Statement of the American Cancer Society Cancer Action Network

IOM Committee on the Governance and Financing of Graduate Medical Education

December 19, 2012

The American Cancer Society Cancer Action Network (ACS CAN) is the nonprofit, nonpartisan advocacy affiliate organization of the American Cancer Society dedicated to eliminating cancer as a major health problem. Ensuring an adequate and appropriate cancer care workforce to treat cancer patients in the coming years is critical to the American Cancer Society's mission. We appreciate the opportunity to share our perspective on graduate medical education (GME) with the IOM GME Committee. GME is a key workforce policy issue that impacts the funding and distribution of health care professionals across the country and directly affects the numbers of future cancer care professionals. In our statement, we would like to highlight the following points:

1) Coordinated, team-based care can and should be an increasingly important component in improving the quality of overall cancer care. Training for physicians should reflect an emphasis on the skills required for team-based care.

2) Palliative care is a model of coordinated, team-based healthcare delivery that merits specific consideration by the Committee as an effective means of addressing complex chronic conditions. We request that the Committee examine the need for GME slots in new subspecialties such as palliative care.

3) Several enhancements in residency education and training are needed. There is a need to re-evaluate current physician training to allow for greater physician diversity in terms of both the specialty mix and geographic distribution of physicians, with a stronger emphasis on primary care. There is also a need for increased training opportunities in nonhospital settings and for additional training in skills related to healthcare delivery system reform.

Changing Healthcare Delivery System

Our healthcare delivery system is undergoing a significant transformation. This delivery system change is being ushered in by a multitude of factors, including an aging society, a changing cancer care landscape, and the emergence of new healthcare payment and delivery system models. Our society is becoming increasingly older with those aged 65 and older reaching 71 million by 2030. Cancer is a

disease of the aging and the risk of developing cancer increases with age. About 77% of all cancers are diagnosed in those 55 and older.[1]

The world of cancer care is also changing. Cancer care expenditures and the numbers of cancer patients and survivors are climbing. In 2007, it was estimated that the overall costs of cancer were $227 billion.[2] Cancer care has become increasingly unaffordable in the last 10 years, with treatment costs ranging from $40,000 to $100,000. The numbers of cancer patients and cancer survivors are also expected to rise due to advances in the early detection and treatment of cancer. There are currently 14 million cancer survivors. This year alone, it is anticipated that more than 1.6 million Americans will be diagnosed with cancer, and more than 500,000 will die from cancer.[3]

New models of healthcare delivery are also being developed that emphasize team-based integration and coordination of care. Integrated delivery models, such as Patient-Centered Medical Homes and Accountable Care Organizations will be critical components in the transformation of our healthcare delivery system. These new payment and delivery models have the potential to improve the quality of care delivered to cancer patients by promoting team-based care, encouraging the adoption of health information technology tools, and enhancing doctor-patient communication.

Workforce Shortages

In order to weather all of the changes and challenges that are brewing in our healthcare system, a strong healthcare workforce will be needed. However, most experts agree that workforce shortages in areas that are critical to cancer care; such as, primary care, oncology, and palliative medicine currently exist, and are projected to increase over the next decade. These workforce shortages combined with a shift towards a more coordinated, integrated healthcare system will require a workforce that is better able to manage care for patients and families impacted by cancer. ACS CAN is particularly concerned that these workforce shortages could significantly affect access and quality of care for cancer patients, survivors, and their families for years to come.

By 2025, it is anticipated that there will be 65,800 fewer primary care physicians.[4] Primary care physicians are often the first point of contact for many cancer patients and these practitioners are instrumental in the delivery of healthcare coordination, education and preventive cancer screening. Despite broad agreement on the need for growth in the primary care workforce, the number of specialist physicians still outweighs the number of primary care doctors by about two to one. Interest in primary care among medical school students has declined in recent years due to substantial income disparities between specialists and primary care physicians. An aging population will increase the

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[1] Cancer Facts & Figures 2012. http://www.cancer.org/acs/groups/content/@epidemiologysurveilance/documents/document/acspc-031941.pdf. Pg. 2

[2] *Id*.

[3] Seffrin, John R., "*Commentary: A Post-Election Road for Cancer Control*," The NonProfit Times, December 9, 2012.

[4] Association of American Medical Colleges, "*The Impact of Health Care Reform on the Future Supply and Demand for Physicians Updated Projections Through 2025*," June 2010.

primary care shortage due to greater demand for physicians to manage the complex conditions of older Americans.

The demand for oncology services is also expected to increase and will be driven by an increasing aging population, increased cancer incidence, and improvements in cancer survival rates. However, the oncology workforce is aging and retiring in large numbers. Many oncologists are at or near the age of retirement with the largest percentage of currently active oncologists between the ages of 50-59.[5] By 2020, it is anticipated that there will be a shortage of 2,550 to 4,080 oncologists.[6] The nation is expected to face an acute shortage of oncologists in the near future unless there are dramatic changes in cancer treatment and delivery.

Palliative Care

Currently, 9 million people are living with serious illnesses, and this number is expected to more than double over the next 25 years. Those living with serious illnesses, such as cancer, often experience fragmented care, inadequately treated symptoms, and poor communication with their doctors. Palliative care programs have emerged as a model of care to address these gaps in care by providing coordinated, team-based, and patient-centered care that is particularly important for patients and families facing a serious illness such as cancer. This type of care is appropriate at any stage in a serious illness and can be provided in conjunction with curative treatment across a range of settings; not just at the end of life or for incurable patients.

Over the last ten years, palliative care has been one of the fastest growing trends in health care, with hospital-based palliative care programs increasing by 138 percent since 2000.[7] However, a major barrier facing further expansion of palliative care services is a lack of palliative care professionals. While there is one oncologist for every new 141 newly diagnosed cancer patients, there is only one palliative medicine physician for every 1,200 persons living with a serious or life-threatening illness.[8] ACS CAN has several legislative initiatives that are focused on increasing patient quality of life through greater access to coordinated palliative care. These legislative initiatives would expand opportunities in palliative care research, education, and training. The Palliative Care Education and Training Act would increase the number of permanent faculty in palliative care, promote education in palliative care and hospice, and would support the development of faculty careers in academic palliative medicine. While most palliative care programs are currently hospital-based, this model of care should be woven into settings outside of hospitals so patients who receive care in the community can also access these vital services.

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[5] Association of Medical Colleges, "*Forecasting the Supply of and Demand for Oncologists: A Report to the American Society Oncology (ASCO) from the AAMC Center for Workforce Studies*," March 2007, Pg. 18.
[6] *Id*. at 62.
[7] Center to Advance Palliative Care, "*A State by State Report Card on Access to Palliative Care in our Nation's Hospitals*, " May 2011, pg. 5.
[8] *Id*. At 6.

Residency Education and Training

ACS CAN has concerns about several aspects of residency education and training that we would like to bring to the Committee's attention. First, there is a need for greater physician diversity in order to increase the current specialty mix and geographic distribution of physicians. The current specialty mix of physicians that is being produced is not well matched to the needs of a changing healthcare delivery system. Increasingly, residents are choosing to subspecialize or become hospitalists after residency. There are also gaps in physician distribution, with fewer physicians coming from rural and inner city areas, which could mean reduced physician supply and access in these underserved areas. For cancer care, sufficient numbers of primary care physicians and other healthcare professionals will be needed in order to provide necessary cancer research, prevention, and treatment services. These professionals will need skills in team-based care, care coordination, symptom management, and cultural competency in order to handle the demands of both an aging population and a population with greater cancer incidence.

Second, under the current GME system, residents have limited exposure to practice in nonhospital settings. It is vital for residents to gain experience in nonhospital settings such as nonhospital clinics, nursing facilities, home care, and physician practices in order to gain experience in the management of chronic conditions. Eight-four percent of Americans with cancer are treated in nonhospital settings, and exposure to these types of settings would aid in the preparation of the next generation of cancer care professionals.[9] We have often heard from cancer patients that they prefer to receive care in their own communities. GME payment policies should create more incentives for residency programs and medical schools to create more opportunities for community-based rotations for residents.

Third, residents need training in skills that will be necessary for a reformed healthcare delivery system. The current GME system does not place a sufficient emphasis on the training necessary for delivery system reform. Residents need exposure to areas such as health information technology, evidence-based medicine, care coordination, team-based care, and the core principles of palliative medicine in order to provide quality care for complex conditions in a changing demographic and healthcare environment. For cancer care, team-based training is critically important. Team-based care enhances care coordination and can improve the quality of overall cancer care. Team-based care is also an important element in appropriate cancer survivorship care as survivors report problems navigating physicians after receiving treatment. Cancer patients have reported that a team-based approach to cancer care increases greater patient satisfaction. Patients feel that they have greater communication with their providers, increased understanding of their treatment plans, and participate in shared decision making with their providers. Physicians alike also noted the positive impact that a team-based approach can have on quality cancer care.

Conclusion

[9] http://www.communityoncology.org/UserFiles/pdfs/fact-sheet-about-coa.pdf.

Cancer patients and their families depend on specialized treatment and access to a broad range of healthcare services and providers throughout the continuum of cancer care. ACS CAN strongly believes that access to quality cancer care depends on maintaining a strong and diverse workforce that can work collaboratively to deliver high quality cancer care. One avenue to achieving a strong workforce is to provide training in the skills required for team-based, coordinated care. As the Committee examines the current state of GME, we request that training for physicians reflect an emphasis on the skills required for team-based care. We also request that the Committee examine the need for new GME slots for primary care and new medical subspecialties such as palliative care, that are currently at a disadvantage due to the current cap on residency slots nationally. Palliative care doctors are trained in symptom management, care coordination and high quality patient centered care, and will serve an important role in the health care workforce of the future. The current GME system will face mounting pressure as our population increases and becomes older, with the public placing additional demands on an already overburdened system for additional health care services. Ultimately, we need a GME system that will produce sufficient numbers and types of physicians who will bolster the treatment of cancer care, but will also produce physicians that will increase the quality and value of healthcare in the United States.