

Core Data and Methods Issues: Where Do We Stand?

- National Measures of Burden of Disease and Ill Health
 - Use of currently available data sources
 - Data we don't have but wish we did
 - Scope of what is included? Are all the right concepts represented? All the right "feasible-to-capture" concepts?

Core Data and Methods Issues: Where Do We Stand?

- Prevalence cost, incidence cost, and the interplay
- Attributable cost of disease, net cost of disease
 - Are all the concepts & issues nailed down?
 - What additional types of data or data sources might be useful?

Core Data and Methods Issues: Where Do We Stand?

- “Modeling” the measurement of cost: going from available data sources to that thing called “cost”
 - Are all the concepts & issues nailed down?
 - What additional types of data or data sources might be useful?

Core Data and Methods Issues: Where Do We Stand?

- Characterizing Costs (and Benefits) in ways relevant to decision makers, and to the decision at hand? What is required for this?
 - Simply being a more astute analyst? Asking and answering the right question
 - Additional data, not routinely available, to facilitate this?

Core Data and Methods Issues: Where Do We Stand?

- Statistical modeling for understanding the determinants of cost and for predicting cost (conditional on exogenous and possibly other endogenous variables)
 - What additional work is needed – where do we go from here?
- Reporting findings
 - Most significant shortcomings?

To Promote Standardization in an Effective and Feasible Way, What Would a “Reference Case” Approach Entail?

- Standardized set of **cost sub-categories**, within the following **cost categories**
 - Direct medical
 - Direct non-medical
 - Productivity effects; other economic consequences for individual, firm, payer, economy
- Standardized set of **diseases or disease clusters**

To Promote Standardization in an Effective and Feasible Way, What Would a “Reference Case” Approach Entail?

- Standardized **cost catalog**
 - Must select time frame and “basic atomistic unit”, e.g., cost of X person per day (daily meds); cost of the entire service (e.g., CABG)
 - Should consider alternative perspectives: patient, provider, payer, firm, society → a given unit of activity may have alternative cost multipliers
- Strategic identification of **data sources** needed for cost sub-categories and cost catalog

To Promote Standardization in an Effective and Feasible Way, What Would a “Reference Case” Approach Entail?

- Is there a case for a Reference Case for the statistical analysis of cost?
 - functional form?
 - model validation?
 - other?
- In general, identify any downsides and minimize them (e.g., discourage inflexible, inappropriate applications; encourage ongoing experimentation and improvement)

To Promote Standardization in an Effective and Feasible Way, What Would a “Reference Case” Approach Entail?

- Getting off the starting blocks: initiating the effort
 - Start small? E.g. Select a single disease area
 - Start not-so-small? Select disease cluster
 - Focus early efforts at selected provider sites (more generally, sites that have a great concentration of the required data) to enhance probability of demonstrating proof on concept?
Concerns, then, about generalization?

Beyond all this, what else
would you do to promote
better health cost analysis
and application?