

GUEST EDITORIAL

Tightening Our Belts in the New Healthcare Economy

Coming soon: austerity in healthcare. During the “Great Recession” of recent years, those of us employed in healthcare have largely avoided the tumult experienced in other sectors, like housing and finance. Jobs have actually been added to the healthcare sector, payments for healthcare services have remained stable enough to sustain the system, and new opportunity presents itself with more Americans likely to obtain coverage as a result of the Affordable Care Act (ACA). Let’s face it, we’ve been quite fortunate.

However, from a budgetary standpoint, we face unprecedented challenges. The fiscal cliff legislation, passed at the 11th hour on January 1, preserves payments to physicians but cuts payments for end-stage renal disease (estimated savings \$4.9 billion), resets the base for certain types of Medicaid payments to hospitals (estimated savings \$4.2 billion), and recoups past overpayments to hospitals through documentation and coding adjustments (estimated savings \$10.5 billion). Additional healthcare spending reductions are likely in coming months when Congress renews its battle over increasing the debt ceiling, and tradeoffs in the form of more spending cuts are already part of the political discussion.

The addition of newly-covered patients under ACA, coupled with these budgetary challenges, means the system will have to provide more care for less money. Meanwhile, the overhead cost of simply “doing business”—compliance with regulations, performance measures, and accreditation standards—seems to be going up. As someone who has grown accustomed to stability, these changes are fast, furious, and frightening. What will be the key to our success in this new era of healthcare? I’ve thought about this and keep coming back to the same word:

efficiency. Never has there been a greater need to understand how to best spend our healthcare dollars. We need to recognize what are the most resource intensive components of care, and determine whether there are ways to deliver those components more cheaply or quickly—all while maintaining our shared priority of excellence in patient care.

As an applied health economics researcher for 15 years, I’m seeing the “efficiency” theme play out every day in my work. The overall demand for cost data is increasing, but the nature of the questions to be answered by these data is changing. A decade ago, a common question was: “Is the treatment cost effective?” Now, the usual questions are: “What will it cost to implement this treatment?”, “How can the treatment be implemented most efficiently?” and “What will be the return on investment if we implement this treatment?” In other words, the conversation is shifting away from a willingness to accept increased costs for treatments that are more effective, and towards purely budget-based and operational decision making aimed at determining how to do things more affordably. From a scientific perspective, this shift suggests that cost-benefit analyses will emerge as the most relevant type of cost analysis (the goal being to determine whether investment in a treatment results in net financial benefits, i.e., savings, elsewhere in the system), with the more traditional cost-effectiveness analyses (where one considers the incremental cost per incremental health benefit compared to the standard of care) potentially falling out of favor.

Consider, for example, a key area of pharmaceutical innovation -- the new oral anticoagulants dabigatran, rivaroxaban and apixaban. While real-world evidence on the effectiveness and safety of these drugs is still emerging, from an economic

standpoint the key question is whether the higher price of these drugs is offset by measurable efficiencies in the form of reduced patient monitoring and counseling requirements when compared to warfarin. Next, consider improved testing for diagnosis and staging of prostate cancer. Here the question is also whether the additional costs of the test are offset by more efficiently targeting men who need treatment, and avoiding unnecessary treatment in men who are unlikely to benefit. Finally, consider patient support programs for seniors with mild-to-moderate dementia. Again, the key question is whether investment in coaching the patient and their family caregivers -- perhaps even making infrastructural improvements to the home -- could delay formal paid caregiving and admission to long-term care. Just start looking around at the innovations being considered in your area of healthcare and you will notice this shift which now spans across drugs, devices, diagnostic assays, and patient support programs.

Members of the healthcare community, we need to collectively acknowledge this new reality and embrace it because, short of a miraculous economic recovery, healthcare budget cutting will present very difficult challenges. It may be politically unpopular for the government to formally support or mandate cost analyses, but we desperately need these data in order to understand how to treat patients most efficiently. Those of us in the trenches can and will be doing this work—we no longer have a choice. I hope you will join me in supporting it as a key component of the critical real-world evidence necessary to inform healthcare decisions. ■

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