Economic Instability and Its Impact on Decision Making in Health Care

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INTRODUCTION

It’s no secret that the current economic crisis is having a major effect on the myriad financial decisions that individuals and families are facing. This is especially true in terms of health care usage. The situation has posed tremendous difficulties for working and retired people, forcing many to forgo some basic needs, such as food and housing. Those who are fortunate to be financially stable enough to continue to afford basic necessities are now being forced to choose between health care and other basic needs, and people who were once financially secure are feeling the strain from increasing health care costs and decreasing economic security. Cost has prompted a perceptible shift in our traditional societal view of the priceless nature of life toward a view that now requires us to attach a value to life, often in the form of a price tag. This dilemma is particularly troublesome for patients with chronic illnesses, whose medical costs account for a substantial portion of annual health care spending in the U.S.

The Example of Cancer

Newer treatments have increased the life expectancy of cancer patients, in many cases changing the illness from an acute condition to a chronic disease that must be managed with maintenance therapy. This results in an older age demographic that is living with various types of cancer, often into retirement age (i.e., beyond age 65). With the economic recession, consumers’ assets and savings have plummeted; some of the hardest-hit individuals are retirees and workers who had hoped to retire in the near future. Chemotherapy treatment, especially with newer biologic agents, is expensive and poses a significant, ongoing financial burden to patients even when the economy is doing well. Partly as a result of the high cost of newer monotherapies or combination treatments and the increases in commercial and Medicare insurance cost sharing, patients’ health care costs have grown year after year. The use of expensive biologic therapies, which are now recommended because they offer slight improvements in effectiveness (as well as a substantial profit margin for oncologists) has also contributed to the financial strain borne by patients. Cost is now considered a “side effect” that cannot be ignored when a patient begins or continues cancer treatment.

As illustrated by a recent report, many cancer patients are declining treatment deemed necessary by their oncologists, choosing to preserve their finances instead of their health. This “resignation to fate” may be seen in patients at the end of life who are undergoing palliative care as well as those who are receiving standard maintenance therapy to induce or prolong remission. This new trend in health care economics is one that requires rethinking of therapeutic decision making by all health care stakeholders, including physicians, insurers, employers, and the patients themselves. In fact, new guidelines that direct physicians on how to approach patients about cost, in their discussions relating to therapy, were expected to be released by the time this issue of P&T went to press.

This shift in thinking is not isolated to oncology; it is observable across the entire spectrum of health care. Spending on prescription drugs as a whole decreased for the first time in a decade during the first and second quarters of 2008, and elective procedures, such as knee replacements, have also declined. Patients are reporting fewer visits to their physicians; also, they are not taking medications as prescribed, so that they can extend their supply of medications and reduce the frequency of pharmacy visits. Both of these practices enable them to avoid copayments.

Patients are now beginning to look at the value of life from a new vantage point. As a society, we have been conditioned to believe that everyone has the right to prolong life if a treatment is available and that this right should be exercised regardless of the cost or the length to which life may be extended.

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Quality of life has always been an important issue in health care, but it has now been thrust to the forefront because of the economic recession.

Is a newer, targeted biologic therapy that costs thousands of dollars per month truly worth the extra expense and the potential for adverse effects, when it provides a modest extension of overall survival of only a few extra weeks or months? In the past, many patients have looked at this extension as a chance to live another year or more. In just the past few months, however, many cancer patients and their families have begun to rethink these attitudes. They are considering the financial costs that are associated with this additional time and other implications as well. What quality, what value of life will they experience? Is living longer worth declaring bankruptcy? Or is it more valuable to preserve one’s financial assets so that they can be passed onto posterity?

Such matters also have ramifications for health care providers and P&T committees. Patients have undergone a shift in priorities, precipitated in part by the current economic conditions; this, in turn, has prompted the need for health care administrators to come up with new ways of thinking about cancer treatment and health care more broadly.

Should end-of-life measures be pursued in lieu of additional treatment? Are palliative care and supportive management of associated symptoms more viable alternatives to treating the underlying disease with active and aggressive courses of therapy?

Hospice is an end-of-life program that provides assistance to terminally ill patients who have abandoned treatment options and have chosen instead to focus on comfort during their last months of life. Hospice admissions have been steadily increasing over the past five years; an estimated 1.4 million patients received its services in 2007. Hospice care is covered under Medicare, Medicaid, and most private insurance, and patients receive care whether or not they can pay.11 Hospice care is covered under Medicare, Medicaid, and most private insurance, and patients receive care whether or not they can pay.

A 2007 study demonstrated the cost savings of hospice care for both beneficiaries and Medicare to be an average of $2,309 per patient; for cancer patients, hospice use decreased Medicare costs for up to 233 days of care. Hospice and other forms of palliative care are increasingly being viewed as preferable to more costly, end-of-life treatment efforts—especially for the elderly, who may be fighting for only a few more months of life at an exorbitant cost. With the economy apparently acting as a catalyst in the shift in societal opinions about death and the value of life, hospice care and other end-of-life measures seem likely to continue to increase steadily or perhaps even to spike sharply in the future.

The traditional patterns of medication use are also likely to change, with therapeutic doses being adjusted to provide a palliative rather than a curative effect. When one is deciding about which medications to use, overall survival will no longer be the primary focus; instead, the focus will be on quality of survival, an increasingly important marker of effectiveness, even though it is subject to a variety of interpretations.

Drug therapy aimed at managing symptoms, such as pain and depression, is another alternative to consider in place of the traditional drug regimen intended to combat a specific disease. Less intensive therapies can provide an acceptable quality of life without exorbitant costs or untoward side effects, commonly experienced with the aggressive use of biologics and other chemotherapeutic agents. Stakeholders in health care should consider these options, possibly at a much earlier point in the disease course than they used to—particularly with patients for whom comfort and quality are equally if not more important than overall survival.

CONCLUSION

The current economic crisis has called into question our society’s historical tendency to delay death whenever possible and at all costs. Now more than ever, value and quality of life are gaining in importance, a trend that will force stakeholders to determine the value proposition of therapies in a different way. That is, they will need to consider not only whether a therapy is safe and effective but also the true value it might bring to patients in terms of health benefits and quality of life in relation to its cost. This is a timely topic that everyone involved in health care will be forced to address, in response to patients’ demands and needs. This shift in attitudes will undoubtedly continue to disrupt and thereby influence our models of health care utilization and the pharmacoeconomics of new medications.

REFERENCES