Healthcare Reform, Quality Care, and Value

BY GEORGE KOVACH, MD

Healthcare reform continues to take center stage this year. And although cost, quality, and value are the common buzzwords of healthcare reform, the definitions of these terms continue to engender debate. Providers are getting better at defining quality care, but objective criteria for determining the value that patients receive from treatment, for example, are lacking. If we do not understand the metrics of value, better define the forces driving cost, and educate providers about clinical guidelines that incorporate cost-effectiveness information, we are doomed to err in our attempts to control the spiraling costs of healthcare.

To rein in the high costs, tough questions require closer attention and more objective answers. When is a high-cost treatment "worth" the expense in terms of delivering better health to patients? How much benefit, in additional months of life expectancy, would a new drug need to provide to justify its cost and warrant its use in an individual patient?

Writing in the April 2012 issue of *Health Affairs,* Peter A. Ubel and colleagues surveyed oncologists in the U.S. and Canada to find an answer. The majority of oncologists agreed that a new cancer treatment that might add a year to a patient's life would be worthwhile if the cost was less than $100,000. But when given a hypothetical individual patient case to review, the oncologists also endorsed a hypothetical drug whose cost might be as high as $250,000 per life-year gained.

The authors went on to say that expensive new cancer treatments that can extend life raise questions about whether physicians are prepared to make "value for money" trade-offs when treating patients.

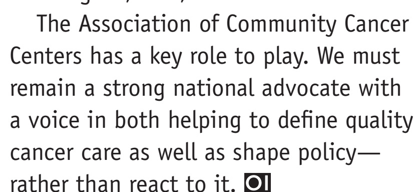
We know that multiple influences drive cancer care costs, including new technologies and pharmaceuticals, regulation, and the growing numbers of patients as the population ages and we benefit from more effective treatments for disease. Attempting to control costs by decreasing payments to providers is, however, clearly a no-win proposition for either the provider or the patient.

Consider the SGR, for example. Each year the sustainable growth rate (SGR) formula compares the cost of healthcare relative to the Gross Domestic Product (GDP) and determines a reimbursement adjustment, positive or negative, to be applied the following year. The current adjustment is estimated at negative 35 percent on January 1, 2013, and the cost to fix this flawed system is now over $300 billion. Each year, Congress has had to step in with a legislative "fix" to prevent these physician reimbursement cuts. And yet the relationship between GDP and healthcare costs is obscure at best. Case in point—if the GDP underperforms, is healthcare at fault?

Even as we await the U.S. Supreme Court's decisions on the constitutionality of the Affordable Care Act, healthcare reform in some shape is inevitable. New payment models, growing attention to evidence-based medicine, and increased consolidation are already underway and unstoppable.

On a positive note, many aspects of the Affordable Care Act, such as the CMS Innovation Center, are tasked with providing more detailed reporting on healthcare costs, access, and quality. These data may afford the oncology community an opportunity to educate policymakers in Washington, D.C., and at CMS.

The Association of Community Cancer Centers has a key role to play. We must remain a strong national advocate with a voice in both helping to define quality cancer care as well as shape policy—rather than react to it. OI



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