THE FUTURE OF CANCER CARE: MAKING THE PIECES FIT

CANCER CARE IS RIPE FOR TRANSFORMATION. BUT THE CHANGE WILL NOT BE EASY OR FAST, REQUIRING FUNDAMENTAL SHIFTS IN CLINICAL EXCELLENCE, ORGANISATIONAL APPROACH, INFRASTRUCTURE AND STRATEGY THAT MUST FIT TOGETHER IN PROFOUND NEW WAYS.

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“You have to understand”, a frustrated cancer service line manager at a major international hospital system once told us, “most hospital managers don’t even see cancer on the priority list—it’s fragmented, complex and far away from the cardiovascular dominated world in which they grew up.”

But as anyone who works in health provision already knows, this picture is changing. According to the American Cancer Society and LiveStrong, cancer is projected to become the leading cause of death worldwide and currently accounts for the largest economic costs of any cause of death worldwide. Cancer will be diagnosed in one-in-two men and one-in-three women. It is estimated today by the Economist Intelligence Unit that at least $151 billion is spent on direct medical costs alone for cancer worldwide, with a further $19 billion spent on research. Furthermore, the number of new cancer cases worldwide is expected to increase from 12.9 million in 2009 to 16.8 million in 2020 and 27 million in 2030.
THE IMPERATIVE

Few segments of medicine will be more affected by new health legislation, new technology and demographic shifts than oncology. The cancer landscape is ripe for change, the sort of change that leads to better care for patients, lower costs and—for provider organisations capable of reinventing themselves—greater market participation. The aging of the population and advances in treatments are expanding the market. Leading oncologists have recognised that a major opportunity is emerging to change the value formula at a time when governments, insurers and patients alike are looking for more value. In fact, a few leading cancer service organisations have figured out how to increase the value of cancer services (measured in terms of improved outcomes and greater patient satisfaction), while decreasing the cost by 10—20 percentage points.

When viewed through the lens of healthcare value and affordability, cancer is a high-opportunity area—but to take advantage of the opportunity, fundamental change is required. Drivers of growth and change include the following:

THE NEED FOR CANCER CARE IS DRIVEN BY STRONG FUNDAMENTALS

The aging of the population has driven strong growth in the European cancer market and is a trend that will continue for the foreseeable future. Cancer is currently the second leading cause of death in most countries in Western Europe and, given global trends, will likely surpass heart disease as the leading cause of death in the near future. But the growth in cancer services is also related to the availability of break-through treatments that let many patients live—and receive treatment—longer, thereby increasing both the prevalence and the cost of the disease.

REPUTATION AND EXCELLENCE ARE RECOGNISED BY PATIENTS

Healthcare organisations have a great deal to gain from delivering superior cancer care and building a strong reputation (“brand equity” in business jargon). Cancer patients value clinical excellence and are willing to travel to access high-quality care as shown in Exhibit 1. Organisations 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 cities.

CLINICAL AND PATIENT CARE EXCELLENCE CHANGES THE GAME AND HAS BETTER ECONOMICS

As governments, taxpayers, commissioners and employers struggle with the affordability of healthcare, the cancer landscape 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—governments, insurers and taxpayers. The latter group has traditionally not had a great deal of influence but that is changing as the availability of information through online media fuels consumer activism. Hospital organisations stand to gain much by meeting these challenges—but only if they can develop a deep understanding of the clinical economics of complex cancer care and then build systems that deliver both excellence and value. The stakes are high and the clinical change agenda is complicated, but those who take the lead will have an advantage in the increasingly value-based environment.

THE EXISTING MODEL IS BROKEN

The existing system, for all its achievements, is in no way aligned to deliver consistently excellent cancer care at an affordable cost. Outcomes vary substantially across European countries and anecdotal evidence suggests quality is variable as well. This is especially true at smaller hospitals that have trouble keeping up with the latest technology or are not geared up to deal with higher acuity cases.

Patient experience varies as well. Cancer treatment involves a lot of moving pieces: physicians, treatment options and delivery sites. In many situations, the job of managing those pieces is left to the patient. In addition, the specific treatment requirements
of different tumour sites and stages vary greatly, forcing providers to stretch their organisations to be flawless and diligent at routine activities (such as breast screening programmes), 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—with limited coordination—between treatment sites and across different treating physicians. The result: many provider networks fail at what should be considered basic, threshold capabilities. Top areas of deficiency in European systems include (we recognise that these vary in applicability for different systems):

- Limited control of practice variation across the whole continuum of care.
- Absence of consistent molecular profiling and personalised medicine.
- Limited prospective multi-disciplinary treatment planning and collaboration in non-academic settings.
- Limited patient navigation (detailed tracking of patients through care and for many years afterwards).
- Inconsistent supportive care and survivorship care, without funding mechanisms.
- Gaps in clinical information needed to enhance decision making.
- Absence of quality assurance systems aligned across all modalities and focused on cancer (rather than focused on all activities within a hospital).
- Insufficient access to clinical trials.
- Sub-scale depth in specific tumour sites and related treatment options.
- Suboptimal patient experience (focus of clinics only on clinical and functional flow).

WINNING AT CANCER EXCELLENCE WHILE DELIVERING VALUE

A cross-section of leading cancer organisations from Europe and the United States have pioneered excellence in cancer care and fundamentally changed the health and value equation for their patients. They have adopted a value-based care formula in cancer clinics and become total patient managers, taking on clinical risk and accountability for defined tumour-specific performance measures. As shown in Exhibit 2, the most successful organisations are outpacing the rest. We have summarised here a few of the most critical ingredients of this new formula.

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

Leading organisations recognise 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, some 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 excellence 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 organisations that can assist in the deployment, as well as offer access to clinical trials.

EXHIBIT 2: THE WIDENING GAP
Hospitals which are pioneering excellence are outpacing those which are not

Selected NHS trust cancer admitted episode and patient growth, 2005-2009

Source: NHS HES database; Oliver Wyman analysis
Note: Admitted patients only; Distinct patients with ICD codes Cxxx or D0xx in diagnosis considered; All episodes from selected patients considered; Calendar year date ranges used; Trusts with fewer than 2,000 patients or 10,000 episodes truncated; Only trusts in existence in both 2005 and 2009 considered
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4. Have a “total care” mindset

The cancer organisations that we admire most believe in a holistic approach to patient well-being (See Exhibit 3). Whether it is thinking about how a breast cancer screening facility can be made to look non-clinical and more welcoming, figuring out the best way to escort a patient into the treatment suite, setting up charities to fund survivorship programmes, 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 as well as management and clinical attention to develop excellence in treating it. The best organisations strive to codify what they do well as much as possible, so it can be replicated (and improved upon) as quickly as possible. Taken to its logical conclusion, process replication and improvement result in “clinic 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.

EXHIBIT 3: OVERVIEW OF A VISION FOR CANCER EXCELLENCE

World class care involves treating the whole patient and carers, not just the tumour

Source: Oliver Wyman analysis
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 tumour-stage-specific treatments. Over time, leading cancer centres 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, centres will integrate personalised medicine and health factors to create guidelines for smaller and more narrowly defined segments—segments that factor in not just tumour and stage, but age, lifestyle, co-morbidities, drug metabolism, and more. As centres 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. Capture the benefit of clinical excellence and better economics through transparent outcomes and cost effectiveness measures

Governments, taxpayers, insurers, patients, employers and commissioners will recognise improvements in quality and value and reward cancer service providers through new patient volume and different pricing or value-capture models. Over time, cancer care will come to commissioners as discrete service offerings with 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 as cancer centres begin to differentiate on value.

TURNING THE NEW MODEL INTO REALITY

The vision of the future is compelling, but the path to excellence and better value is difficult and presents many real barriers. Cancer service leaders in hospitals and commissioners 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 organisational change is a heavy lift—and the real work is in the execution. A few hard-earned “lessons learned” for hospitals considering change follow below and in Exhibit 4:

- Share the vision (deeply) with the full physician group. Make the case for change compelling, and be clear about the practice and economic implications.
- Recognise the scale and nature of the change and plan realistically. Think about economic implications, information systems work, shifts in the patient management model, etc.
- Redefine the organisation to include the network of services you need to deliver excellent, integrated, patient-centred care; keep the patient as the point of departure.
- Change the performance management and reward systems to align practice behaviours to new patient-centred clinical goals.
Focus on the clinic’s new information needs, providing performance feedback and integrating patient information across the delivery network. Take a data-based approach and underpin the network with strong, robust economic data (patient flows, referral patterns, revenues by modality, a value perspective across tumours) 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 organisation 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 organisations talk about the new model, but so few practice it.
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