Re: Cost of Care for the Elderly Cancer Patients in the United States

We thank Yabroff et al. (1) for highlighting the cost of care for elderly cancer patients in the United States. With the growth and aging of the US population, the prevalence of cancer will increase, as will the cost of cancer care to the Medicare program. This study highlights the need to develop more age-appropriate treatment protocols that take into account health-related quality of life and psychological well being, as well as physical outcome measures.

The authors found that the costs of care varied by tumor site, phase of care, stage at diagnosis, and survival. Although segmenting the costs by the above factors may help to project the impact of interventions to improve prevention, screening, and treatment on costs of care and survival, we would like to put forth individualized care as the key to optimal outcome with potential lower costs. The aging population is diverse in terms of life expectancy and treatment tolerance, but this diversity is poorly reflected in chronologic age. A more reliable assessment of physiologic age may be obtained by a comprehensive geriatric assessment that involves function, comorbidity, nutritional, social, and economic needs (2). In addition, a comprehensive geriatric assessment may unearth conditions, such as malnutrition, mild memory disorders, inadequate care provided by a caregiver (which may compromise access to care), and treatment outcome (3). Older patients with cancer have been shown to be more likely to require functional assistance than those without cancer (4). Since its beginning, the Geriatric Oncology Consortium has designed clinical trials for older individuals that are based on physiologic rather than chronologic age. The Geriatric Oncology Consortium and the National Comprehensive Cancer Network also recommend that all individuals aged 70 years or older should undergo a basic comprehensive geriatric assessment before any form of cancer prevention and cancer treatment is initiated. The small investment in the comprehensive geriatric assessment, which has already proved extremely useful in preventing functional decline in older individuals, may result in saving a substantial amount of money by selecting patients who are most likely to benefit from antineoplastic treatment and by preventing serious and costly therapeutic complications.

Because most of our current treatments will benefit the patient overall, they will also produce some measure of adversity. For older cancer patients, many of whom may be affected by comorbid health conditions such as heart disease, diabetes, and arthritis, adverse effects from cancer treatment can have a profound impact on their health and quality of life. Thus, we strongly encourage the incorporation of comprehensive geriatric assessment into research studies for older patients with cancer to improve our ability to individualize treatment and improve the outcome of older patients with cancer. The Geriatric Oncology Consortium (www.thegoc.org), an organization created to focus on advancing geriatric oncology research, and the H. Lee Moffitt Cancer Center consider one of our research priorities to incorporate geriatric assessment into research trials and to assess its impact on the costs of care in the older cancer population.

Geriatric oncology is a field with much room for research and education and will be one of the greatest challenges of this century.

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Response
We agree with the points raised by Balducci et al. in their correspondence and also by Balducci (1) that measures of physiological age, rather than just chronological age, are important in treatment decision-making and outcomes in elderly cancer patients. Our population-based estimates of the average cost of cancer care in the elderly in the
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and comorbidity (2). We believe that future work estimating the costs of cancer care that considers such factors, including functional status, comorbidity, social support, patient preferences, and quality of life, will be an important part of a geriatric oncology research agenda. Implementation of this research agenda may be difficult, however, because such patient data are not routinely collected or measured in a single large data source. Few observational databases, including the linked Surveillance, Epidemiology, and End Results (SEER)–Medicare data used in our study (2), include all of these important measures and all types of health care costs. These measures and costs are not routinely collected in clinical trials either.

Routine inclusion of health services resource use and cost of care information in clinical trials of treatment efficacy, particularly those that are conducted in the elderly and include comprehensive geriatric assessments, will be an important next step. Understanding the effectiveness and cost-effectiveness of such therapies in the general population of elderly treated outside of clinical trials will require the addition of more detailed health and quality of life assessment data in medical records and in tumor registry programs. Cost of care measures will also need to be added directly or with data linkages. The resulting high-quality observational data may also be used to provide information that could be used in clinical care for elderly populations when trials are not ongoing or planned and to evaluate the delivery of guideline-consistent cancer care (3).

Currently, the SEER registry areas represent approximately 26% of the US population (4), and the linked SEER–Medicare data do not include information on the care received by patients covered by managed care. Additional efforts in data linkages, such as the Cancer Research Network, which links medical care for cancer patients in managed care organizations with tumor registry data (5), will also be necessary. The National Cancer Institute has supported ongoing work in the use of existing data from claims and medical records to measure comorbidity (6) and in efforts to improve and standardize patient-reported outcomes in the context of clinical trials (7).

Finally, we agree with Balducci et al. that the challenges to the Medicare program to provide optimal care for cancer patients within budgetary constraints will only increase with increasing cancer prevalence in the elderly. We encourage them, and others, to test their hypotheses about the efficacy, effectiveness, and cost-effectiveness of comprehensive geriatric assessment and individualized care in cancer care delivery for the elderly in large community-based health-care delivery settings and in clinical trials. Such findings should improve the quality of care for an important and growing population.

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