# Comparative Effectiveness – A Key to Health Care Reform

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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, of course—the uninsured

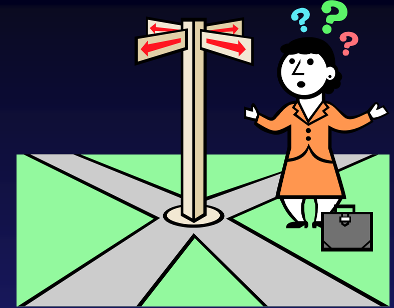
# Slowing Spending/Improving Value is Critical

- ⬆ 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

# Better 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 *More* Data; *Better* Data**

Means a major investment in
***Comparative Effectiveness information***

That is … 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 i***nterventions/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: <u>All</u> data have limitations

# How to Bring in Cost-Effectiveness

- Fund cost-effectiveness studies with same funding stream as CCE
- Strong preference to keeping activities separate
  -- at AHRQ or CMS or wherever
- CMS needs 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 in private sector
- Reward healthy lifestyles by consumers

# Will Better Information, Better Information Systems and Better Incentives --

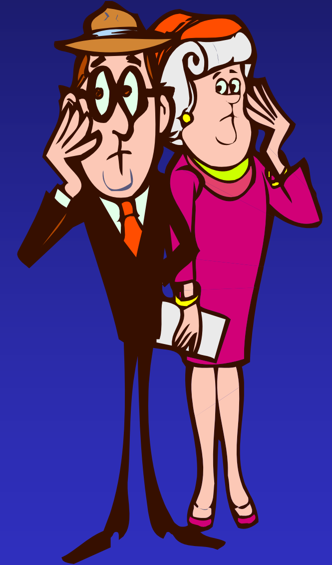
- Improve Values?

  Yes, should improve values

- Moderate spending growth rates?

  Should – but don't know for sure

Better than the Alternatives!



# Lots of Interest

- Some interest across the political parties
- Industry support is mixed –
  - Big pharma ok as long as 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 August; superseded by Senate
  - Baucus/Conrad Bill introduced August 2008
- Presidential candidate's recognize imp. of CCE

2009 should be the year!