Policy Rounds: A New Series and a Call for Papers

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In this issue of *Medical Decision Making*, David H. Howard, PhD, Associate Professor in the Department of Health Policy and Management at Emory University, and his colleagues describe a cost-effectiveness analysis of expanding the size of the national cord blood bank. The analysis was commissioned for the Institute of Medicine's Committee on Establishing a National Cord Blood Stem Cell Bank Program. To assist the Institute of Medicine (IOM) committee in identifying the optimal inventory level, the authors developed a model of the cord blood inventory level to estimate total costs as a function of the number of stored units. They found that the cost per life year gained associated with increasing inventory from 50,000 to 100,000 units is $44,000 to $86,000 and from 100,000 to 150,000 units is $64,000 to $153,000, depending on the assumption about the degree to which survival rates for cord transplants vary by match quality. They also concluded that increasing the inventory to greater than 150,000 units was not a good use of health care resources.

The analysis was published in full by the IOM.[1] In this issue of *Medical Decision Making*, the authors summarize the main findings, describe working with the Institute of Medicine committee's members, and assess the impact of their model on the committee's recommendations to Congress.[2] The analysis appears to have influenced the committee's recommendations to Congress that, "On the basis of preliminary analyses of all existing outcome data and an economic analysis of the costs and benefits of various inventory sizes, the committee made preliminary estimates of an efficient inventory size. The committee estimates that at least an additional 100,000 new, high-quality cord blood units are needed in the national inventory."[1] As Howard and his colleagues point out in their article, the impact on the legislation that Congress eventually passed—The Stem Cell Therapeutic and Research Act of 2005—is less clear.

We are inviting other analysts whose work has had an impact on decision makers to submit articles for future installments of "Policy Rounds." Two of Dr. Howard's coauthors served on the IOM committee. Future "Policy Rounds" may feature this kind of collaboration, but we are also interested in considering paired articles, one by the analysts describing their work, the other from the perspective of a member of the policy-making group that used the work. A happy ending is not required: there is as much if not more to be learned from frustrated attempts at collaboration between researchers and policy makers.

Why? Working on real-life problems with real decision makers is a great stimulus to innovation and refinement of modeling methods. Many of the best processes for making recommendations for coverage decisions, benefit design, and practice guidelines invite interested parties to critique the policy-making group's decisions and the evidence the decisions were based on. Sometimes this public critique raises concerns about the structure of a model or its assumptions and analysis that influence decision makers. A robust process involving researchers, policy makers, and stakeholders exposes flaws in methods, uncertainties in data, and, sometimes, dogma that cannot survive the high standards that characterize the best policy-making environments. Although stressful, such scrutiny beats the alternative of being published, archived, and forgotten. Remember that it is the demand for explicit, fair, and defensible methods for making coverage decisions and other policies that opens the door to cost-effectiveness analysis (CEA) and other types of modeling in the first place. Working with suspicious policy makers or stakeholders creates opportunities for improving methods, especially when it exposes ways in which our methods fall short of our own standards for transparency and fairness. The record of economists and modelers involved in the United Kingdom's National Institute for Health and Clinical Excellence illustrates how

Note: Dr. Helfand is the Editor of Medical Decision Making. Dr. Sanders is the President of the Society for Medical Decision Making.

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applying modeling methods in highly scrutinized, high-profile decisions that affect people can spur methodological development and strengthen modeling practice. They have also seen how the interaction of modelers and economists with policy makers and stakeholders has sometimes been a difficult or complicated one, and have learned ways to make it work better.

We also hope the series will help promote the use of models in policy making. Governmental health care agencies in Canada, Australia, and many European countries use CEA to prioritize coverage decisions. We hope analysts in these countries will share their work and experiences—both good and bad—with our readers.

The situation in the United States is different. U.S. advocates of wider use of CEA must face the question, "Does Anyone in America Really Use CEA?" Indeed, this question is the title of a chapter in Peter Neumann's 2004 book, *Using Cost-Effectiveness Analysis to Improve Health Care: Opportunities and Barriers*.[3] "[This] question," Neumann writes in the book's preface, "has been posed frequently, even (or especially) by analysts themselves, but then left hanging, shrugged off like a remark about the weather or the latest impasse in the Middle East." In fact, Neumann finds several examples of the use of CEA in the United States.

While many SMDM members are asking, appropriately, why decision analysis, CEA, and modeling are not more widely accepted, an equal or greater number have been asked to develop and present decision models by panels, committees, and other bodies involved in policy making or guideline development. These analysts have important stories to tell—not only about the model itself and its findings but also about how decision makers came to want one, how they worked with the researchers to figure out what information they needed from it, how well the analysis met their needs, how it influenced policy, and how it affected clinical care and patient outcomes.

Analysts have offered many explanations for resistance to the use of modeling in policy making. Marc Berger, writing in 1999, blames society's failure to accept the need for allocating scarce resources as well as the "short-term parochial financial perspective" of payers and providers and unrealistic expectations that CEA could answer fundamental ethical and political issues.[4] In his book and a related journal article,[3,5] Neumann refutes several possible factors, such as "a lack of understanding about the conceptual approach, a mistrust of motives, and ethical, regulatory, and legal barriers." He concludes that resistance to CEA is grounded in Americans' "penchant for medical innovation" and our distaste for limits and for institutions that seek to impose them. Recently, though, Marthe Gold and colleagues have begun to refute the idea that Americans are unwilling to accept limits in health care,[6] and consumer surveys indicate that consumers would like more, not less, information about the value for money health care services provide.[7,8]

At the ground level, though, the best way to promote wider use of models is through practical experience of how to formulate questions, conduct analyses, and present results in ways that meet the needs of decision makers. In recent years, Jonathon Lomas and his colleagues at the Canadian Health Services Research Foundation (CHSRF) have brought attention to differences in how policy makers and researchers think about evidence,[9] and to the fact that many researchers and policy makers do not know how to work effectively with one another, even when they have the desire to do so.[10] As an example of this awareness, the CHSRF offers formal training for policy makers who want to learn to work with researchers and researchers who want to learn how to make their work relevant to the policy makers. The SMDM board is currently exploring the idea of sponsoring a policy fellowship to provide a similar experience to our SMDM members.

We look forward to sharing with the readers of *MDM* future installments of "Policy Rounds." We encourage our readers to submit to the journal examples of their policy-relevant work and the outcomes of these collaborations. We hope that through this series we will not only demonstrate to our readers the existing impact of medical decision making research on policy—but also will stimulate both research into methods to help address identified limitations and new collaborations applying current methods in broader policy venues.

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