EDITORIAL Costs, innovation, and change management

D. Robert Siemens, MD, FRCSC

CUAJ Editor-in-Chief

Correspondence: Dr. Robert Siemens, Department of Urology, Queen's University, Kingston, ON, Canada; siemensr@KGH.KARI.NET

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In this issue of the *CUAJ*,we feature several important publications, including two outstanding papers accepted as the 2017 Canadian Urological Association prize essay winners. One of these is particularly timely: a contemporary Canadian cost analysis of blue light cystoscopy (BLC) with hexaminolevulinate (HAL) by Klaassen et al.[1] The management of bladder cancer remains one of the most expensive of any malignancy, with a majority of those outlays due to ongoing surveillance and treatment for frequent recurrences. Despite some renewed enthusiasm in novel immunotherapeutics, such as the checkpoint inhibitors, it could be argued that BLC remains one of only a few substantive additions to our armamentarium for non-muscle-invasive bladder cancer (NMIBC) over the last decade.

HAL has been commercially available in Europe (Hexvix®) and the U.S. (Cysview®) for many years and received Health Canada approval in January 2015. Several randomized, controlled trials have described a significant reduction in recurrence rates of NMIBC using BLC. Facilitating a thorough and complete resection should indeed lead to downstream benefit or "savings" from both patient and payer perspectives; however, adoption of BLC, particularly in Canada, has been poor, likely secondary to cost constraints of the Cysview itself and the capital costs for the necessary equipment. This recent cost-consequences assessment, using contemporary recurrence and progression rates and costs from three Canadian provinces, demonstrates a definite cost to setting up a BLC program ($1200–1400/patient), but also provides evidence of decreased tumour recurrences and may potentially save hospital bed days.

The authors speculate that if BLC, perhaps used preferentially for higher-risk patients, were to decrease progression rates, then further reductions in these expenditures (and even a potential overall cost savings) is possible. A recent publication reanalyzing a multicentre trial using an updated definition of NMIBC progression suggests that BLC may indeed decrease progression events.[2] Although this analysis doesn't provide sufficient evidence to definitively justify BLC use to decrease progression, there is overwhelming evidence that BLC does perform better than white light cystoscopy in detecting NMIBC and a more widespread adoption should benefit a decent cohort of the 9000 or so patients diagnosed with bladder cancer each year in Canada. Embracing BLC may be an uphill battle in Canada, given potential concerns of false positive rates/learning curves, patient (and surgical team) convenience, and the real-life costs well-described in this article.

Relevant to the above discussion of advocacy and innovation in our complex work environment, this issue also features a stimulating installment of the *CUAJ* "Business of Urology" series. This review by Oake et al focuses on change management in our practices and hospitals.[3] The concepts involved in change management emanated from corporate entities, but have increasing relevance in healthcare, particularly in our not-for-profit environment. To facilitate healthcare reform in Canada, managers and other decision-makers (including physicians) must have an understanding of how change occurs to create a setting that is encouraging for innovation adoption. I challenge you to consider and reflect on a particular initiative in your own professional lives, perhaps adoption of BLC as described above, when reviewing this article. As a change agent, how could you best gain commitment and overcome resistance to sufficiently cultivate an environment receptive to bringing a novel and transformative technology or practice change? Perhaps keep front of mind the concepts and solutions addressed in the article at the upcoming CUA annual meeting in Toronto, which has a stated focus on enhancing quality of urological care in Canada. Good reading and excellent lessons for us all!

References

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