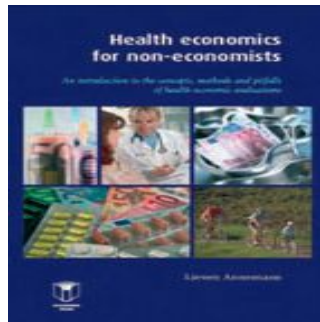

IQ_2012_06_venus - Health Economics

Weighing up the Benefits of IR



In an ideal world, patients would have unlimited access to all the treatments they might need. In reality, however, healthcare decision makers face the difficult task of balancing need with availability. With limited resources, cost effectiveness is central to any decision.

Lieven Annemans, Professor of health Economics at Ghent university and Brussels university (VUB) and author of “health economics for non-economists” talks to IQ about how interventional radiology (IR) rates, and what interventional radiologists and hospital directors should bear in mind.

Why do You Think it's Important for Doctors to Understand Health Economics?

For too long, doctors and nurses have only been considering the health consequences when treating a patient. That's normal: when you have a patient in front of you, you want to make them better. But we have to be realistic and accept that there are budgetary limits. On the other hand, there are also managers of hospitals or regions that focus too much on cost and on budgets, and that's not good either.

The objective of healthcare is to gain health in the population – but you have to gain this by respecting the cost-effectiveness of what you are doing.

What can be Done to End this Stand-Off?

I see the role of the health economist as finding a compromise. What exists now is a kind of deaf man's discussion – neither side will listen to the other. People tend to stay in their comfort zone, and so doctors may try to avoid discussing economics, but if they can understand some of the principles and basic calculations used, they will better be able to enter a constructive debate.

Understanding the ratio between costs and effects and recognising which therapies should be prioritised and preferred is very helpful to this discussion. If doctors can feel comfortable reading and using this language of economics, they will find themselves better able to negotiate.

How Cost-Effective is IR?

I have been involved in evaluating the management of critical limb ischaemia (CLI), and while the technologies are changing all the time, what has been studied so far looks good. Peripheral vascular interventions are cost-effective compared to doing nothing and compared to surgery. So in that field it is quite clear that overall, the ratio between its costs and its effects is very favourable.

There are many interlinking factors to consider when coming to a conclusion like this. Even when a therapy might seem expensive, you need to weigh that cost against outcome and impact: if the treatment is beneficial to the health of the patient, that is not only good in itself, it could actually save money in the long-term.

If an expensive intervention such as coil embolisation leads to improved disability levels in a stroke patient, then you have saved yourself the costs of the chronic intensive care that would otherwise be needed for the remainder of their life, which could run to tens of thousands of euros.

But you have to demonstrate this first, of course – good, solid data is crucial.

Randomised Controlled Trials (RCT) are both expensive and require large patient populations – how do you suggest interventional radiologists find convincing data?

The first thing to do, in my view, is to observe patients treated with a new technique. Develop a case series and compare your findings with historical controls. OK, it's not randomised and you have to correct for possible differences in patient characteristics and so on, but at least it gives you a good idea of the potential benefits of the new technique. Smart payers know that an RCT is not always possible and, therefore, they should be open to your evidence.

Where does One Start – How do You Get Approval for Those First Patients?

One tried and tested method is to develop clinical guidelines that take cost-effectiveness into consideration. That's not an easy task, but your message would be much stronger if you say, "this technique is effective and first data shows potential cost-effectiveness."

If a technology is still in development, but has good preliminary evidence supporting it, your hospital manager, regional decision maker or health insurer can try to reach a performance-based agreement with the company, saying, "your evidence base is not yet perfect, but we will cover a part of the costs and run a case series, allowing you to broaden your data."

If the company's claims were found to be true, or if the technology has a greater application than predicted, the agreement can be revised. Interventional radiologists can play a key role in advising and supporting their management in such a venture, which is beneficial for the hospital – it allows you to offer your patients cuttingedge technology at a preferential price.

Many IR Devices are Quite Expensive – is this Partially Related to the Small Market Base that they Currently Hold?

If the market for a new technology is rather limited, the company does their own calculations in order to be viable. But if it turns out to be effective and its use can be increased, then the cost would also come down. And that could even be part of the performance-based agreements: if the technology can be more widely used than originally established, then there should also be a consequence for the price.

We have seen that with the coronary stents in the cardio - vascular field. Initially it was not really clear to what extent the stents could take the market share of the balloon and market share of the bypass field. As the evidence base grew and stents became more popular, their cost started to decrease. You cannot ask a company to sell a technology for a loss, but you cannot tolerate that they ask prices that are not affordable by society. So it's a question of finding that happy medium. The happy medium is what health economics is all about!

C.M.

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