The Fifth “C” Is Cost: Highlights From ASCO 2011

In a highly memorable marketing campaign, the diamond wholesalers De Beers thoughtfully created a system of 4 “C”s—color, cut, clarity, and carats—to help guide shoppers purchasing a diamond engagement ring. Those who have participated in this cultural ritual, however, know that the crucial C is the fifth one: cost. Being the season for ASCO highlights, this editorial discusses 2 interesting presentations that centered on cost in 2 very different clinical circumstances.

Early-stage breast cancer is among the most common of all cancer diagnoses and is particularly prevalent among older women. For many reasons, older women with breast cancer have better prognoses than younger women: the distribution of breast cancer subtypes in older women is more favorable; most breast cancers in older women are estrogen-receptor positive and thus sensitive to adjuvant endocrine therapy; and older women are at greater risk for health problems not related to cancer, which can dilute the impact of the cancer itself.

Hassett et al. [J Clin Oncol 2011;29(Suppl 1):Abstract 6001] used the fee-for-service Medicare registry to examine costs, quality benchmarks, and outcomes for women 65 to 70 years old diagnosed with breast cancer between 1997 and 2005. They compared rates of compliance with quality measures, including 20 recommended therapies and 7 therapies recommended against. Overall compliance was high (> 80%), and overall outcomes were excellent (≥ 85% of women alive at 5 years). To explore interactions among compliance, outcome, and cost, the authors distributed the 15,357 cases into quintiles of median expenditure and analyzed costs and outcomes by quintile. A trend suggested that greater concordance with “recommended against” guidelines was associated with lower cost. However, the cost varied hugely, with median cost per diagnosis ranging from $17,319 to $27,233—a variance of nearly 60%. At the same time, no difference in outcome was found by cost quintile (i.e., amount spent per patient had no bearing on long-term results).

The study has limitations. One could argue that the appropriate therapy was delivered and that higher cost was needed to assure good outcomes in trickier cases, for instance. That favorable outcomes in these older women may mask subtler differences observed in younger women or different patient populations is also true. However, the aggregate findings suggest that variance in costs of care in this population does not yield substantial differences in outcome. The next step will be to accomplish high-quality care without spending as much money.

The other presentation, by De Souza et al. [J Clin Oncol 2011;29(Suppl 1):Abstract 6002], addressed patients with metastatic colorectal cancer receiving antineoplastic therapy. In this study, the investigators examined treatment in more than 1000 cases of advanced colon cancer in a UnitedHealthcare database. They concentrated on treatments delivered after prior progression with the same or similar agents, practices that were specifically recommended against in the NCCN Guidelines because they were known to be ineffective or to lack any efficacy data. These included bevacizumab beyond progression with bevacizumab, capcitabine after fluoropyridimidine regimens, and panitumumab or cetuximab after prior epidermal growth factor receptor (EGFR) inhibitor treatment. Despite the NCCN Guidelines admonitions, many patients received non-recommended treatments (10% received bevacizumab, 16% inhibitors, and 49% capcitabine). Costs for these therapies alone averaged nearly $2000 per case.

How these treatments affected outcomes or quality of life is not known. However, this study again suggests that cost containment could be achieved without significant impact on quality of care. Undoubtedly, we can learn much from these experiences, which could inform better clinical decision-making and help optimize care both for an early cancer diagnosis and for late stage cancer management. Containing costs is a looming challenge in medicine; these initial reports are pieces of a mosaic that may begin to suggest where and how one might go in oncology. One shared feature in both papers is the sense that guidelines—particularly those that articulate strong “do not do this” recommendations—can offer ways to make cancer care less expensive without making it less effective.