Better Information for Better Decisions –
The Role of
Comparative Effectiveness Research

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Lots of U.S. Challenges ---

♦ Spending growth rates that are unsustainable
  - slowed for several years; expected to grow 1.3% faster than GDP

♦ Lots of problems with patient safety
  250,000 deaths from medical error?

♦ Lots of problems with quality
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…

♦ 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. Needed Something Different

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…*

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Setting Priorities for Comparative Effectiveness

**Starting Point:** High cost medical conditions with lots of variation in treatment

**Proxy:** Conditions reflecting highest cost DRG’s with substantial geographic variation

**Also:** Allow private funding of CCE assessments, subject to guidelines/with auditable results
Good Decisions Need Data from Different 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.

But “Spending Smarter” Also Means Better Incentives

♦ Realigning financial incentives
♦ Rewarding institutions/clinicians who provide high quality/efficiently produced care
♦ Using “Value-based” insurance in private sector
♦ Rewarding healthy lifestyles by consumers