Pharmaceutical Cost Containment and Quality Care
Conflict or Compromise?

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Abstract

Existing methods of pharmaceutical cost containment are relatively primitive weapons of expenditure restraint. Their effectiveness is generally limited to short term savings. The conflict between cost containment and quality is epitomised by the ‘Drug Budget’, which conditions payers to regard pharmaceuticals solely as a cost input without considering the results of their use in terms of integrated health outcomes, crossing the budgetary boundaries between drugs, hospitals, ambulatory and other forms of healthcare.

A further problem, also related to the separation of inputs from outcomes, is the contention by healthcare payers that, even if ‘expensive’ innovative drugs offer Value for Money, budget holders cannot afford the required Money for Value. The limits of affordability are real in poor countries. In rich industrialised nations, the affordability of quality is in essence a political rather than an economic issue. In making choices and determining priorities, elected governments are usually responsive to public opinion, which is coming to regard the issue of quality in healthcare as one of the highest social priorities.

Pharmaceutical innovation has much to contribute to quality in healthcare. A compromise between pharmaceutical cost containment and quality is feasible, based on input/outcome considerations, rational drug pricing, and re-engineering decision-making by payers away from the simplistic notion that the cheapest drug budget is necessarily the best.

To set the scene, here is a quotation from Carpenter et al. [1] in their article entitled ‘Must we choose between quality and cost containment?’:

‘We argue that the healthcare debate, as framed, starts with the wrong issues, asks the wrong questions, and uses inadequately defined terms, often interchangeably. We further argue that the United States will not be able to contain expenditures, either public or private, until quality and the true cost of providing quality are more clearly understood and defined.’

These forthright remarks ring a number of bells as much in Europe as in the US, and also in the narrower field of pharmaceutical cost containment and pharmaceutical quality, which is the subject of the current article.

At a time when nearly everyone worships at the altar of pharmaceutical cost containment, we need to bring quality nearer to the centre of the debate.
This is easier said than done, because cost containment and quality inhabit different worlds.

1. Pharmaceutical Cost Containment

Cost containment deals with budgets and finance, spending and management, quantities and measurement. It represents all the reassuring hands-on certainties of running a tight ship, and bureaucrats tend to revel in it.

Pharmaceutically, cost containment now boasts of an impressive arsenal of weapons, from old-fashioned price regulation – which could be described as the pharmaceutical equivalent of gunboat diplomacy – to the modern guerilla warfare of reference prices, delayed reimbursement, generic substitution, no payments/co-payments/penalty payments, and open and closed formularies.

Briefly summarised, direct control over pharmaceutical pricing and reimbursement is currently being exercised in industrialised member states of the Organization for Economic Cooperation and Development (OECD) by the methods outlined in table I.

Although product-by-product price control has a poor record of expenditure restraint and may actually be stimulating volume growth, it remains the dominant mode in the majority of OECD member states. Indeed, many direct controls seem to succeed only in the short term. In most countries, new controls have had to be introduced at frequent intervals. At the outset, each new measure seems budgetable, measurable, credible, or at least plausible. A year or two later, there is disappointment, because drug expenditure has resumed its traditional rapid growth.

Cost containers are perpetually in search of the perfect technique without questioning the basic rationale of what they are trying to achieve. They are concerned with means, not with ends; with inputs, not with outcomes. The purpose of cost containment is to contain costs, not to improve health nor to fulfil the needs of patients, nor is it to encourage the pharmaceutical industry, one of the few successful ‘knowledge’ industries in which the US and Europe still lead the world. Cost containment does nothing to promote the use of innovative therapy. On the contrary, most forms of technological innovation are perceived by cost containers as unwelcome threats to budgetary stability.

2. Pharmaceutical Quality

‘Quality’ is a more difficult, less precise concept than cost containment. Quality takes us away from the comfortable universe of quantity measurement to one where value judgments set the tone. In this new world, targets are defined both for the cost of inputs and for the quality of outcomes.

Quality, too, can be measured. Health economic studies often include quality-of-life measures, and efforts are being made to perform to measurable quality-of-care standards. Methodology, however, remains imperfect and contentious. The need to develop more reliable methods of measuring quality in outcomes is widely appreciated. To be effective in decision-making, outcomes must eventually be judged by yardsticks that are not purely financial, but can nevertheless be accepted as valid by payers.

The Health Care Financing Administration in the US has summarised future requirements to ensure quality of care to beneficiaries of Medicare and Medicaid in terms of 5 goals:

<table>
<thead>
<tr>
<th>Table I. Pharmaceuticals: direct price and reimbursement controls [Organization for Economic Cooperation and Development (OECD) member states 1997; Iceland not analysed]</th>
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<tbody>
<tr>
<td>Method</td>
</tr>
<tr>
<td>1. Product-by-product price control</td>
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<td>2. Reimbursement control</td>
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<td>3. Profit control (UK)</td>
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<td>4. Volume control (France, Spain)</td>
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<td>5. Promotion expenditure control (UK, France)</td>
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<td>6. None except (2): (US, Germany)</td>
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<sup>a</sup> Australia, Austria, Belgium, Canada (patented drugs), Czech Republic, Denmark (via average European price), Finland, France, Greece, Hungary, Ireland, Italy, Japan, Mexico, The Netherlands (via price links to selected countries), New Zealand, Norway, Portugal, Spain, Sweden, Switzerland, Turkey.

Sources: Author’s database; Redwood<sup>2</sup> updated to 1997.

<sup>2</sup> Copyright OECD/Heinz Redwood.