THE WALL STREET JOURNAL.
WSJ.com

HEALTH JOURNAL | JULY 28, 2009, 10:53 A.M. ET

Injecting Value Into Medical Decisions

In Debate on Reform, Many Say Quality Should Trump Quantity, But What's Best Isn't Always Clear

By MELINDA BECK

It's widely estimated that 30% of U.S. health-care spending—some $700 billion a year—is spent on tests, treatments and procedures that provide no value. But one man's waste may be another's life-saving treatment. And there are hundreds of medical quandaries with no clear answers.

When is angioplasty appropriate for patients with clogged arteries?

How often should patients with gastroesophageal reflux disease have upper endoscopies?

Which of eight expensive drugs for rheumatoid arthritis work best and are worth the potentially harsh side effects?

What works best to treat low back pain or prevent obesity, hypertension and diabetes?

Is weight-bearing exercise better than bisphosphonates in preventing hip and spinal fractures in older women?

As lawmakers battle over how to expand coverage for more Americans and how to pay for it, an equally contentious issue is looming: Many experts, doctors and politicians want to revamp the U.S. health-care system to reward the quality of care. That's a big departure from the decades-old practice of paying medical practitioners for the quantity of services they provided. It could mean fundamental changes, philosophically and practically, to a system that has long allowed doctors great leeway to use their own medical judgment and has given many patients the luxury of not having to make treatment decisions based on cost.

But who would determine what makes us healthier? What if the evidence isn't clear, or your doctor disagrees? What about a screening test with only a small chance of finding cancer? Or an expensive, last-ditch treatment that may add only a few months to your life? Setting up rigid rules could risk overlooking the idiosyncracies of each patient.

The government is making a big push for data that compare which treatments, tests, drugs and procedures work for a wide variety of conditions, known as comparative-effectiveness research. Experts inside government and out have been slowly collecting such information for years, much of it under the auspices of the federal Agency of Healthcare Quality Research, or AHRQ. This spring, Congress allocated $1.1 billion in stimulus funds for the effort, and the government's influential Institute of Medicine recommended 100 health topics that should get priority attention, from remedies for back pain to preventing falls in elderly.

Many doctors welcome the information as a way to inform their own decision making, assist patients who want to research their own conditions and help counter the power of pharmaceutical marketing to drive medical choices. A coalition of 62 medical associations has endorsed the comparative-effectiveness effort, noting that in some cases, such research could help identify high-quality, low-cost treatments, and in others, it could help persuade payers and providers that expensive new technology is worthwhile.

Some doctors say the government must be wary of drawing broad conclusions for large groups of patients. "If they are going to establish that prostate cancer grows so slowly that few men will die from it and therefore screening is not helpful, that would be a devastating situation for a lot of men," says David Samadi, who performs robotic surgery at New York's Mount Sinai Medical Center. He notes that 27,000 U.S. men die each year from prostate cancers, some of which are aggressive.

Elizabeth Lee Vliet, a women's health physician in Tucson, Ariz., notes that much medical data don't differentiate between women's and men's genetic and hormonal makeup. She points to the conclusions initially drawn from the Women's Health Initiative, which prompted millions of women to stop taking hormone-replacement therapy, even though later analyses found that HRT was a net gain for women who started shortly after menopause.

"Over the course of a year, you see stories with completely opposite conclusions about the treatment of heart disease and obesity. I don't have a great deal of confidence that a federal health board will necessarily be able to sort through all that and come up with reasonable conclusions," says Joseph Antos, a health-policy expert at the American Enterprise Institute. On the other hand, he says, "If we really have this information and it's any good, it would be absolutely idiotic not to use it to set policy or make very strong recommendations in the case of Medicare or Medicaid."

Proponents say that it's exactly in the case of contradictory studies that comparative-effectiveness data can be most useful. What's more, the stimulus bill specified that the new research effort cannot be used to set clinical guidelines, or mandate coverage, reimbursement or policies for public or private payers. "We are just focusing on developing better information," says AHRQ Director Carolyn M. Clancy. She notes that in four years of doing comparative-effectiveness research, "we haven't had a study yet that found one option is terrific and the other is thumbs down. It's always shades of gray, just like in real life."

The AHRQ's Effective Healthcare Guide for localized prostate cancer, for example, concludes: "There are a lot of good options, including watchful waiting, and we don't have good evidence yet to say which path is superior."

Even so, conservative critics fear that comparative-effectiveness research, also known as evidence-based medicine, will ultimately be used to justify rationing health care—and that the elderly could be most vulnerable. Under the U.K.'s single-payer system, the National Institute for Health and Clinical Effectiveness makes coverage decisions based on "quality-adjusted life years"— taking into account a patient's life expectancy.

Other critics believe that research into treatment outcomes is critical, but that it shouldn't be centered with the government, since political pressure will inevitably prevent the agency from conducting useful research. "The graveyards of Washington are littered with agencies that once performed comparative-effectiveness research and ended up questioning the value of special interests," says Michael Cannon, director of health-policy studies at the Cato Institute, a research foundation.

Indeed, some health-care experts say the government should go much further to insist on getting value in Medicare and Medicaid, where it foots the bill.

As it is, Medicare rates are set by Congress and are subject to intensive lobbying every year. New treatments that provide a "net value" are approved without regard to cost. Payment rates vary dramatically across the country, and encourage the use of expensive specialists rather than primary-care physicians. Staffers who give patients nutrition and other counseling aren't reimbursed at all.

White House Budget Director Peter Orszag last week proposed creating a new independent body to make recommendations on Medicare rates—much like the military base-closing commission. Its recommendations would go into effect automatically unless Congress blocked the entire package. But House leaders balked at the idea, and on Saturday, the Congressional Budget Office suggested that such an effort would likely save only a few billion dollars. Meanwhile, several conservative Democrats who want to increase Medicare payments to rural areas continued to oppose the House plan.

The House reform plan does contain some ideas for rewarding quality rather than quantity in Medicare, along with cutting an estimated $500 billion from its budget over 10 years. Provisions call for improving pay for primary-care doctors, eliminating co-pays on preventive services and giving hospitals incentives to reduce readmissions.

The House bill also sets up pilot programs to test the idea of a "medical home," in which doctors and nurses coordinate all the care a patient might need. Another program would test "accountable care organizations"—the kind of group practices where salaried doctors collaborate on treating patients and often produce high-quality care at lower prices. President Barack Obama last week traveled to the Cleveland Clinic to spotlight its operation. But it remains to be seen how widely that model could be replicated, since most doctors prefer to work independently. As it is, the Cleveland Clinic also offsets its Medicare losses with private insurance reimbursements, foreign patients who pay high rates and philanthropic gifts.

The biggest petri dish of all for experimenting with quality-not-quantity health care would be the giant public insurance program that the House plan envisions. The public plan would have the authority to develop innovative payment rates and encourage "high-value" services, according to the proposal. Would it keep a tight rein on costs and ration care? Would it be subject to frenzied lobbying as Medicare is? Or will it be defeated as a step too close to a single-payer system? Stay tuned.

Write to Melinda Beck at HealthJournal@wsj.com