Observations from a Hospital Executive (Decision Maker) on the Article “Long-Term Resource Use and Cost of Percutaneous Transluminal Coronary Angioplasty versus Stenting in the Elderly: A Retrospective Claims Data Analysis”

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Who should pay for new innovations?

Coronary stenting has demonstrated superiority to the angioplasty percutaneous transluminal coronary angioplasty (PTCA) in both the restenosis (18% vs. 32%) and revascularization for target vessel in 6 months following the initial procedure (10% vs. 27%) [1]. While the initial hospital cost for stenting is higher than the PTCA (owing to the price of the stent), the 1-year follow-up hospital costs for the PTCA eventually catch up with the initial higher cost as shown in a randomized clinical trial by Cohen et al. [2]. There was no accounting for the outpatient and physician costs in this clinical trial. The article by Subramanian et al. [3] in this issue of Value in Health provides us a method of evaluating the initial hospital and 2-year follow-up costs of PTCA vs. stenting using the Medicare claims data. In their analysis, they included the outpatient, physician, skilled nursing facilities, and home health costs. It is a more comprehensive analysis and provides the decision makers a better understanding of the long-term costs associated with these two treatments. The results of the study indicate that there is no significant difference in the initial hospitalization and 2-year follow-up costs comparing the bare metal stenting with the PTCA.

From the payer perspective, introduction of the stenting technology has created no long-term cost savings. The 2-year cost analysis yielded a cost-neutral position. We can argue that there was no cost-saving benefit gained by the payer. The rate of return for the investment in paying for the stents is zero. All the cost savings procured from the stent treatment had passed to the producers.

From the patient’s perspective, the improved clinical outcome with the new innovative stenting technology has resulted in fewer revascularizations. It definitely is an improvement to their quality of life. From a hospital provider “cost” perspective, it is a losing situation. Although the stenting group had shorter average length of stay for hospital admissions in the second year of the follow-up period, the cost savings from the last several days of these procedure admissions could not cover the expenditure for the stents. Most of the costs for the procedure admissions are accounted for during the early days of the total length of stay. Therefore, hospitals were financing the downstream health benefit gained from stenting technology between 1995 and 1998. Even though there was reimbursement, it was insufficient. As a decision maker for a hospital, my colleagues and I struggle daily to prioritize the resource allocation in hope of the best care for our patients with the limited available dollars. The article by Subramanian et al. is very informative. It is comforting to know that we are providing a better care to our patients and with no significant long-term additional cost to our payers. From a societal perspective, the stenting treatment is certainly effective, but at whose expenses? The results of this study show that all savings from the decrease in revascularizations and rehospitalizations had gone to the patient.
price of stents. From health-care policy perspective, should the producer assume all the cost savings, or benefits, by setting the product price at the maximum dollars saved or should some of these benefits be shared with other parties involved in the process in the society?—Peter K. Wong, PhD, MBA, RPh, Good Samaritan Hospital, Center for Outcomes Research & Clinical Effectiveness, Dayton, OH 45406, USA.

References