

Comparative Effectiveness in Health Care: Operationalizing Evidenced – Based Medicine

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Project HOPE

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We All Agree on the Problems

- ◆ Unsustainable spending growth
- ◆ Lots of problems with patient safety
- ◆ Lots of problems with quality/clinical appropriateness



And, for the U.S. — the uninsured

Slowing Spending/Improving Value is Critical



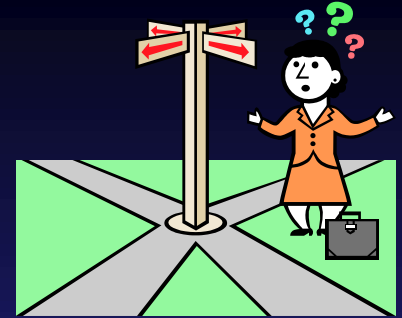
- ◆ ↑ in spending is biggest driver of uninsured
- ◆ Improved value/slower growth will facilitate coverage expansions
- ◆ Rising health care costs putting huge pressures on:
Employers, Employees, Federal Budget

What We Know



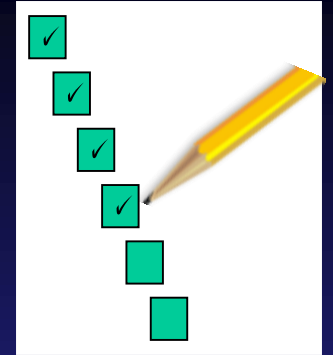
- ◆ Huge variations in care exist
- ◆ Spending *more* not the same as *more quality*
- ◆ Spending growth partly relates to technology growth, need to learn how to “*spend smarter*”
- ◆ Spending growth largely related to growth in chronic disease, need to learn how to “*treat smarter*”

To Change Where We Are...



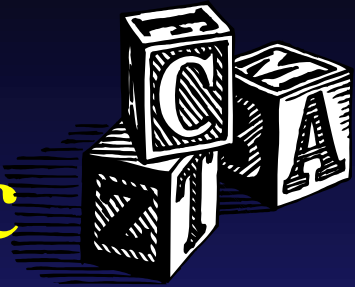
- ◆ We need to *measure better*
 - need a “score-card”
 - quality, efficiency, “patient-centeredness”
- ◆ We need *better information*
- ◆ We need to *change the incentives*
 - *Medicare* – 25 years getting it exactly *wrong!*
 - *Private Sector* – not much better

Some Data is Starting to be Available



- ◆ “Hospital Compare” - public data
- ◆ New P4P measures being collected for docs
Really P4R, started July 1, 2007
- ◆ JCAHO “Quality Check” – Public reporting

Need Better Information – Comparative Effectiveness - Basic Building Block ...



Information on...

“What works when, for whom, provided by...”

also...

Recognition that “technology” is rarely

always effective or *never* effective

CCE Needs the Right Focus



Elemental building blocks to “spending smarter”

- ◆ Focus on *conditions* rather than *interventions/therapeutics*; *procedures*, not just Rx and devices
- ◆ Invest in what is not yet known; use what is known more effectively

Dynamic Process...

Comparative Effectiveness Should Include Data from Many Sources



- ◆ “Gold Standard” - - double-blinded RCT
- ◆ “Real World” RCT (Sean Tunis)
- ◆ Epidemiological studies; medical record analyses
- ◆ Administrative data

Need to understand: All data have limitations

To Be Useful Information *must be*

- ◆ Objective
- ◆ Credible
- ◆ Timely
- ◆ Transparent
- ◆ Understandable

What a U.S. Center on CCE will *NOT* be ...



- ◆ *Not* providing a new coverage requirement used for practice decisions/*reimbursement*
- ◆ *Not* a decision-making center
- ◆ *Not* a cost-effectiveness center

Cost-effectiveness is important, but...
should be dealt with separately

How to Bring in Cost-Effectiveness



- ◆ Fund cost-effectiveness studies with same funding stream as CCE
- ◆ Keep C/E analyses *separate*
- ◆ Medicare will need new authority to use C/E
 - reimbursement vs. coverage
- ◆ Private payers can fund additional C/E studies
 - universities; free standing centers

“Spending Smarter” Also Means Better Incentives



- ◆ Need to realign financial incentives
- ◆ Reward institutions/clinicians who provide high quality/efficiently produced care
- ◆ Use “value-based” insurance and “value based” purchasing
- ◆ Reward healthy lifestyles by consumers

What This Means for Industry...



- ◆ Raises the bar for ↑ reimbursement
“Get more if do more”
- ◆ Needn't delay entry time to market - - especially if
company “*goes at risk*” for addit'l reimbursement
- ◆ *Significant* change for the medical community
will need support of “thought leaders”

Lots of Interest



- ◆ Some interest across the political parties
- ◆ Industry support is mixed —
 - Big pharma wants transparent process,
minimal extra delay
 - Small pharma/biotech worried about delays;
Device companies nervous about small
incremental improvements
- ◆ Physician groups beginning to “declare themselves

What Next?



- ◆ Congressional interest continues...
 - Part of CHAMP bill passed in 2007; superseded by Senate
 - Baucus/Conrad Bill introduced August 2008
- ◆ President-elect Obama supported CCE in the campaign

2009 should be the year!