

## Summary of Workshop #1

### Technology and Outcomes Assessment

#### **Paper 1: Steven Pearson—Harvard and NIH: Technology Assessment**

This paper noted that previous and current technology assessment in the United States is done poorly for four main reasons:

- Poor coordination, technical standards and uneven quality.
- Weak legitimacy since many payers pay for the assessments and poor transparency to give public confidence in objectivity of the results.
- Limited usefulness since assessments take too long and, more important, they fail to integrate cost into assessments.
- Poor or no integration of technology assessments with coverage decisions.

Examples of technology assessment, especially the National Institute for Clinical Excellence (NICE) in the UK were examined and shown to have important characteristics for a successful technology assessment initiative in the United States.

The study of past and existing efforts in the US and experiences in foreign countries lead to 5 key recommendations:

- Define common nomenclature and classification. Pearson offered a comparative clinical effectiveness matrix as an example.
- Enhance transparency of the assessment process by engaging all stakeholders including technology manufacturers, physicians, payors, patient advocates, etc.
- Integrate costs into technology assessment. This is key for determining the value of a new technology.
- Integrate technology assessment into benefit design, mainly by having higher co-payments for technologies that are less effective or more costly.

**Commentary #1: Osnat Luxenburg: Israeli Experience:** Israel has 4 competing health plans and government specifies an itemized basket of services that the health plans are paid to deliver to citizens; health basket has about 3500 technologies from drugs to surgical procedures. Technology assessment is conducted by the Ministry of Health. Assessments are directly integrated into what technologies will be placed in the basket of services will be paid for. Thus technology assessments are done each year—very rapid, in about 6 months. The process is multi-step:

- Identify new technologies
- Collect clinical, epidemiological and economic data on technologies. This entails cooperation with international agencies that also conduct technology assessment, such as those in Canada, Australia and UK.
- List services and identify those which might be potentially included in the basket, those that would be desirable to include, and those excluded
- Input from health plans, technology companies, physicians

- Recommendations presented to the Public Committee which includes all the stakeholders, government, and the public.
- Government then approves the inclusion of the recommended technologies based upon available funds.

Advantages include centralized process, stakeholder involvement. These enhance legitimacy although there are some groups that criticize particular decisions. The short time is viewed as an advantage in that it does not permit a vacuum in which technologies might be adopted that cannot be cut or time for political interference. Rapid decisions agree with slower NICE decision in over 90% of cases and most disagreement is the result of not enough money to cover a technology.

**Commentary #2: Stirling Bryan: NICE Experience:** In Britain coverage decision are made at two levels, locally by trusts and by NICE. There is mandatory guidance from NICE to local trusts. NICE is a relatively slow process. Technology manufacturers can provide data and analysis but otherwise are not involved in the assessment process to reduce conflict of interest. NICE has been criticized as too slow. There is a new fast track assessment but it relies solely upon manufacturers' supplied data.

What is technology assessment trying to achieve? Efficiency, coverage decisions or equity? Bryan strongly disagrees that manufacturers should be a stakeholder in technology assessments. Asks why AHRQ could not do the technology assessments in the US?

**Commentary #3: Sharon Levine: Health Plan Perspective:** At the moment, Kaiser and other health plans are prohibited by law from using cost-effectiveness assessment for coverage decisions. Thus cost-effectiveness decisions are made surreptitiously. Agrees with following views:

- Technology assessment must be done at the federal level because assessments by individual health plans lack legitimacy.
- Standardized form for assessments and technology categorization is essential.
- Must have campaign finance reform to have technology assessment. PHARMA pays too much in campaign contributions to have objective assessment.
- Technology assessment needs to have a mechanism to revisit decisions in light of new data. This is key to legitimacy with physicians—having assessments that are current and accurate.
- Must have way to change consumer perception that new technology is necessarily a better technology.

## General Discussion

- 1) No political appetite in Washington for a central technology assessment entity, but AHRQ could do more technology assessment.

- 2) Technology assessment organization needs a big budget because it must be able to both examine existing data and initiate head-to-head comparisons that will not otherwise be conducted.
- 3) While technology assessment must be done with speed and thoroughness, the bias should be to thoroughness otherwise mistakes discredit process. Can get speed by issuing of interim reports.
- 4) Technology assessment organization should be divorced from coverage decisions. This enhances credibility. Coverage should be decentralized among health plans.
- 5) Technology assessment will send price signals to manufacturers. This may be welcomed by manufacturers because gives them some predictability about how things will be evaluated and what will be covered.

### **Paper #2: Jonathan Skinner--Dartmouth: Outcomes Assessment**

Technology assessment is only part of the information necessary to try to ensure the health care system pays for value. There is huge variability in costs even when the technology used is similar. This variability suggests it is not just the technology that is key, but how it is implemented, by whom, on what patients with what other conditions, and the surrounding services that are provided where there are no clear assessments, such as how many follow-up office visits and what follow-up laboratory and radiological tests.

What is necessary for an effective outcomes assessment process?

- Accountable health care organizations so that we know who is responsible for the outcomes.
- A way to validly and reliably measure the outcome. This will entail not just a measurement tool but also real time ability to collect data from accountable health care organizations.
- Interventions and other mechanisms to improve low performing organizations.
- Incentives—rewards and punishments—that can induce organizations to improve and improve the outcomes.

### **Commentary #1: Stirling Bryan**

Outcomes assessment compliments technology assessment. Skinner's data on heart attack variations in outcomes and cost highlights that health care is a local event. This means the data we have from clinical trials and other studies break down at the level of the delivery of care to a large population.

### **General Discussion:**

- 1) There are important differences between technology and outcomes assessment but they are complimentary. Technology assessment begins with technology in an ideal setting. Outcomes assessment begins with groups of patients and how a combination of interventions work over time and different locations.
- 2) To implement findings from outcomes assessment need better management skills.

- 3) The current situation in which there is either on-label use of drugs and interventions or off-label is too crude. In Israel, on-label use is permitted and paid for. But this creates its own problems when off-label use is good and cost-effective but for reasons companies don't apply for other use, e.g. lucentis and avastin.
- 4) There was recognition that much of assessment today is about processes of care, but processes of care do not always translate into good outcomes. We need to measure both processes and outcomes of care and try to better understand how they are related.
- 5) Part of the key to giving the right incentives may not be the amount of money, but recognition—both positive and avoidance of negative public image—as well as help in figuring out what interventions to implement to improve outcomes.
- 6) In the outpatient setting, outcomes require the input of multiple doctors, so it is hard to assign accountability. Thus for true outcomes assessment it will require some important changes including 1) cooperative among physicians, 2) payment systems that encourage cooperation as well as improvement.

Attendees at FRESH-Thinking Workshop on Technology and Outcomes Assessment  
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**Co-Principals:**

Ezekiel J. Emanuel, MD, Ph.D.  
Chair, Department of Clinical Bioethics  
National Institutes of Health  
Bethesda, MD  
[eemanuel@nih.gov](mailto:eemanuel@nih.gov)

Victor R. Fuchs, Ph.D.  
Professor Emeritus, Department of Economics  
School of Medicine  
Department of Health Research and Policy  
Stanford University  
Stanford, California  
[fuchs@newage3.stanford.edu](mailto:fuchs@newage3.stanford.edu)

**Paper Writers:**

Steven D. Pearson, MD, MSc  
Senior Scientist  
Department of Clinical Bioethics  
National Institutes of Health  
Bethesda, MD

Jonathan Skinner, Ph.D.  
Professor of Economics  
Department of Economics  
Dartmouth College  
Hanover, NH

**Commentators:**

Dana Goldman, Ph.D.  
Director, Health Economics, RAND  
RAND  
Santa Monica, CA

Sharon Levine, M.D.  
Associate Executive Director  
The Permanente Medical Group, Inc.  
Oakland, CA

Stirling Bryan, PhD  
Professor of Health Economics  
Director, Health Economics Facility  
University of Birmingham  
Birmingham B15 2RT  
UK

Osnat Luxenburg, MD, PhD  
Director of the Medical Technology and Infrastructure Administration  
Ministry of Health, Israel.  
Jerusalem, Israel.

**Participants:**

Carolyn M. Clancy, MD  
Director  
Agency for Healthcare Research and Quality (AHRQ)  
Rockville, MD

Jan Pietzsch  
Consulting Assistant Professor  
Department of Management Science and Engineering  
Stanford University  
Stanford, California

Haya R. Rubin, M.D., Ph.D.  
Executive Director, Research Institute  
Palo Alto Medical Foundation  
Palo Alto, CA

Earl Steinberg, MD, MPP  
President and CEO  
Resolution Health, Inc.  
Columbia, MD

Sean Tunis, MD  
Founder  
Center for Medical Technology Policy  
Baltimore, MD

Paul Yock, MD  
Professor and Director of Biodesign Department  
Stanford, CA

Martha M. Marsh  
President and CEO  
Stanford Hospital and Clinics  
Stanford, CA

Kenneth J. Arrow, Ph.D., Chair of the Advisory Committee  
Joan Kenney Professor of Economics and Professor of Operations Research, Emeritus  
Stanford University - Department of Economics  
Stanford, CA

Alan M. Garber, MD, PhD  
CHP/PCOR Director and Core Faculty Member; and  
Henry J. Kaiser, Jr. Professor, Stanford University  
Stanford, CA

Harold S. Luft, Ph.D.  
Director, Institute for Health Policy Studies  
University of California San Francisco  
San Francisco, CA

Stephen Shortell, Ph.D.  
Dean of the School of Public Health  
University of California at Berkeley  
Berkeley, California

**Rapporteur:**  
Paul M. Vronsky  
Stanford Law School