Comparative Clinical Effectiveness and Reimbursement

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What's the Problem?

- Spending growth rates are unsustainable
  - 2.5% annual growth faster than the economy (1960-2004)
- Lots of problems with patient safety
  - 95,000 medical errors
- Lots of problems with quality
  - On average, about half of what's appropriate

Not *Just* a U.S. Issue

- U.S. spends a lot compared to other countries

  but…

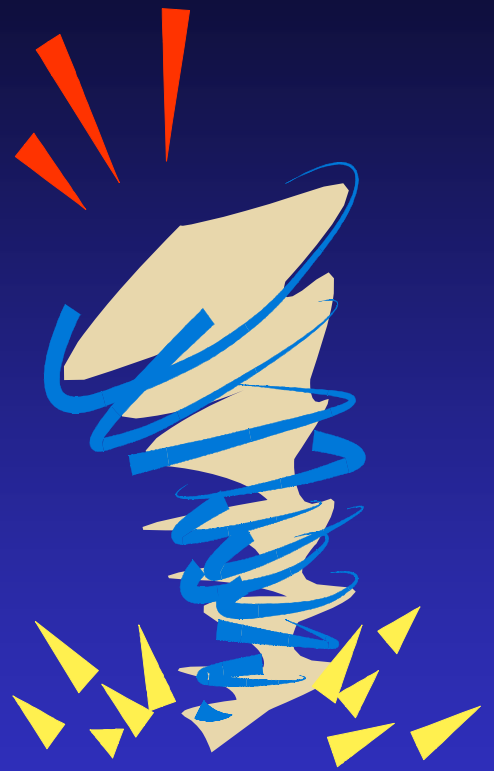
- ***Growth rates*** aren't ***so*** different

  although...

- Canada, Germany, UK have done better in moderating spending

To Change Current Patterns

Health Care needs ---



- Better information
- Better information systems
- Better incentives
  (or much more stringent controls)

Current Disconnects in Healthcare; esp. in the U.S.

- Very sophisticated medical devices and procedures

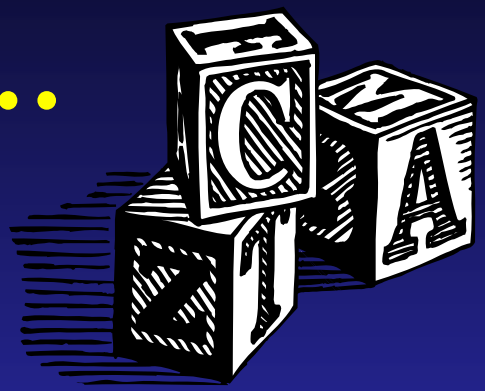
but ---

- "Cottage Industry" in terms of systems and information

and ---

- No rewards for low cost, high-performing providers

Comparative Effectiveness Information
A Basic Building Block…



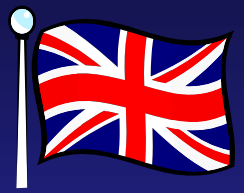
Information on…

"What works when, for whom, provided by…"

also…

Recognition that "technology" is rarely
always effective or ***never*** effective

Other Countries Are Ahead

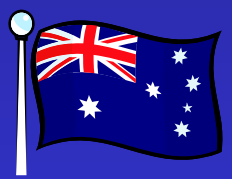


- Have comparative effectiveness Centers

--NICHE in United Kingdom

--CDM in Canada

--PBAC in Australia



But, mostly for Rx and devices

That misses where most of the money is!

Other Countries…

- Mostly centralized process of CCE and economic assessments; literature review focus
- Agencies are usually part of government

  Not surprising – use centralized payer systems

but…

- ***Differ*** on mandatory nature of recommendations
- ***Differ*** on transparency of process

U.S. Needs Something Different

"Center for Comparative Clinical Effectiveness"

- Elemental building block to "spending smarter"
- Focus on ***conditions*** rather than
  i***nterventions/therapeutics***;
  procedures, not just Rx and devices
- Invest in what is not yet known

Dynamic Process…

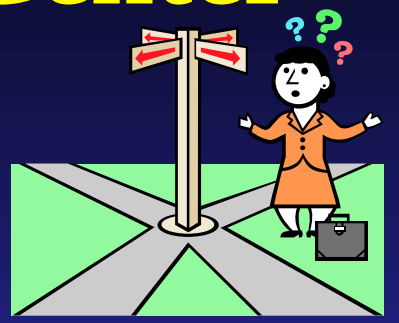
Center Would Include Data from a Variety of Sources

- "Gold Standard" - - double-blinded RCT
- "Real World" RCT (Sean Tunis)
- Epidemiological studies
- Medical record analyses
- Administrative data

To Be Useful Information *must be*

- Objective
- Credible
- Timely
- Transparent
- Understandable

Different Views on Placing the Center



- In HHS?
  Separate agency; FFRDC, AHRQ
- Free standing agency in Exec. Branch
  like FTC, FRB
- Quasi-Gov't
  IOM/NRC

"Close to Gov't…But not too close"

Funding of Center

- ***Preferred*** Strategy:
  - direct appropriation
  - information is a "***Public Good***"

- ***Realistic*** Strategy:
  - direct appropriations
  - contribution from Medicare trust fund
  - Small "user fee" on all privately insured

What the Center is *NOT*

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

C/E and C/B important, but…
should be dealt with separately

Incentives Are Also a Big Problem

- Need to realign financial incentives
- Reward institutions/clinicians who provide high quality/efficiently produced care
- Also need to involve consumers
  - "value-based" insurance;
  - reward healthy lifestyles

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"

What Next?

- Lots of interest
  Industry, Insurance, Congress, MedPac, etc.
- Some legislation beginning to emerge

But --

Too soon to know

And--

"The devil is in the details"