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 *interventions/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”