Cancer and Healthcare Reform: Making the Pieces Fit

The Opportunity
The public tends to think of healthcare reform as being primarily about healthcare coverage for the uninsured. Certainly, that is one of its most important features, and it will likely bring about striking changes in the broad healthcare marketplace. Based on an “intent to buy” survey we conducted, we expect roughly 39 million of those currently uninsured to enter the market in the next few years, bringing with them $150 billion in annual buying power. But there has always been more to reform than signing up the uninsured. The economic forces set in motion as these consumers buy coverage will lead to a dramatic transformation in how care is delivered, therapeutic area by therapeutic area. The hope is that competition and the new business models enabled by the Affordable Care Act will tame the relentless medical inflation that has marked the past two decades and will make healthcare affordable for Americans.

Few segments of medicine will be more affected by healthcare reform than oncology. The cancer marketplace is ripe for change, the sort of change that leads to better care for patients, lower costs, and—for provider organizations capable of reinventing themselves—greater profitability. The aging of the American population and advances in treatments are expanding the prevalence and the cost of the disease. The US cancer market has been growing strongly at more than 5% per annum in recent years, and cancer-related spending looks set to surpass $100 billion in the next 5 years (Figure 1). This is partly a product of the aging of the population, which has increased the number of people diagnosed with cancer. Within the next 5 years, cancer will surpass heart disease as the leading cause of death in the United States, and cancer will be diagnosed in one in every two men and in one in three women. But the growth in the cancer market is also related to the availability of breakthrough treatments that let many patients live—and receive treatment—longer, thereby increasing both the prevalence and the cost of the disease.

Cancer is a growth market
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Brand excellence leads to expansion
Healthcare organizations have a great deal to gain from delivering superior cancer care and building brand equity. Cancer patients value clinical excellence and are willing to travel to access high-quality care. And organizations with a reputation for excellence have consistently expanded both their market share and their geographic service area. This pattern of brand excellence leading to market dominance is seen in a number of major European and American cities.

Clinical and patient care excellence changes the game
As policy makers, health plans, government sponsors, and employers struggle with the affordability of healthcare, the market is poised for a historic shift. The fee-for-service model, in which the more you do the more you make, will give way to a fee-for-value model, in which payment models and profit dynamics are tied to performance and outcomes. Imagine a world where physicians collaborate on an integrated value-based treatment plan and work with patients to set the optimal course—hospice care instead of surgery for some late-stage lung cancer patients, or informed decision making for patients with prostate cancer, or more consistent use of evidence-based guidelines for chemotherapy.

This move to value is being driven by the groups that ultimately pay for health benefits—sponsors and consum-

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The Existing Model Is Broken

When we think about the delivery of cancer care in the US healthcare system, an old Irish saying comes to mind: “If you want to go there, you shouldn’t start from here.” The existing system, for all its achievements, is in no way aligned to deliver consistently excellent cancer care at an affordable cost. Outcomes are good by international standards, but they vary widely, and they are costly (Figure 2). Patient experience varies as well.

Cancer treatment involves a lot of moving pieces: physicians, treatment options, and delivery sites. In most models, the job of managing those pieces is left to the patient. In addition, the specific treatment requirements of different tumor sites and stages vary greatly, forcing cancer practices to stretch their organizations to be flawless and diligent at routine activities (such as breast screening programs), while at the same time coordinating the most advanced technologies.

The complexity of cancer treatment means that many patients are ill-served by the existing fragmented provider systems. Patients can find themselves being passed—without coordination—between independent diagnostics organizations, major acute hospitals for surgery, and even treating physicians. The result: many provider networks fail at what should be considered basic, threshold capabilities—and “value leakage” in cancer care is surprisingly high. Top sources of this sort of leakage include:

• Limited control of practice variation across the whole continuum of care.

Data from: American Hospital Association; SEER Cancer Statistics (http://cancercontrol.cancer.gov/prevalence/prevalence.html#survivor); Medical Expenditure Panel Survey (http://www.meps.ahrq.gov)

*aHeart disease is defined as coronary artery disease and/or congestive heart failure.

*bA complete course of chemotherapy or radiation therapy is counted as one visit.

Figure 1: Cancer Care Market Value Trends and Market Opportunity—The increase in the prevalence of cancer shown in graph A is reflected in the increase in cancer-related expenditures, which is highlighted in graph B. CAGR = compound annual growth rate; COPD = chronic obstructive pulmonary disease; SEER = Surveillance, Epidemiology and End Results.
Absence of recommended molecular profiling and personalized medicine.
- Limited multi-disciplinary treatment planning and collaboration.
- Limited patient navigation.
- Inconsistent supportive care and survivorship care.
- Gaps in clinical information needed to enhance decision making.
- Absence of quality assurance systems aligned across all modalities.
- Insufficient access to clinical trials.
- Sub-scale depth in specific tumor sites and related treatment options.

It is no surprise that four of the top ten cancer hospitals in the US News and World Report rankings are cancer-focused centers, and that none are community-based. These centers offer focus, scale, technology, training, patient programs, and immersion in clinical trials and the science of cancer treatment, all of which are directly correlated with program excellence.

In a fee-for-value marketplace, America’s cancer practices will be challenged to deliver excellence and to change the value formula; on the basis of our client work, we are convinced that a reasonable goal is 10% more value for 20% less cost. Without continued improvement in cost and quality, coverage will become unaffordable.

**Delivering Cancer Excellence and Winning in a Value-Based Marketplace**

A cross-section of leading cancer organizations from Europe and the United States have pioneered excellence in cancer care and fundamentally changed the value equation for their patients. They have adopted a value-based care formula in which oncology practices become total patient managers, taking on clinical risk and accountability for defined tumor-specific performance expectations. We have summarized here a few of the most critical ingredients of this new formula.

1. **Take a network strategy perspective, not an individual facility perspective**

Leading organizations recognize that cancer care has to be delivered by a network of integrated capabilities, often across multiple sites, including alliances with key partners that deliver unique local care capabilities. They very deliberately build these networks to run deep, including not just agreements to coordinate activities, but also true shared capabilities: integrated information technology (IT) and patient tracking systems, shared quality assurance platforms, joint clinical excellence programs, and so forth.

They ensure that patients flow through the facilities best able to support their care needs—even if this runs counter to the interests of individual sites—and they make tough decisions on where to concentrate volumes in their network to leverage scale effects.

2. **Develop true network and care integration infrastructure**

The best players invest substantial time and effort building “invisible” infrastructure to ensure that their networks operate efficiently—quality systems and dashboards, patient navigation programs, aligned informatics and cancer-focused IT systems, aligned evidence-based medicine (EBM) guidelines, and network management structures, to name but a few. This is hard for provider networks to do well: culturally, they would much rather spend their money on capital equipment. But infrastructure can have a greater effect on quality of care than a new scanner or surgical suite. Once in place, it not only supports care but also attracts partners who can “plug in” to the network as true integrated team members.

3. **Rapidly integrate the latest technology and research**

Whether it is deploying a molecular profiling capability with the latest mutation panels, evaluating the benefits of lung spiral CT screening for 30 pack-year smokers over 50 years of age, or rolling out intra-operative radiation therapy (IORT) for breast cancer patients, the leading players are always...
seeking to be responsible first movers. A critical ingredient in the ability to be in the forefront of innovation is strong partnerships with research organizations that can assist in the deployment, as well as offer access to clinical trials.

4. Have a “total care” mindset
The cancer organizations that we admire most believe in a holistic approach to patient well-being. Whether it is thinking about how a breast cancer screening facility can be made to look non-clinical and homey, figuring out the best way to escort a patient into the treatment suite, setting up charities to fund survivorship programs, or never failing to call patients at home after treatment to see how they are doing—the best players excel at this. It is core to their culture and permeates all they do.

5. Set the framework for continuous improvement
Cancer is complex, and it takes time and management and clinical attention to develop excellence in treating it. The best organizations strive to codify what they do well as much as possible, so it can be replicated (and improved on) as quickly as possible. Taken to its logical conclusion, process replication and improvement result in “franchise models” that codify excellence across many dimensions in a detailed “cookbook”—key process maps, facility specifications, lab and ancillary services turnaround times, quality and management performance indicators, IT system specifications, aligned protocols, staff training and enculturation programs, and so on.

6. Commit to an evidenced-based approach
Evidence-based guidelines, when integrated with a collaborative clinical culture, are the path to reducing practice variability and improving quality. It is not that evidence-based medicine is a panacea, but that it provides a foundation for more consistent care and a basis for beginning the discussion about optimal patient treatment plans. Indeed, without consistency in practice it is nearly impossible to evaluate the effectiveness of tumor-stage–specific treatments. Over time, leading oncology practices will consider evidence-based guidelines in conjunction with cost-value data to improve the quality of care for their patients. And in the long run, practices will integrate personalized medicine and health factors to create guidelines for smaller and more narrowly defined segments—segments that factor in not just tumor and stage, but age, lifestyle, comorbidities, drug metabolism, and more.

As practices get comfortable with an evidence-based approach—supported by electronic health records—they will dramatically improve both the speed and effectiveness with which they manage clinical trials and integrate new treatments into practice.

7. Commercialize the differentiated clinical performance through consumer-driven growth and strategic pricing
Health plans, consumers, and referring physicians will recognize improvements in quality and value and reward oncology practices through new patient volume and different pricing or value-capture models. Over time, cancer services will come to market as discrete service offerings and a clear value proposition—for example, total care for stage II breast cancer with top decile survival rates. Differentiated services are likely to be rewarded in the market as oncology practices begin to compete on value.

Turning the New Model Into Reality
The vision of the future is compelling, but the path to value is difficult and presents many real barriers. Cancer service leaders must create the vision, embrace the change agenda, and drive the roadmap in order to make the strategic and clinical changeover to value. Make no mistake, leading and driving organizational change is a heavy lift—and the real work is in the execution. A few hard-earned “lessons learned” follow:

- Share the vision (deeply) with the full physician group. Make the case for change compelling, and be clear about the practice and economic implications.
- Recognize the scale and nature of the change and plan realistically. Think about cash flow implications, information systems work, shifts in the patient management model, etc.
- Redefine the organization to include the network of services you need to deliver excellent, integrated, patient-centered care; keep the patient as the point of departure.
- Change the performance management and reward systems to align practice behaviors to new patient-centered clinical goals.
- Focus on the business’s new information needs, providing performance feedback and integrating patient information across the delivery network. You need strong, robust economic data (patient flows, referral patterns, revenues by modality, a value perspective across tumors) and clinical data (quality metrics, outcomes, physician activity). Without them, the effort is flying blind.
- Move to a partnered leadership model in which clinicians and practice managers work together to improve clinical quality while making patient care more affordable; both leadership perspectives are critical.

Implementing the new model will challenge the very fabric of the organization and will require a committed leadership and aligned clinicians to make the change. Knowing what to do is very different from knowing how to drive the required change. This is why many organizations talk about the new model, but so few practice it.

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