



When Comparing Effectiveness, You Can't Ignore Costs*

By John E. Brush Jr., M.D., F.A.C.C.

In the current health care reform debate, there has been considerable discussion about comparative effectiveness. This method of evaluation could provide valuable information on the relative value of competing drugs, devices and treatment strategies — which could then improve outcomes, efficiency and satisfaction. Critics are concerned, however, that comparative effectiveness could be used to deny

active effectiveness research will give policymakers important information that will help them set priorities for spending. Granted, at the level of the patient and provider, comparative effectiveness analysis, like guidelines, should inform but not dictate clinical decisions. Publicly-available information about comparative effectiveness should enhance, not encumber the doctor-patient relationship.

We face an unfortunate truth – the growth in health care spending is not sustainable, and it is making health care unaffordable for average Americans. In health care, we can have nearly anything we want – we just can't have everything we want.

coverage, squelch innovation and ration care. Because of these concerns, some stakeholders argue forcefully that comparative effectiveness evaluations should be totally devoid of cost considerations.

But, how can you compare competing treatments and ignore costs? Using heart failure as an example — could you really compare the relative effectiveness of ACE inhibitors and left ventricular assist devices and ignore the wide difference in costs between the two treatments? In addition, isn't the public's desire to gain "more bang for the buck" what's driving health care reform in the first place?

Cost effectiveness research is difficult and has recognized limitations, yet no method of research is perfect or definitive. Although cost effectiveness research has limitations, we should not reject the useful information that it provides for comparative effectiveness analysis.

There is a compelling need to contain costs in order to extend health care coverage universally in America. Compar-

Transparency and Separation Important

Oversight of comparative effectiveness research and analysis requires a disciplined and transparent approach. Advisory boards should be absolutely free of financial conflicts of interest and should be shielded from undue political influence. For years, the National Institutes of Health has distributed billions of dollars in funding, using established methods that are generally respected as fair and non-biased. Similar independence and discipline can be established for overseeing comparative effectiveness.

Comparative effectiveness research using cost considerations should be a two-part process. The first should pertain to relative clinical effectiveness, and the second should pertain to costs. For competing treatments with similar clinical effectiveness, direct cost comparisons to determine the optimal strategy would be straightforward. However, for comparisons where one treatment is more effective, careful analysis of costs will be necessary to estimate the relative value — or the cost

per unit of effectiveness — of the competing strategies.

A firewall should be constructed between comparative effectiveness evaluation and insurance coverage decisions. The funding level for coverage is a political or a business issue, not a scientific issue. Congress — and ultimately the taxpayers — decide funding levels for Medicare. Purchasers and benefit design managers determine funding levels for private health plans. Physician groups can advocate for coverage and reimbursement, but such efforts should be walled off from comparative effectiveness analysis.

To separate comparative effectiveness analysis from coverage decisions, we could borrow a method commonly used to determine grant funding. When judging grants, the judges evaluate the grants based on the scientific merit of the grant, without consideration of whether the grant will actually receive funding. Grants are graded on a relative scale, and the top grants that fall within the funding range are awarded. Judging grants and funding grants are independent processes. A similar method could be used to ensure that comparative effectiveness judgments are isolated from coverage decisions.

An Unfortunate Truth

The device and pharmaceutical industries are predictably worried about comparative effectiveness. Undoubtedly, comparative effectiveness will put pressure on pricing, which is generally lacking when providers and patients pass costs on to third-party payers. Transparent comparative effectiveness would give consumers of health care an opportunity to shop for greater value, which will help contain overall costs. The resulting market pressure should spur, not squelch, innovation.

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Providing a basic level of care to all Americans is simply a matter of triage. The current method is haphazard, expensive and inadequate. Given escalating costs and limited funding, we need to differentiate medical treatments with high value from those with little incremental value. Without objective analysis of comparative effectiveness, the costs of medical care will continue to rise — to the detriment of our patients and our profession. Comparative effectiveness analysis that includes cost considerations will help our country provide adequate care for all and will help us provide the most effective treatment for our patients.

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***Adapted from editorial on LewinReport.acc.org.**



Letters

Positive Vote on Single-Payer Option

A single-payer system is essential to produce a significant saving in our health care system. It would eliminate layers of redundant administrative costs. A public health option would minimize the current, sometimes obscene, profits and salaries of the private health industry. As it is, our expensive, wasteful health care system does not give Americans adequate, quality health care.

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Board Exams, a Hot Issue for Practicing Physicians

I am glad to see ACC finally address the numerous certification boards issue. I for one do not agree with having boards for every single aspect of cardiology. For those of us who are out of training, in addition to the expense, we face a loss of work and wages while preparing for and taking the exams.

In addition, many insurance companies are now taking advantage of these unnecessary boards to cut reimbursements. In addition to the cost implications of these unnecessary boards, they are now a powerful medico-legal tool with implications for the practice of medicine. This in itself should prompt us to do away with these expensive, unnecessary boards. The regular cardiovascular boards, I believe, are comprehensive and should be of a standard necessary to practice good medicine.

I would like to see a common platform through ACC for third-party reimbursements, so that individual members do not have to deal with this.

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