

ADVANCES IN DRUG DEVELOPMENT

Current Developments in Oncology Drug Research

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Rationing Cancer Care: the Emerging Debate

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H&O Can you provide some background on the current state of cancer care costs?

DC The most important thing to be said is that with the growing elderly population, the cost of cancer care is increasing very rapidly. The National Cancer Institute (NCI) has projected that there will be a 27% increase in healthcare costs between the years 2010 and 2020, from \$125 billion to \$158 billion or even higher. The NCI believes that the aging of society is the main factor driving cancer care costs. The key problem in regard to cancer care is that there are no large-scale cures for cancer. There are certainly cures for some cancers, but overall, cancer has not been cured, and the main cost originates from the success of cancer research and the care provided to keep people with cancer alive longer. In my opinion, this is the ultimate ironic dilemma—that it is the very success of allowing people to survive longer which itself is the major source of the cost problem. There are a number of cancer therapies that are very expensive (\$35,000 to \$100,000) and whose benefits are comparatively slight (they extend life by a few months). These dramatic costs have forced us to think about the role that cost plays in cancer treatment. The larger problem, apart from the expensive drugs, is that people with cancer are kept alive by continued treatment over a long period of time. The treatments work and patients live longer, but not inexpensively.

The subject of rationing medical care arises because these costs are becoming paramount, and the Medicare program is on an unsustainable economic path. Rationing care for the elderly becomes a consideration because this is the largest group needing cancer treatment.

H&O What is healthcare rationing?

DC One can talk of rationing in 3 ways. One way is direct rationing. This refers to a federal program or private insurance refusing to pay for medical care because of its cost or its value in relation to cost. Currently, Medicare is forbidden by Congress to use costs in its calculations, although I think it manages to obliquely incorporate such considerations. Medicare is constantly faced with questions of whether to provide certain types of treatments and whether to pay for them. Direct rationing would base these decisions on the money spent in relation to the benefit achieved. Another type of rationing—indirect rationing—refers to copayments and deductibles. These 2 methods force people to spend more of their own money for treatments and services. Both Medicare and the private insurance industry use these techniques. I think of copayments and deductibles as rationing because the goal of the government and the private sector is to keep costs down, thereby forcing the user of the service or benefit to pay more out of pocket.

The third type of rationing is covert rationing. This was seen in the United Kingdom in the 1950s–1970s. Without any written formal basis, physicians developed their own rules against providing patients over the age of 55 with dialysis or expensive heart procedures. This was handled by telling patients there was nothing that could be done—physicians did not tell patients that the reason was economic; they let them believe that no treatment was actually available. The government did not officially sanction this practice, but the fixed budgets had limited available funds, and it was well known that heart procedures and dialysis were very expensive procedures. It is not unimaginable that this type of covert rationing could happen in the United States as well.

H&O What is your stance on rationing of medical care?

DC I think that, at least for the public Medicare program, we have an obligation to help young people become old but not to help old people become indefinitely older. I do not see an obligation on the part of society to provide care regardless of age and cost so that every elderly person can get whatever care they might need or want. At some point, it is necessary to draw the line. So far, this has been avoided mainly because no one wants to make these decisions. However, I do think the time has come and not only because of the cost of the Medicare program, which is one of the largest components of the federal budget, but also because it is not clear how much benefit the patients are actually receiving from many treatments.

H&O What are the arguments against age-based rationing?

DC One of the main arguments against age-based rationing is that it seems unfair to treat the elderly any differently from any other age group. The elderly have contributed in taxation to the Medicare program and they deserve to collect the benefits. One thing that is not widely known, based on a recent study, is that the average person will get back 3 times as much in financial benefits out of the Medicare program than they actually contributed to the program as workers. Therefore, the argument that elderly patients have paid into Medicare and should get these benefits later in life is not accurate.

Increased taxation has been a suggestion by opponents of age-based rationing. However, what is often forgotten is that the population that is presently using Medicare is not paying for it. It is the children and grandchildren of the elderly that are being taxed, and it becomes an excessive burden for young people. It is evident that in our society one of the ways to deal with the financial problem of Medicare is to raise taxes, but there has been tremendous resistance to this both from liberals and conservatives. Also of note is that the ratio of workers to retirees is changing. Currently, there are approximately 4 retired people over 65 years of age for every person that is still working and paying taxes to support Medicare. This ratio is expected to change over the next 20 years, resulting in significantly fewer workers paying the taxes for significantly more elderly people. When we think about rationing we need to ask ourselves: If we do not want to ration medical care, then who is going to keep paying for it?

H&O What are the long-term benefits of rationing medical care?

DC The main long-term benefit is to save the Medicare program. The recent reform legislation has built-in provisions to reduce payments to Medicare beneficiaries and to hospitals and physicians who care for the elderly. The political problem is that the long-term fate of the legislation is uncertain because the Republicans have said that they want to kill it. It will probably take 10 years to see how this will play itself out. The Trustees of the Social Security and Medicare Trust Funds had said earlier that the program has approximately 8 years to go before it will run out of money. With the reform legislation, the most optimistic estimate is that the program may last 17 years. The need for rationing is the long-term solvency of the program; if we do not institute a rationing program, then we need to either force people to pay more taxes or cut benefits, or do a combination of both.

H&O How do we go about setting limits? Is it possible for the United States to put in place an institution like NICE in the United Kingdom?

DC I think the British system of the National Institute of Health and Clinical Excellence (NICE) is the best approach. The aim of NICE was not specifically to ration healthcare, but to assess the quality of new technologies as well as the cost burden of introducing those new technologies. This program runs fairly well, and only approximately 5% of NICE's recommendations are negative. Many do, however, argue that NICE has driven the cost up, since there are a lot of things that they decided would be good for patients that were not being provided in the past. NICE does not automatically lead to rationing or cost cutting, but some of its decisions are moving in that direction. I think that it would be great if the United States creates committees like NICE to mandate cost controls.

H&O Taking into consideration both sides of this debate, what do you think is the best possible cost savings approach?

DC I think the situation is very difficult. Among political conservatives, there is a situation where on one hand they want to find a way to reduce the cost of these expensive programs, particularly Medicare—which is one of the most expensive—but on the other hand, any propositions for cost control are disputed. It is a contradictory position to hold, so we first have to resolve this issue. Even on the lib-

eral side there is no enthusiasm: there are some who worry that if we begin rationing, we will reduce quality, and both liberals and conservatives are worried about interfering with the doctor-patient relationship. Most people do not agree with committees making these decisions; they would rather have doctors/patients making them.

The pharmaceutical industry has never been happy with the idea of rationing, due to the possibility of price controls. Thus, there is an interesting combination of some physician resistance to rationing as well as industry resistance. Both the liberal and conservative groups have been less than eager to get into this battle, and it has been known for years that politicians do not want to discuss the idea of rationing.

There are some who say we have to change the current system because there is no other way to control medi-

cal costs. However, there is too much political resistance, and I think that it is going to be very hard to institute direct rationing. For this reason, indirect rationing might become the more common type of rationing strategy; surprisingly, there are fewer complaints about higher premiums than there are about direct rationing.

Suggested Readings

Callahan D. *Taming the Beloved Beast: how medical technology costs are destroying our health care system*. Princeton, NJ: Princeton University Press; 2009.

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