

ACP Issues Call for Cost-Effectiveness Research

It's time to back up treatment decisions with solid cost-effectiveness data, asserts the ACP in a position paper.

BY JANE ANDERSON
Contributing Writer

WASHINGTON — The American College of Physicians, saying it is time for patients, physicians, and policy makers to consider the economic impact of health care choices along with their clinical impact, has issued a call for the creation of a new, independent entity that would conduct and disseminate such research.

Acknowledging fears that “this could be one of the first steps down the road to the rationing of care,” Neil Kirschner, Ph.D., senior associate of regulatory and insurer affairs at the ACP, said that “the college believes this type of information should be used as a tool.

“Cost is already playing a major role in health care decisions,” and patients and physicians deserve solid clinical and cost-effectiveness information to back up treatment decisions, Dr. Kirschner said at a press briefing about the ACP’s new position paper outlining the need for better clinical and cost-effectiveness research.

The call comes at a time when lawmakers have shown some enthusiasm for research into comparative effectiveness. Last fall, about \$375 million in proposed funding for such research—through the Agency for Healthcare Research and Quality (AHRQ)—was included in the Children’s Health and Medicare Protection Act, but that bill failed to pass the Senate.

The position paper, released at the ACP’s annual meeting and published simultaneously online in the *Annals of Internal Medicine* (www.annals.org/cgi/reprint/0000605-200806170-00222v1.pdf), recommends a different approach: The

ACP advocates an independent national research organization—sheltered from special interest influences—that could supply reliable information about what health care approach works best for patients in specific clinical situations, within a limited budget.

The proposed new entity would develop and disseminate evidence on comparative clinical effectiveness and cost-effectiveness in health care, according to the ACP. It also would educate the public about what the ACP said is the urgency of modifying “an American cultural bias toward downplaying the cost of health care—especially when payment seemingly comes from a health insurer or other third-party payer rather than from patients’ own pockets.”

“Cost is not going away,” ACP Regent Stephen Pauker said at the briefing, held during the ACP’s annual meeting. “We are a country and a society of finite resources, and if we have limited resources we need to use those resources wisely.”

Traditionally, researchers have compared treatments with placebo, but treatments must be compared with each other to gather information that would be useful in comparing cost and clinical effectiveness, Dr. Pauker noted. “Cost should be considered, but should never be considered without the simultaneous consideration of outcomes.”

The ACP’s position paper notes that many insurers already use information about cost because they must manage finite budgets.

“Of note, the strongest opposition seems to come from such constituencies as elderly persons and patients with certain

chronic illnesses, for whom the incremental benefits of expensive interventions are typically small,” the paper reads.

The ACP is lobbying to add funding to that Medicare legislation for creation of a new entity that would study both cost and clinical effectiveness, said ACP President David Dale.

“Who wouldn’t want the most they can get for their money?” Dr. Dale said at the briefing. “On the other hand, this aspect of medicine has many complexities.”

There is a research gap when it comes to studies comparing cost and clinical effectiveness of different treatments, according to the ACP’s paper. “The college reviewed the national and international literature on comparative effectiveness information and came to the conclusion it is in incredibly short supply,” Dr. Kirschner said.

For example, when comparing two cancer drug therapies, “A” could be substantially more expensive but could hold the potential for an additional 5 years of life, which could give it a cost-effectiveness advantage over less expensive therapy “B,” Dr. Kirschner said. However, if the two therapies are similar in effectiveness but “A” is more expensive, then “B” would be preferred, he said.

“This type of relative economic value information is very little produced and very little used,” Dr. Kirschner said. The National Institute for Health and Clinical Excellence in the United Kingdom produces this type of information for use in the U.K.’s National Health Service, he noted, but U.S. funding for such research at the AHRQ amounts to only \$15 million a year.

There are concerns that development of this type of information could lead to limited access to more expensive therapies, and trigger a backlash from patient groups and other health system stakeholders, Dr. Kirschner said. For example, he said, “Medicare, on two different instances, tried to implement cost information in coverage, and both times has had to back off.”

That’s why the ACP is advocating that an independent, mostly federally funded entity conduct such research, Dr. Dale said. “The public and clinicians will only trust such information if it comes from an independent research source that does not itself have an economic conflict of interest in the results of its analyses.”

The ACP would support adding such research funding to the AHRQ’s budget if the studies could be adequately protected from the influence of special interests, Dr. Kirschner said.

However, the ACP believes that AHRQ may not be the best place for such a research effort, he said. As an agency within the executive branch of government, AHRQ “may not be protected enough from influence” from various stakeholders, he said.

Instead, the ACP in its position paper recommends establishment of a completely independent national entity that is “protected from undue government and private sector influence.” The entity should be completely transparent, should include extensive stakeholder involvement, and should implement processes to ensure the general dissemination of its findings, according to the position paper. ■

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Barriers to Greater Electronic Health Information Use Remain

BY JANE ANDERSON
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WASHINGTON — Although e-health activities are becoming commonplace, a variety of legal, financial, and logistical issues still must be addressed for the technology to realize its potential for physicians and patients, the American College of Physicians said in a position paper.

The challenges for effectively implementing e-health activities lie not only in the adoption of universal technical standards for the exchange of electronic health information, but also in the more fundamental concern of economic support for health information technology, the ACP said in its new position paper, which was released at the group’s annual meeting and can be found at www.acponline.org.

“ACP believes that patient portals and personal health records may provide the biggest benefits to patients when they are used collaboratively with physicians,” said ACP President David Dale at a press briefing at the meeting.

But Dr. Dale added that, “the biggest single concern of physicians is the substantial cost in acquiring and main-

taining the necessary technology, which averages \$50,000 per physician.”

The paper, “E-Health and Its Impact on Medical Practice,” analyzes the benefits, technical and financial challenges, and legal issues related to adopting and implementing e-health activities for physicians and patients.

These issues include the privacy of medical records, financing and payment for physicians adopting electronic records and communication systems, computer literacy among patients, and telemedicine development and funding.

The ACP also recommends the creation of national standards for e-health Web site content.

Dr. Joel Levine, chairman of the ACP Board of Regents, said at the briefing that e-health initiatives have great potential to transform health care in the United States, especially as part of the development of the patient-centered

medical home.

“ACP recommends ongoing investment in demonstration projects ... within the context of the patient-centered medical home,” Dr. Levine said.

However, Dr. Dale and Dr. Levine both said that payment policy reforms are needed to compensate physicians

appropriately for their investment in and implementation of e-health services.

The new fee structures likely would include some sort of flat fee that would cover all communications with a patient, they said.

“This is the management of chronic health we’re talking about—you can’t do that by giving me 25 cents every time I click on my Blackberry,” Dr. Levine commented.

In addition, confidentiality, privacy, and standardization are needed to create a trusted nationwide health information network, according to the ACP, as health care providers and individuals are likely to be reluctant to adopt e-health activities unless they are confident that the systems are secure and accurate.

In the paper, the ACP calls on technology developers and policy makers to support standards that address interoperability, functionality, security, privacy, content, and legal liability. In addition, it recommends the use of secure Web messaging infrastructure rather than standard e-mail to ensure the highest levels of confidentiality for electronic communications between physicians and patients.

Records of communication fall within the parameters of the Health Insurance Portability and Accountability Act and therefore must be protected according to HIPAA standards, the ACP said. ■

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