

A physician's take on budget-driven health care

By Peter McAllister

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In the examination room, every patient is unique. A treatment that works for one may spell trouble for another. Thanks to amazing advances in medical technology, physicians are increasingly able to customize health care to fit a patient's particular needs. For countless Americans, it means longer, healthier lives.

A proposal gaining momentum on Capitol Hill could aid doctors' ability to personalize treatments. But it could also undermine it — if bureaucrats fixated on cutting costs get their way.

Congressional lawmakers are pushing to establish what is known as the "Center for Comparative Effectiveness." The agency's primary charge would be to conduct large-scale comparisons between new, more expensive pharmaceuticals and their older, cheaper peers. The agency's findings could then be utilized by bureaucrats determining what medicines would be covered by public health-care programs.

In theory, a comparative effectiveness agency helps patients and physicians avoid purchasing newer drugs that aren't worth their higher price tag. Physicians and patients will be able to use this valuable information to weigh the costs and benefits of particular drugs.

However, in practice, for this government center to be truly effective, the right checks must be in place. For, far too often, government run comparative effectiveness studies have proven to be unreliable, incomplete, or flat-out wrong.

Take, for example, a 2002 comparative effectiveness study bankrolled by the National Institute of Health that found that older blood-pressure drugs were just as good as newer ones. A member of the NIH research team, Dr. Michael A. Weber, later disavowed the findings, saying that the study was "poorly designed, the interpretations were disingenuous, (and) it violated appropriate scientific reporting."

There are similar doubts surrounding the work of England's comparative effectiveness agency, the National Institute for Clinical Effectiveness.

NICE has always been reluctant to approve cutting-edge medical treatments. A lung-cancer drug called Tarceva, for instance, has been widely used in America since 2004, but NICE has yet to make a final decision on its use in British patients. And NICE didn't approve reimbursements for the prostate cancer drug Taxotere until July 2006, even though it has been a go-to treatment in America since 2004.

Denying patients access to proven therapies is the inherent danger when the government serves both as the judge of clinical effectiveness and the primary funding source for health-care programs. This danger exists because government health programs can save money by sticking to older, cheaper drugs, so it is the self-financial interest of a government run comparative effectiveness agency to determine that newer medications aren't worth the costs.

How, then, does Congress ensure that a new comparative effectiveness agency informs, not undermines, physicians' care of patients?

For starters, the agency's findings shouldn't be binding. Doctors need to be able to tailor drug regimes specifically to individual patients. Top-down controls inevitably fail to take into consideration the astounding biochemical variety doctors see in patients every day.

Further, the agency's data needs to be open to public scrutiny. Having independent eyes on the data will reduce the risks that government interests taint their scientific findings.

With the right checks, Congress can make sure a government-run comparative-effectiveness agency doesn't

put dollar signs before patient access to personalized treatments.

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