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 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-blind RCT
- “Real World” RCT (Sean Tunis)
- Epidemiological studies; medical record analyses
- Administrative data

Need to understand: All data have limitations
How to Bring in Cost-Effectiveness

(Target)

♦ 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!