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A Need of Metrics in Cancer Economics: Myth or Hope

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Novel therapies in oncology pose a weighty financial affliction with a relative shy increase in life expectancy. Cost effectiveness analyses were found critical to gauge the value of such therapies. However, validity of these approaches is interrogated due to several biases including for example pharmaceutical sponsorship or publication favoritism [1]. Purportedly, if the increase dollar spending on cancer care in the US improve outcomes; then maintaining fitted cost thresholds are crucial [1]. Nonetheless, criteria such as the Drummond's ones were found important to control the legitimacy of these cost analyses [1,2].

Regulations

On April 16, 2015, President Obama signed legislation (H.R.2 - Medicare Access and CHIP Reauthorization Act of 2015) to lastingly replace Medicare's sustainable growth rate formula. In signing this bill into law, the President stated that it would also ameliorate physician reimbursement because it incites compensation based on quality and not on quantity. Notably, over the past recent years relative value units (RVUs) based physician compensation and productivity became increasingly adopted in numerous institutions. One of the benefits proposed with this system is the ability of physicians to focus on patient care as opposed to spending time on managing the business aspects of medicine. However, many community oncologists are pessimistic about the productivity system. In fact, it encourages these physicians to increase their RVUs' numbers i.e., quantity would eventually trumps quality. However, this system is promoted so that administrators and physicians may have a well-defined comprehension of the difference between the Centers for Medicare and Medicaid Services (CMS) Resource-Based Relative Value Scale (RBRVS) method, and the specific formula being used in the reimbursement section of employed physicians' agreement.

Method of assessment

One of the last contributions of Dr Wetzler chief division of leukemia at Roswell Park Cancer Institute prior to his unexpected passing tackled a critical issue of cancer economics. His work on applying Cost effectiveness analyses and economic model in a cancer population of acute myeloid leukemia highlighted the intricacies of incorporating cost as a criterion for drug approval. Dr Wetzler's work suggested that a drug such as decitabine

may be arguably considered for elderly newly diagnosed AML patients given the economic pressures in the US health system; however, this is not a criterion for drug approval [3]. However, as certain cancers are rare; applying economic model to clinical outcome to demonstrate which drug is more cost effective in an era of increasing economic pressures is reasonable [4]. Especially those cancer patients who express fear of bankruptcy in light of the costly cancer care [5].

The Real world

Therefore, we have raised concerns how to better calculate our financial risk in oncology?[6] It is key to revamp how our healthcare systems run in the USA [6]. This entails multiple layers from physicians to hospitals and indeed medical insurance companies. It is interesting to note that the New England Journal of Medicine explore if empathy can be taught and what are some of the barriers to sustained empathy among physicians [7]. Consequently, empathic physicians may be more sensitive to numerous of their patients' concerns including most importantly the financial ones. On the other hand, community practice oncologists have been frustrated how patients have been forced to change their network as it was dictated through the Affordable Care Act reforms [7].

The Real value

Another important issue is the lack of studies that try to establish the most efficient cost of providing screening services. Additionally, there is deficient information on the relative costs of delivering screening services in particular in colorectal cancer [8]. However, what seems to drive the value of these services or the quest for treatment is exactly what the patients evaluate and find essential to pursue. In fact, a survey found that 77 percent of cancer patients with melanoma, breast cancer, or other types of solid tumors preferred hopeful gambles to safe bets [9]. The real dilemma of providing services to patients is how to portray the value of a reasonable acceptable cost-effectiveness ratio in the end-of-life scenario [9].

The Challenges for Transition

Health care systems in the US face joint defy in transforming to a health care delivery structure based on value and not on volume. Such value-based payment system would focus on

clinical outcomes, patient population and a patient-centered care approach. As hospitals and health care systems shift from the volume-based first curve to the value-based second curve, they must transform their businesses and health care delivery models to poise quality, cost, patient preferences and health status to achieve real value and outcomes. Therefore, healthcare systems are expected to espouse new metrics to detect clinical, financial, edifying and practice improvements; integrate proper incentives; and evaluate results.

What the Future holds?

For the US healthcare system to meet those challenges, chief executive officers ought to craft and quantify organized processes. The new system will compel the integration of value, the ability to meet patient expectations and clinician engagement on several layers. Using these metrics, administrators can weigh the development in meeting the challenges of a vibrant, sprouting health care setting. This will aid leaders to fill in the space while payment models continue to transition to a value-based organism.

The Right population health

Choosing the right measures in the right population ensures that the latter achieves its goals. Unfortunately, it is noted that the metrics to measure are lagging behind and perhaps selecting a reliable metrics remain a tangible dilemma. Outcomes seem to be less utilized as criteria in the current traditional quality metrics versus tracking processes. This is a crucial difference as process measures are fundamentally centered along sick care, discounting the core doctrines of wellness and health. In the current era, we need to get to the end of the point and that we concur on metrics that focus on quality and outcomes [10]. Working towards metrics became the truth of strategy. Metrics in cancer care are our Global Positioning System (GPS) to guide us in the transition from volume to value-based healthcare delivery system [10].

The New Global Positioning System of healthcare

Metrics became the new GPS of healthcare. Without a GPS, we can't find our way. Consequently, healthcare leaders and providers can't check whether or not the systems function accurately and that our patients are being served appropriately. Metrics are the method to communicate and to set targets for people to aim for. Metrics became 'the reality of policy' [11].

How do we move forward and what we should expect?

Leaders and administrators agree that this is a difficult and not a straightforward task to attain our next state of a value-based system. It is even problematic how would we even define success! Delivering meaningful care for patients to improve their outcomes through innovative partnerships. Therefore, aligning cost and quality constitute the basics of these new metrics to develop original supply models.

Conclusion

Without sounding pessimistic, community practice oncologists don't see the light at the end of the tunnel. The new era of practicing oncology is not reassuring between an increasingly assertive sizeable health care institutions forcefully eating up small groups to subsequently generate more profits. On the

other, medical insurance companies became indirectly the true decision makers on the choice of the next treatment. Cancer specialists are squeezed in so many ways that they feel that is challenging to face an unclear tomorrow in a blurred economy. However, cancer specialists remain committed to patient care to provide what remained hope to cherish.

Remembering Dr Meir Wetzler, chief of leukemia at Roswell Park Cancer Institute, Buffalo NY (1954 – 2015).

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