ICU
MANAGEMENT & PRACTICE

ICU Volume 11 - Issue 4 - Winter 2011/2012 - Editorial

Cost-Effectiveness

As medical professionals, we are always seeking new, improved ways to save lives and provide a high quality of care. Coupled with the increasing pressure being applied during these increasingly unstable economic times, it comes as no surprise that one of the growing topics is that of addressing and achieving costeffectiveness. How can we create an optimally financially sustainable environment in the critical care department, in a way that also benefits our patients? Decreasing the duration of patient stays is one of the most powerful and direct tools we, as medical professionals, have at our disposal, to impact on cost-effectiveness. But, of course it goes without saying that this can only be considered beneficial when a shorter duration of stay provides the same positive outcome and excellence of care as if the patient's stay were governed by no economic limits whatsoever. Our cover story asks: how can we balance economic pressures with the delivery of high quality in patient care? What methods are at our disposal, and what do we know about their cost-effectiveness? Therefore, in this edition's cover story, we take a look at three innovative ways in which cost effectiveness can be measured and improved. One paper, authored by Kees H. Polderman, is entitled "Therapeutic Temperature Management in Critically Ill Patients: Indications for Cost-Effective Outcomes". In it, Polderman posits that the use of hypothermia in certain patient groups can effectively deal with fever, explains in which cases this is so, and covers some interesting and significant data that demonstrates the current knowledge regarding its cost effectiveness. He also cites the European Resuscitation Council (ERC) and the American Heart Association (AHA), who are now fully behind the use of hypothermia in survivors of witnessed cardiac arrest, regardless of the initial rhythm.

This focus on reducing length of stay without negatively impacting mortality rates, is dealt with by expert Robert Barraco, who tackles the case of delirium, one of the main drivers of costs in the treatment of the elderly population. As he reports, delirium is strongly associated with poor outcomes in ICU patients and he lists the complications and poor outcomes associated with delirium, which, if neither properly nor early enough identified, can lead to longer stays. Delirium itself is reported to increase nursing time per patient as well as drive up hospital costs, making it an important focus for this cover story. In this paper, Barraco demonstrates effective prevention strategies for delirium, as well as describing the ways in which it can be identified, to aid detection and ensure control over its severity and thereby improving the prognosis for patients.

Another significant tool for reducing costs, that of treating the patient in such a way as to require less medication, is described by author Arzu Topeli Iskit, who covers a recent multi-centre trial that demonstrates a novel way to reduce the number of days a patient spends in the hospital by the utilisation of procalcitonin measurement to assess antibiotic requirements more precisely. In her article, she provides evidence that such a treatment tool can reduce costs in a way that does not increase mortality, neither does it increase length of stay, and importantly, it does not cause a relapse in infection.

Our country focus this issue covers the structure and provision of ICU care in Bulgaria. The usefulness of our country focus section cannot be underestimated; each country we profile is facing separate but no less important challenges in meeting its health goals. The fact of sharing such challenges is, however, not this section's continuing goal, but to share the ways in which its contributors are coping with and addressing those challenges. In Bulgaria, there are key political problems that are applying pressure to all practitioners and institutes of healthcare, including the ICU. Notably, for Bulgaria this means a shortage of trained practitioners, an exodus of trained residents to other economic regions, the lack of continuing medical training in the face of an outdated system that relies heavily on mentorship from the older generation, and the need for greater modernisation. This edition's Viewpoints section interviews four luminaries in the critical care field, who each communicate their opinion on what the hot topics were for ICU during 2011. This threw up some interesting and provocative responses, notably the growing role of technology in driving high quality care, the difficulty in assessing whether or not increasing the number of ICU beds improves care, and quality assessment and evaluation. As readers, your opinions are valuable: we welcome your feedback to any of the papers published in the journal, and particularly your thoughts on what the most significant 'hot topics' of 2011 were for you, professionally, and what they tell us about what is needed for the future of critical care for 2012 and beyond.

Published on : Sun, 5 Feb 2012