azvolinsky, PhD

Today we discuss the ethics of cancer care cost containment with Arthur Caplan, PhD. Dr. Caplan is a former professor of bioethics at the School of Medicine at the University of Pennsylvania and the new director of the division of medical ethics in the department of population health at New York University's Medical Center. Dr. Caplan is an influential voice in science and medicine. His expertise spans medical and science ethics, healthcare policy, and the philosophy of medicine.

In the United States, we are rewarded with the availability of new diagnostics and emerging therapies, but these innovations come with a high price tag and not everyone can afford them. New treatments can range from $120,000 for four immunotherapy infusions over a 3-month period for ipilimumab, a metastatic melanoma treatment, or $4000 to $9000 a month for bevacizumab (Avastin), a monoclonal antibody. The cost of cancer treatment has at least doubled since 1987 and there does not appear to be any hint that cancer care costs will decline in the near to midterm.

Arthur Caplan, PhD

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CANCERNETWORK: Dr. Caplan, what in your opinion are the largest reasons for the continued escalation of costs for cancer treatment?

DR. CAPLAN: Well, there is no doubt that one key reason is sophistication in cancer treatment increased greatly over the past 50 years. We are now seeing biotechnology, genomic information, even new ways of manufacturing present in the development of cancer drugs and treatments so these cost more. If you will, technology comes with a price tag. As you start to target particular types of tumors, particular cells, in particular people, if you move more towards personalized medicine you start to see the price tag go up because the investment in these things is much higher.

It's also because the cost of healthcare has gone up. There's just tremendous inflation in price. There are all kinds of factors—profit, labor costs, litigation costs are folded in there—driving up every price in healthcare so that is part of the story as well. But I do think that it is basically new ways of targeting new drugs that's really the culprit behind price.

CANCERNETWORK: *Do you think there actually has been longer discovery to market timing, in terms of recently approved drugs? It feels like there has been an extension of how long it actually takes for drug companies to develop a product and bring it to market successfully. Or is that just a perception?*

DR. CAPLAN: I think it is a little longer than it used to be, but I don't think it accounts for the huge increase in price. It is somewhat longer. New technologies, new techniques for finding cancer therapies take longer. There are also considerations where recruiting people into trials has become more difficult. It is harder to get people into trials than it used to be. There are all kinds of reasons why that is so, but that is true, and that lengthens the time of studies. Week by week you are talking about adding millions of dollars of added costs. There are also probably even more regulatory hurdles to pass through than there were 15 years ago so that can stretch out the time for getting approval of drugs as well. Time is money, as they say, so that is part of the story.

CANCERNETWORK: *Pharmaceutical companies obviously want to be paid for innovation, and the United States is one of the countries that still rewards this innovation. So in your opinion, and you touched upon this, but is this the main contributing factor for the rising cost in healthcare in the United States?*

DR. CAPLAN: It certainly is a major contributor. Many other countries basically set prices. The United States has attracted innovation (literally bringing companies like Novartis into the United States), seeing a movement of research facilities to Research Triangle Park [in North Carolina] and many other places from Europe, because this is where the money is in terms of getting reimbursement for the cost of innovation and in terms of getting better pay for products that are produced. So US healthcare in a way underwrites the rest of the healthcare market in the world. US consumers are paying, if you will, for the cost of innovation, and that drives up prices. I am not saying that is fair, but that is the way it is.

CANCERNETWORK: *The Affordable Care Act was recently upheld. The new law promises to both lower healthcare costs and provide better quality coverage. Is there a chance that either of these claims will be realized within the next decade?*

DR. CAPLAN: Well the healthcare affordability act puts a lot of weight on the evidence—collecting evidence about what works and what doesn't work and ways to contain costs. I am a little skeptical about that. We have many areas of medicine where we know the evidence for the efficacy of things is low, and yet we pay a lot of money for them. You might say the recent history with some of these new drugs in the cancer space where you might see

Herceptin or Avastin adding months of life—cost is far out of proportion to the literal benefit that is brought. I am not sure that evidence, which is what Obama's health reform is betting on, will both allow us to contain costs and ensure quality. It is almost the case that we have to get more social agreement on what really counts as a benefit. Is a month of life worthwhile? Is 6 months of life in bed and sick worthwhile? Without an agreement on what those benefits are, and how much, if you will, how much payers ought to spend on them, I am not sure evidence alone will do.

CANCERNETWORK: *Right. A majority of the cost of cancer care is at the end of life. Do you see doctors as the main drivers of these costs, willing to give cancer patients anything for a chance of a response rather than perhaps switching to palliative care?*

DR. CAPLAN: You know, I think there are a lot of factors that lead doctors to be aggressive. You don't see the same level of aggression in treatment if you go to the VA where there is a capitated system, you tend to see it where there are insured patients, that means that money is driving some of what happens. Fear of litigation, fear of lawsuit definitely drives aggressiveness. Even misunderstanding the concept of informed consent. Many doctors say to me, "Well, if the patient wants it, I have to do it." Now that isn't true. There is nothing about respect for patient choices that means the doctors has to do things that he or she thinks are futile or hopeless of not worthwhile. But, I fear that all of those factors are leading doctors to be far more aggressive than they should be, for patients whose benefits, really if they are lucky, will be small.

CANCERNETWORK: *Do you see a way to change the mindset of physicians, for the collective good and to lower cost?*

DR. CAPLAN: I think a couple of things could be done. We have to educate physicians to give their opinion to say what they think they would do if it was their mom in that bed, let patients know what their recommendation is, don't be afraid to do that. I think we shouldn't go and ask people for permission to stop care for their relatives. We should come with a recommendation when it is time to stop. How those things are presented is very, very important and can lead to better treatment if we let medical expertise be heard by patients and families. We need to start paying less for procedures and more for the outcome. Just paying to do things is going to drive our bills up as it has and will continue unless we get away from it. Certain types of co-pays I think are important—letting the patient feel more of the fiscal burden is important and also having an ethic that says there is nothing wrong with palliative care. You are not abandoning someone, you are moving them into a different situation. We can make some of those changes, malpractice reform as well, and then I think we can get a better handle on cost.

CANCERNETWORK: *Particularly for cancer treatment and even prevention, emotion, politics can trump our rational thinking and evidence. Do you see cost-effectiveness research as something that will slowly help guide the rational treatment decisions?*

DR. CAPLAN: Well, if you look at things like mammography, we have some evidence that it is not useful, and it may even be dangerous for women to get annual mammograms from 40 to 50, but they haven't stopped. There has been so much emphasis on the virtue of doing that, so many people committed to getting women to do that for so long that the evidence alone has not been enough to stop what may be bad practice in terms of prevention and surveillance. So you have to explicitly attend to the ethical side as well as the evidence side in prevention in cancer, or in any other area in medicine, because if you tell people its virtuous to get a mammogram and it's the right thing to do, and it's the responsible thing to do, and you tell them that for 20 years and then you just provide evidence that says, Oops, maybe not, that alone isn't going to change behavior.

CANCERNETWORK: *How do you see the patient–doctor or family and doctor dynamic play into this?*

DR. CAPLAN: I think we are going to need to have more time paid for with patients. We are going to need to have more primary care people trained and to make that more lucrative to go into for medicine and we are going to need more physician extenders, roles for nurses, pharmacists, and physician assistants, we don't really have the man power to do good patient management. Right now we are really good at doing extreme things for very, very sick people, but if we are going to save money and also prevent some of the disease and get at some of the behavioral causes of cancer, we are going to have to do a better job on primary care. That is going to take people and money in that area.

CANCERNETWORK: *Anything else you would like to add in general about cost containment and cancer treatment?*

DR. CAPLAN: I think the other thing that is important in cancer treatment is to have discussions early about when you are going to stop things. I think patients deserve to know right from the start, and their families, if you initiate a particular regimen of treatment, it may be stopped if the patient doesn't respond or doesn't flourish. There is nothing more inimical to cost containment to being very aggressive, and then all of a sudden out of the blue announcing to the family and the patient, "now we need your permission to stop, that didn't work." The earlier you can start discussions of stopping when you begin things the earlier you can raise the possibility that things may not work and we may have to go to a different strategy, I think the better off patients and families will be.

CANCERNETWORK: *Thank you so much for joining us today, Dr. Caplan.*

DR. CAPLAN: My pleasure!