NATIONAL CENTER FOR POLICY ANALYSIS

Abandoning Seniors

- Can government make cost-effectiveness decisions in health care? President Obama has championed a "comparative effectiveness" agency — styled after England's National Institute for Clinical Evidence (NICE) — that conducts reviews and studies on the clinical and cost effectiveness of drugs to inform central rulings on which patients should be eligible for a new treatment. "Cancer survival rates in the U.K. are substantially lower than in the U.S. and the gap continues to widen," NCPA President John Goodman says. Read more by clicking here.

- The *New York Times* reports that the stimulus legislation will appropriate $1.1 billion in grant money to research the "comparative effectiveness" of specific treatments, medical devices, surgical interventions and drugs. The bill creates a council of up to 15 federal employees to coordinate the research and to advise Congress and the President on how to spend the money. Although worded in such a way to incite less fear or outright opposition from stakeholders at risk of having their ox gored, this is still the same concept as the *Federal Health Board* championed by Tom Daschle. To read the full article, click here.

- Daschle may be gone as Obama's nominee as secretary of Health and Human Services, but his *Health Board* is in the Stimulus Package. The National Coordinator of Health Information Technology will monitor treatments to make sure your doctor is doing what the federal government deems appropriate and cost effective. NCPA President John Goodman writes in his blog that the goal is to reduce costs and "guide" your doctor's decisions. These provisions in the stimulus bill are virtually identical to what Daschle prescribed in his 2008 book, *Critical: What We Can Do About the Health-Care Crisis*.

- According to a post on John Goodman's Health Policy Blog, NICE isn't very nice! One of Tom Daschle's more radical proposals was a governmental organization to evaluate the cost-effectiveness of medical treatments. In Britain, a similar organization, the National Institute for Health and Clinical Excellence (NICE), is charged with deciding which treatments the British National Health Service will pay for and which it will not. NICE considers a treatment cost-effective only if the cost per *quality adjusted life year* (QALY) is £20,000 or less (about $35,000). The result is that many advanced cancer treatments (and other therapies) available in the United States and on the European continent are judged too costly and not available to patients in Britain. Read the full blog post by clicking here.

- Although few would argue that knowing the comparative effectiveness of clinical treatments is bad, many people are justifiably worried by the implications. Once the comparative effectiveness of a given treatment is known, the naturally progression is to begin weighing costs versus benefits. Say a newer drug therapy is only slightly more effective than an older therapy but costs ten times more. Government bureaucrats could use that knowledge to refuse reimbursement for the newer drug; or require step therapy where the older drug must be tried first. Taken to its furthest logical conclusion, comparative effectiveness could be used to prioritize which conditions are treated aggressively and which ones less so. This is what is being done in Oregon, where broad, population-based preventive care has been given a priority above life-threatening, critical conditions. To read the NCPA's Brief Analysis, "Rationing Care: Oregon Changes Its Priorities," click here.

www.ncpa.org

Dallas Headquarters: 12770 Coit Road, Suite 800, Dallas, TX 75251

Washington Office: 601 Pennsylvania Avenue NW, Suite 900, South Building, Washington, D.C. 20004

NCPA NATIONAL CENTER FOR POLICY ANALYSIS