COMMENTARY

AHRQ Series Commentary 3: The United States addresses comparative effectiveness but not cost-effectiveness through the Effective Health-Care Program

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Accepted 22 January 2010

In this issue of the journal, authors from the Effective Health-Care Program of the Agency for Healthcare Research & Quality (AHRQ) outline their approach for appraising research evidence and providing “… understandable and actionable information for patients, clinicians, and policy makers” [1]. The methods outlined are not controversial, and it is clear that the program of work is of a high standard. However, in matters of health technology appraisal, the devil is often in the detail or at least in the implementation, and it is interesting to observe controversy emerging when vested interests are challenged.

Slutsky et al. [1] argue that "providing quality evidence that can be easily understood and used in decision making by patients, clinicians, and policy makers is essential to judicial and rational decision making." It is a common belief that the reason we do not always do the rational thing is that we are poorly informed. But, does international experience support the concept that better evidence will lead to better decisions? We argue that the evidence provided by the Effective Health-Care Program is a necessary, but not sufficient, requirement for improved health care resource allocation.

In 1992, the Pharmaceutical Benefits Scheme (PBS) in Australia introduced a fourth hurdle in pharmaceutical reimbursement, where, in addition to the conventional regulatory criteria (focusing on efficacy, safety, and quality of manufacture), only drugs considered clinical and cost-effective were to be reimbursed by the state [2]. This scheme was considered by some to be a major advance [3] and was followed in several other jurisdictions with variants of the approach, including that in the United Kingdom with the introduction of the National Institute for Health and Clinical Excellence (NICE).

Before the development of National Institute for Health and Clinical Excellence (NICE), we (N.F. and M.F.D) worked together on a program funded by the Department of Health in England to provide high-quality systematic reviews of effectiveness and cost-effectiveness to inform decision making in the National Health Service (NHS). Our Effective Health-Care Program was relatively modestly funded compared to that which has been initiated through AHRQ but shared the same name.

A striking conclusion from our experience, and indeed the experience of NICE subsequently [4,5], has been that providing information and guidance is simply not enough. Indeed, although efficiency schemes, such as NICE and PBS, appear quite effective at limiting the use of technologies judged not to be clinical or cost-effective under any circumstances, they are not that good at influencing the use of technologies, where their recommended application is restricted to specific indications. Furthermore, underuse of health technologies is a major problem, and the evidence we have suggests that NICE has little influence on achieving appropriate increase in usage [4,5].

Health care is an expensive business; Everett Dirksen commented “A billion here, a billion there, pretty soon it adds up to real money.” The cost and rate of increase in health care spending is acknowledged to be unsustainable in the United States [6]. As Slutsky et al. point out, current expenditure is approaching US$2 trillion [1]. The level of spending is particularly striking when we consider that this sum does not currently enable universal access to high-quality health care provision.

Although pointing toward the challenges presented by spiraling health care budgets as a rationale for providing
better evidence [1], many outside the United States will find it as a surprising omission that the cost-effectiveness analyses are not conceived as part of the scheme, especially as one of the target groups is health policy makers. It is fairly clear that the exclusion of costs was a political decision, which is necessary to make any progress in a world where there are considerable fears about the use of cost-effectiveness evidence in a process of rationing access to health care. In addition, as Wilensky [7] points out, in a fragmented system with a multitude of decision makers, consideration of cost and cost-effectiveness may be best viewed as a local issue.

Nevertheless, some 20 years after the development of the Effective Health-Care Program in the United Kingdom, we begin to appraise the Effective Health-Care Program in the United States. There is no doubt that health care systems need to be informed by good evidence on the effectiveness and comparative effectiveness of interventions (drugs, devices, and therapies). However, it would be a mistake to consider that improving the provision of this information is enough, and ignoring cost-effectiveness is a serious limitation. Evidence is only as good as what you do with it, and the test for the US health care system will be to see what can be done with the evidence produced by the Effective Health-Care Program. In particular, if evidence on cost-effectiveness is not included, how will cost enter into the decision-making equation, as it surely must? The risk is that, without the availability of studies of cost-effectiveness meeting the high standards that are being proposed for studies of comparative effectiveness, the consideration of costs will be inadequate or inappropriate.

Those interested in health care policy in the United States will follow these developments with considerable interest. We sincerely hope that the comparative effectiveness movement does not go the way of most other innovations in the US health care system and merely serve to further increase costs.

References