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Comparative Effectiveness Research: Implications for Healthcare Executives

© Pat Stanfill Edens, PhD, RN, FACHE
Senior Consultant
The Oncology Group

In the recently passed $787B Economic Stimulus Package Bill, $1.1B is designated for healthcare comparative effectiveness research (CER). A paper developed by the Congressional Budget Office (CBO) in 2007 states that the current healthcare system often implements more expensive treatments, even without knowledge of relative effectiveness and influence on outcomes.(1) The CBO feels that a better knowledge of costs, risks and benefits of treatment options will lead to lower healthcare expenditures without negatively impacting quality of care. While critics compare CER to rationing, comparative effectiveness research generates evidence comparing treatment regimens based on the ratio of dollar spent to outcome. CER may validate, for example, that if two treatment regimens deliver the same outcome, there is nothing inherently wrong in choosing the lesser cost option to free up healthcare and societal resources for others. If healthcare providers embrace CER, the savings in healthcare spending could be substantial without the negative impacts that critics are predicting.

Sample questions that need to be addressed include:

- What is the most cost effective way to treat?
- Will the selected treatment improve the quality of outcome?
- What is the ratio of dollar spent on treatment to the quality of outcome?
- If clinical outcomes standardize care and improve quality, should clinical guidelines also include economic decision making content to control cost?
- Why are U.S. healthcare outcomes not necessarily better than countries with National Health Insurance, as universal health discussions begin?
- If the U.S. spends almost 17% of the national GDP on healthcare and leads all countries in per capita expenditures, why is life expectancy predicted at 28th worldwide by the World Health Organization?

Historically, healthcare in the U.S. has provided aggressive treatment regardless of payer class. In his confirmation hearing statement for appointment as Director of the Office of Management and Budget, Peter R. Orszag stated that the federal budget is on an unsustainable path and the principle driver of the deficits is rising healthcare costs.(2) Medicare and Medicaid funds almost 60% of all hospital stays, which equates to approximately 15 million hospital admissions, while private insurance funds almost 35%, or approximately 13.5 million admissions. The

Agency for Healthcare Research and Quality reports that the total annual costs for heart related disease is $475B, while cancer care is $219B. If 60% of that care is paid by Medicare and Medicaid, a savings of even 5% is over $20B. Given the financial impact, both federal and state governments and businesses who underwrite the majority of private insurance are facing dire financial futures if healthcare costs are not managed.

The initial response to cost effectiveness research is often overwhelmingly negative as both physicians and healthcare executives feel that treatment decisions are being made by non-healthcare entities or non-clinicians. Continuing to believe that the newest drug, device or treatment plan is better, without evidence or proof, will doom organizations to failure given the current economic environment. As pharmaceutical companies and device manufacturers enhance their offerings, it is imperative to demand that cost effectiveness be included in the research effort leading to FDA approval.(3) Continuing to assume that new and improved and often more costly equates to improved outcomes without the evidence necessary to test the proposition is foolhardy.

There is also a need to discuss the microeconomic concept of efficiency, as efficiency enhances effectiveness in a perfect setting. When a product, in this case a healthcare outcome, is produced at the lowest possible cost, economic efficiency is said to occur. Cost based reimbursement does not incent providers to control cost, and market forces are currently not successful at improving quality and outcome or managing cost. Cost efficiency should be an equal part of the discussion in cost effectiveness research.(4)

There is a need to change the status quo. It is not enough to use clinical guidelines; cost effectiveness and efficiency must be incorporated into the lexicon of quality and outcomes. Evaluating clinical guidelines already in existence and use in the hospital and outpatient settings is important, as they presume to mandate best care. Developing quantifiable financial and outcome indicators that can be tracked over time is critical. Using management engineering principles combined with an increasing dialogue with physicians and other healthcare professionals is one step in proactively enhancing cost effectiveness.

The successful healthcare leader today will embrace opportunities presented by comparative effectiveness research which will change business as usual. By participating in the solution to rising healthcare costs, healthcare executives will be an advocate for the patient and the facility and will have no reason to fear the future.

References

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