

Developing Comparative Effectiveness Information

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Project HOPE

December 17, 2008

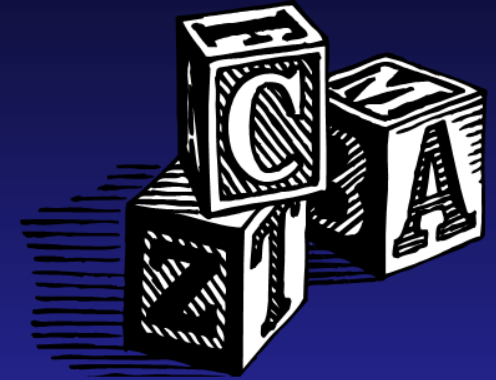


Slowing Spending/Improving Value is Critical



- ◆ ↑ 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

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

CCE Needs the Right Focus



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; 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

Different Views on Placing a CCE Center

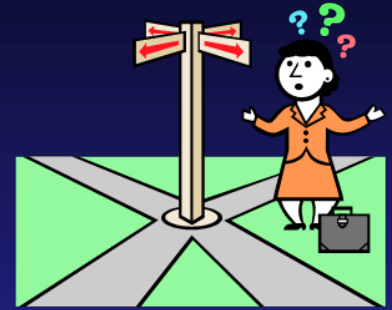
- ◆ In HHS?

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”



Advantages/Disadvantages

+/-

Trade-offs with all placements

- ◆ If use *existing* bureaucracy, don't need to create new one
- ◆ *Vulnerability* of existing institutions to political pressures
- ◆ *Credibility* – stronger inside or outside gov't?
- ◆ *Accountability* – harder the further from gov't

Governance Issues are also Important

- ◆ Governing body to reflect major stakeholders?
 - part of center or freestanding
- ◆ Appointments by Executive branch with confirmation by Senate? Staggered terms?
- ◆ Specialized scientific advisory boards, created for specific issues
- ◆ Include both intramural and extramural activities?

Funding of Center



- ◆ More *usual* Strategy:
 - direct appropriation like NIH
 - information as a “*Public Good*”
- ◆ More *Realistic* Strategy?
 - direct appropriations
 - contribution from Medicare trust fund
 - Small “user fee” on all privately insured

What a Comparative Effectiveness Center is *NOT*



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

“Spending Smarter” Also Means Better Incentives



- ◆ Need to realign financial incentives
- ◆ Reward institutions/clinicians who provide high quality/efficiently produced care
- ◆ “Value-based” insurance
- ◆ Also need to involve consumers reward healthy lifestyles