EDITORIAL Watching the bottom line in urology

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The development of expensive solutions to many of the life-threatening illnesses, as well as chronic disease, in our aging population is escalating pressures on our healthcare system. According to the Fraser Institute, the costs of health care exceed more than 50% of revenues in about half of the provinces, and may surpass 75% of revenues in 5 provinces by 2019.[1]

Although the Canadian Institute for Health Information would suggest that the growth in healthcare spending has slowed, it is obvious that curtailing costs with a focus on physician compensation, hospital spending and drug costs will continue to be our reality for the foreseeable future.[2]

In this issue of *CUAJ*, we present a mini-theme involving studies focused on costs of delivering urological care with a definite Canadian flavour. Moore and colleagues present a prospective review of actual costs incurred for a pediatric pyeloplasty performed either open or laparoscopically.[3] Comparing global costs of procedures is often difficult to interpret given the perspective of the analysis, which is significantly affected by the type of healthcare system. In this paper, local costs were prospectively collected over a short time span and separated into those incurred by different departments involved, including nursing, diagnostic imaging, and the operating room, better allowing identification of real-time, potentially modifiable variables.

The future of conducting trials in many of our clinical settings in Canada appears to be under constant threat with national funding reductions and the above-mentioned need for cost-containment. However, the perception that the costs of care for patients enrolled in clinical trials are greater than standard of care is challenged by Jones and colleagues.[4] Although it is not yet possible to translate these results too widely due to the limited cohort/study window, the lack of a significant difference in direct costs goes a long way to soften the concern that clinical trials are too much of a burden on our universal health-care system.

In another analysis of cost, Klinghoffer and colleagues present a cost-utility analysis of radical nephrectomy compared to partial nephrectomy for small renal masses.[5] The authors use a Markov decision analysis model, specifically addressing health states of chronic kidney disease and dialysis. As outlined, there can be real problems with cost-effectiveness analyses, including difficulties with the quality of data if it is based on a disease simulation models rather than clinical trials. The timelines of the analyses often extend beyond the available data, requiring more modelling of outcome instead of direct measurements. As well, there are significant limitations to the arbitrary $50 000 willingness-to-pay threshold often targeted if it is strictly used for resource allocation.[6] However, the results of this Canadian study help to underscore the increasingly important role of nephron-sparing approaches to small renal masses.

Those responsible for resource allocation in health care, be it public or private, will need to constantly focus on ways to increase efficiency considering both benefits and costs. It is essential that our research community continue to deliver and debate this information if we are to be involved in the stewardship of urological care in the future.

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