

September 2016

Use of Opioid Recovery Medications

Recent Evidence on State Level
Buprenorphine Use and Payment Types



Introduction

The United States is experiencing an epidemic of drug overdose deaths with the Centers for Disease Control and Prevention reporting that since 2000, the rate of deaths from drug overdoses has increased 137%, including a 200% increase in the rate of overdose deaths involving opioids (opioid pain relievers and heroin). ¹ An estimated 2.4 million individuals are living with an opioid use disorder, and most are not receiving treatment or not receiving the most effective care ^{2, 3}.

In light of this public health crisis, more attention is being paid to the role of medications as part of effective addiction recovery programs. The World Health Organization, UNAIDS, the United Nations Office on Drug Policy, and the National Institute on Drug Abuse (NIDA) all agree that people dependent on heroin and other opioids should have access to treatment with medication, known as medication assisted treatment ⁴.

This report focuses on buprenorphine – a partial opioid agonist used to treat opioid addiction - which can be accessed as an outpatient and can play an important role in successful treatment retention and decreased illicit opioid use ⁵.

The focus of this research is to understand the trends in utilization and healthcare payer mix of buprenorphine medications and their use nationally and by state. Coverage of these medicines under public and private insurance programs varies widely. This report has a particular focus on the extent to which buprenorphine is being funded under state-level Medicaid programs (either Fee For Service or Managed Medicaid).

The study was conducted independently by the IMS Institute with funding support from Advocates for Opioid Recovery. The contributions of Allen Campbell to this report are gratefully acknowledged.

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¹ Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report. Increases in Drug and Opioid Overdose Deaths – United States, 2000-2014. January 1, 2016

² Substance Abuse and Mental Health Services Administration. Behavioral Health Trends in the United States: Results from the 2014 National Survey of Drug Use and Health. September 2015

³ Saloner, B. and Karthikeyan, S. Changes in Substance Abuse Treatment Use Among Individuals with Opioid Use Disorders in the United States, 2004-2013. JAMA, 2015; 314(14):1515-1517

⁴ World Health Organization. Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence. 2009

⁵ Thomas CP, Fullerton CA, Kim M et al. Medication-Assisted Treatment with Buprenorphine: Assessing the Evidence. Psychiatric Services 65.2 (2014): 158-70

Key Findings

- The number of prescriptions dispensed through retail pharmacies for buprenorphine medications reached 12.5 million in the twelve months ending June 30, 2016, an increase of 6.4% from the prior year.
- Growth in the use of buprenorphine medications has slowed over the past five years even as there has been an increase in the calls for action to support opioid addiction recovery programs and growing evidence and recognition that medication is key to long-term recovery for patients.
- Public funding through Medicaid programs account for 24% of total buprenorphine prescriptions nationally, with commercial insurance plans covering 57%, Medicare Part D plans covering 7%, and the remaining 11% of prescriptions being paid for in cash.
- States vary widely in the extent of Medicaid funding of buprenorphine use, with more than 40% of buprenorphine prescriptions covered by Medicaid programs in eight states, while in twelve states that coverage is less than 10%.
- Those states with expanded Medicaid coverage are likely to have a higher proportion of buprenorphine prescriptions covered by Medicaid and a smaller proportion paid for by cash compared to states that have not expanded Medicaid coverage.
- Of the ten states with the highest prescription opioid use relative to their population, eight states have a lower than national average level of Medicaid funding for buprenorphine use.
- Patient access to - and reimbursement for - buprenorphine medications used in addiction recovery programs varies widely across states and suggests inconsistent and suboptimal approaches in many parts of the country.

Methodology

Recovery medications examined in this analysis include only buprenorphine and buprenorphine/naloxone combinations. Buprenorphine is a partial opioid agonist indicated for the treatment and maintenance treatment of opioid dependence, and is sometimes used in combination with naloxone. It is available as a generic (unbranded) medicine and marketed under trade names including Suboxone, Butrans and Zubsolv.¹ Probuphine is an implant and was excluded. This analysis does not include two other relevant indicated medications, methadone and naltrexone, as they are not exclusively used to treat opioid use disorder and in the case of methadone, is typically offered through a treatment program and not through retail pharmacy. This study tracks the total dispensing of buprenorphine prescriptions but does not distinguish between use in addiction recovery programs from prescriptions diverted to other uses.

Opioid prescription volume used in this report include all forms contained within USC 02200 for Analgesic Narcotics including oxycodone, hydrocodone, and combination acetaminophen products, among others with the exception of Butrans. Opioid use in this analysis does not include heroin or other illicit opioid forms.

Prescription volume and payer type are based on prescriptions dispensed through retail channels, including chain and independent pharmacies, food-store pharmacies and mass merchandisers. Prescriptions dispensed through public health, prison systems, Veterans Health Administration and mail order are not reflected in this analysis. Tricare activity is included only when dispensed through a retail pharmacy where the transaction is covered by the Tricare plan.

Prescription counts are unadjusted for the length of the prescription, and refer to total dispensed prescriptions (TRx).

Payer types included in the study are classified as Cash, Commercial, Fee For Service Medicaid, Managed Medicaid and Medicare Part D.

Time periods used in the study are 12 months ending June 30 of the year cited.

¹ U.S. Food and Drug Administration. Drugs@FDA. Search Results for Buprenorphine and label information. Available at: <http://www.accessdata.fda.gov/scripts/cder/drugsatfda/index.cfm?fuseaction=Search.SearchAction&SearchType=BasicSearch&SearchTerm=BUPRENORPHINE>

Sources

This study is based on prescription volumes captured by the IMS National Prescription Audit and IMS PayerTrak.

- IMS National Prescription Audit (NPA)[™] is a suite of services providing market insight into prescription activity sourced from over 87% of retail pharmacies in the United States in addition to mail order and long-term care pharmacies.
- IMS PayerTrak[™] provides retail prescriptions by insurance plan and segments those plans into types of insurance including Medicare Part D, Medicaid (including Fee for Service and Managed Medicaid plans), Commercial Third Party insurance, and Cash (prescriptions without insurance).

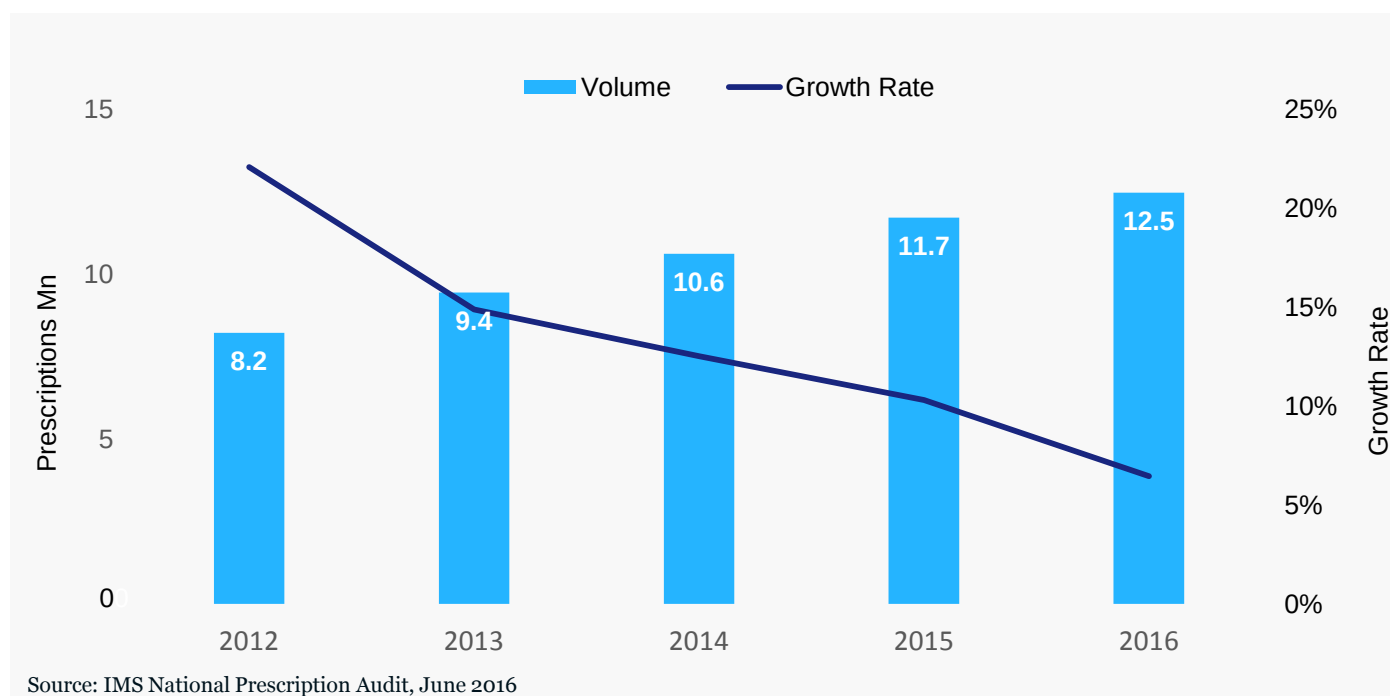
State drug overdose deaths and death rates are sourced from the Centers for Disease Control and Prevention's Morbidity and Mortality Weekly Report "Increases in Drug and Opioid Overdose Deaths – United States, 2000-2014", January 1, 2016.

State population data is sourced from U.S. Census Data for calendar year 2015.

State Medicaid expansion status is sourced from Kaiser Family Foundation.

Buprenorphine prescriptions have increased over the past five years, but growth rate has slowed.

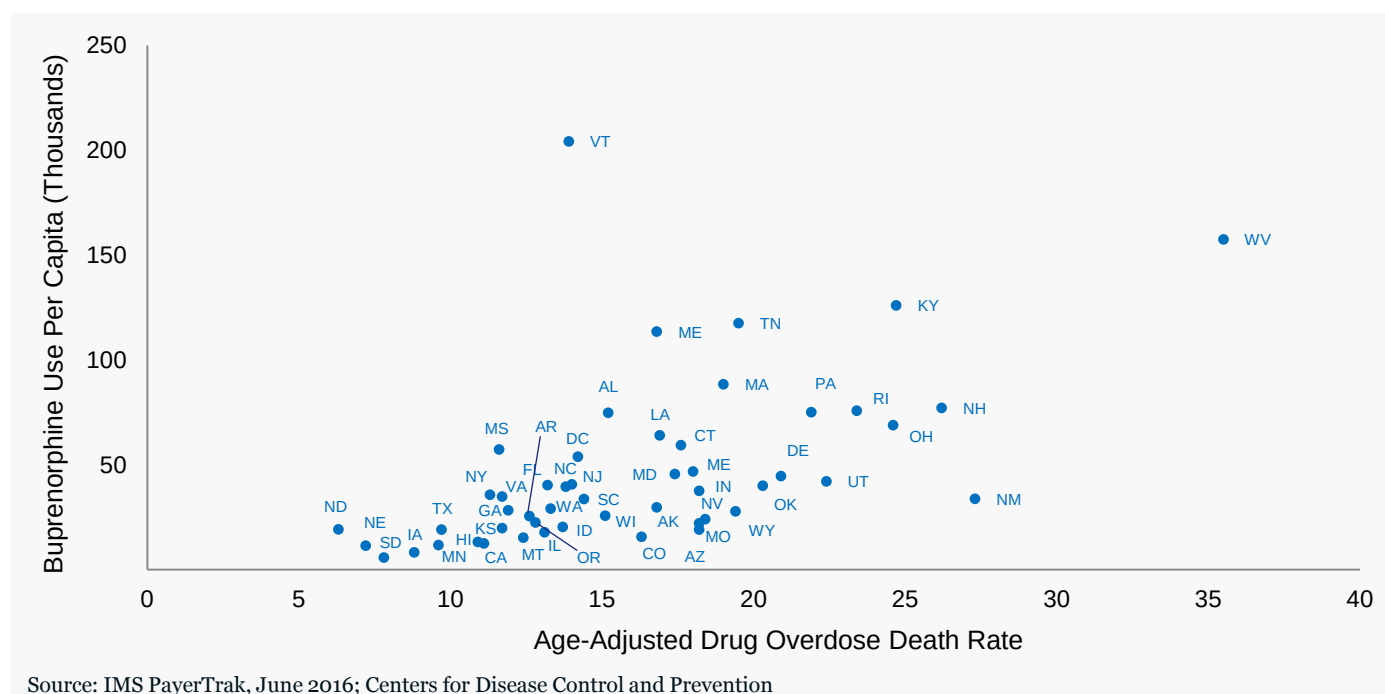
Buprenorphine Retail Prescription Volume and Growth Rate



- The total number of retail prescriptions for buprenorphine increased from 8.2 million in 2012 to 12.5 million in 2016
- Annual growth rates in the number of prescriptions has slowed from 22.0% in 2012 to 6.4% in 2016

States vary widely in their level of buprenorphine use and relative to their level of drug overdose death rates

Buprenorphine Use Compared with Drug Overdose Death Rates by State

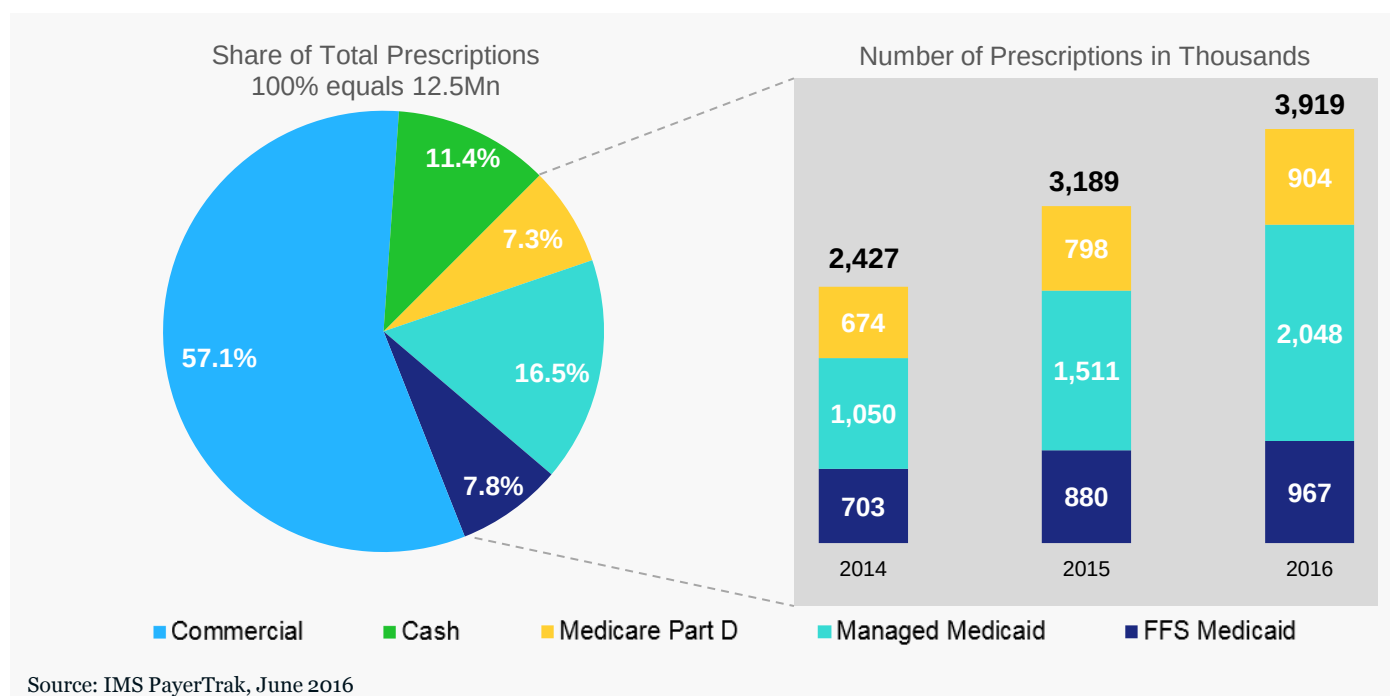


- Nationally, the average use of buprenorphine is 39 prescriptions per year per 1000 population
- State level variation in buprenorphine use is wide, ranging from a high of 204 prescriptions per 1000 population in Vermont in the past twelve months to a low of 6 prescriptions per 1000 population in South Dakota
- While those states with higher drug overdose death rates generally have greater use of buprenorphine, the variation is high
- West Virginia, with the highest drug overdose death rate, has the second highest buprenorphine use rate

Notes: Drug overdose death rate is deaths per 100,000 population, calculated by applying age-specific death rates to the 2000 U.S. standard population age distribution (Source: Morbidity and Mortality Weekly Report. Increases in Drug and Opioid Overdose Deaths — United States, 2000–2014. 2016 Jan 01. 64(50);1378-82. Available at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm?s_cid=mm6450a3_w)

Public funding accounts for about 32% of total buprenorphine prescriptions, with Medicaid programs covering 24% of the total

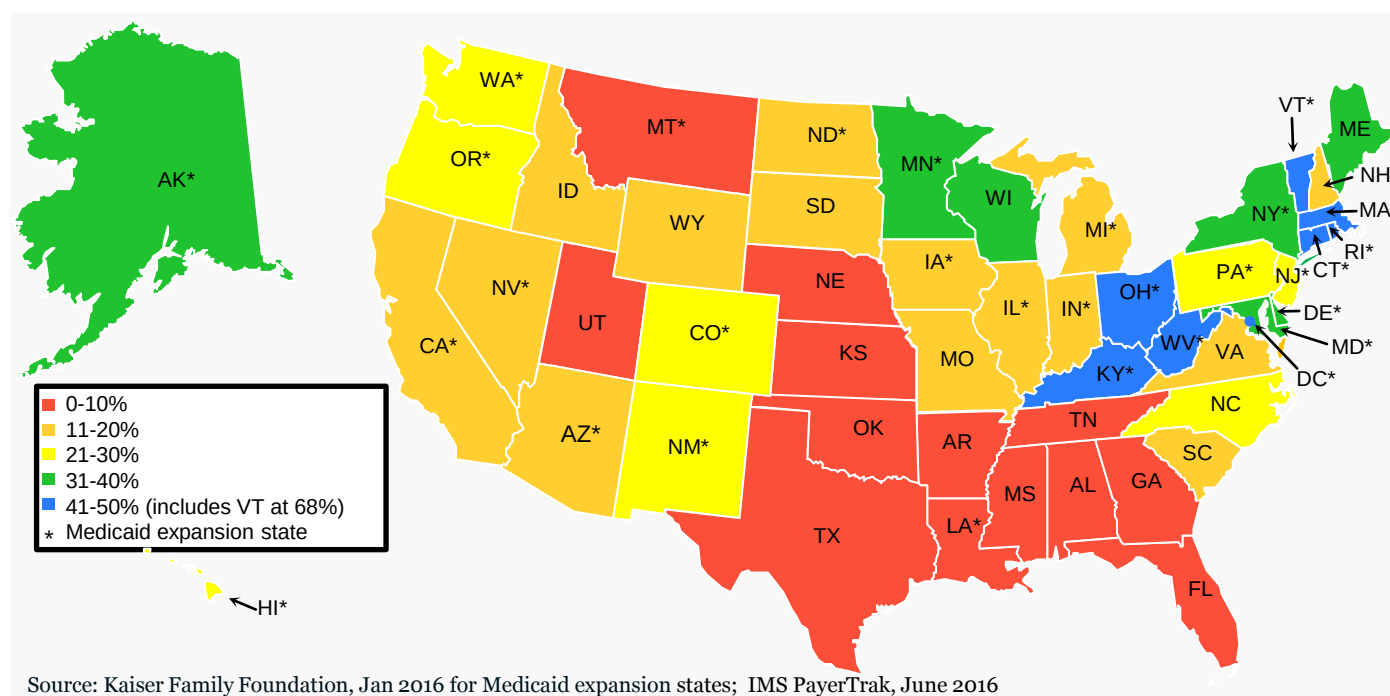
Buprenorphine Retail Prescriptions by Payment Type



- Of the 12.5 million prescriptions for buprenorphine dispensed in the twelve months ending June 30, 2016, 7.3% were filled through Medicare Part D insurance plans
- A further 7.8% of total prescriptions were filled through Medicaid Fee for Service plans, and an addition 16.5% through Managed Medicaid Plans
- Commercial insurance plans were used for 57.1% of total prescriptions filled
- Patients filled 11.4% of buprenorphine prescriptions without using any form of insurance and paid cash
- The absolute number of buprenorphine prescriptions filled through Medicaid programs increased from 1,753,000 to 3,015,000 since 2014

Significant state and regional variation in Medicaid coverage of buprenorphine exists

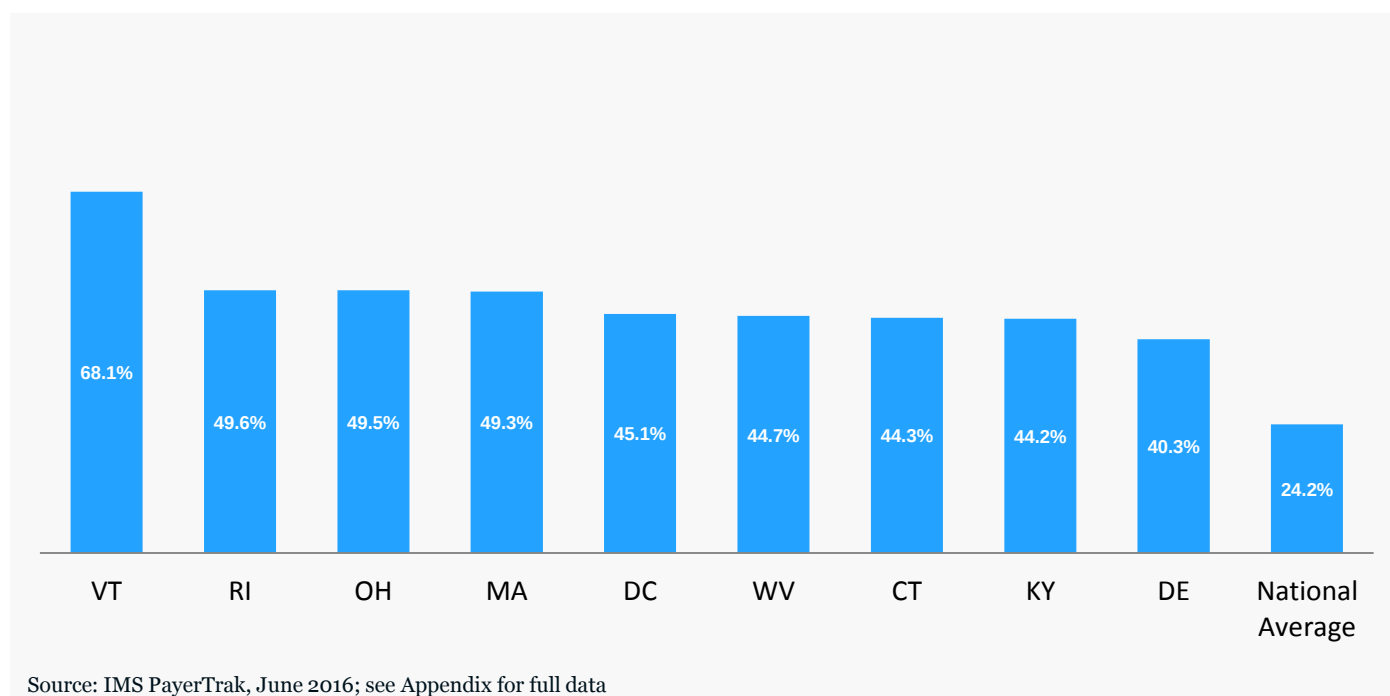
Medicaid Share of Total Prescriptions for Buprenorphine Products by State



- States with the highest share of buprenorphine prescriptions funded by Medicaid include Vermont, Rhode Island, Massachusetts and Connecticut in the Northeast, as well as Ohio, West Virginia and Kentucky
- States with the lowest Medicaid share of buprenorphine prescriptions are located predominantly in the Southern U.S.
- All eight states with Medicaid share of prescriptions over 40% are Medicaid expansion states
- Very few of the states that did not participate in Medicaid expansions have more than 20% of buprenorphine prescriptions covered by Medicaid; Maine, Wisconsin and North Carolina are exceptions to this
- Despite Medicaid expansion, nine states — California, Arizona, Nevada, North Dakota, Iowa, Illinois, Indiana, Michigan and New Hampshire— have less than 20% of buprenorphine prescriptions covered by Medicaid; and two states—Montana and Louisiana— have less than 10%.

In eight states, more than 40% of buprenorphine prescriptions are filled using Medicaid insurance plans

Medicaid Payment Share of State Total Prescriptions

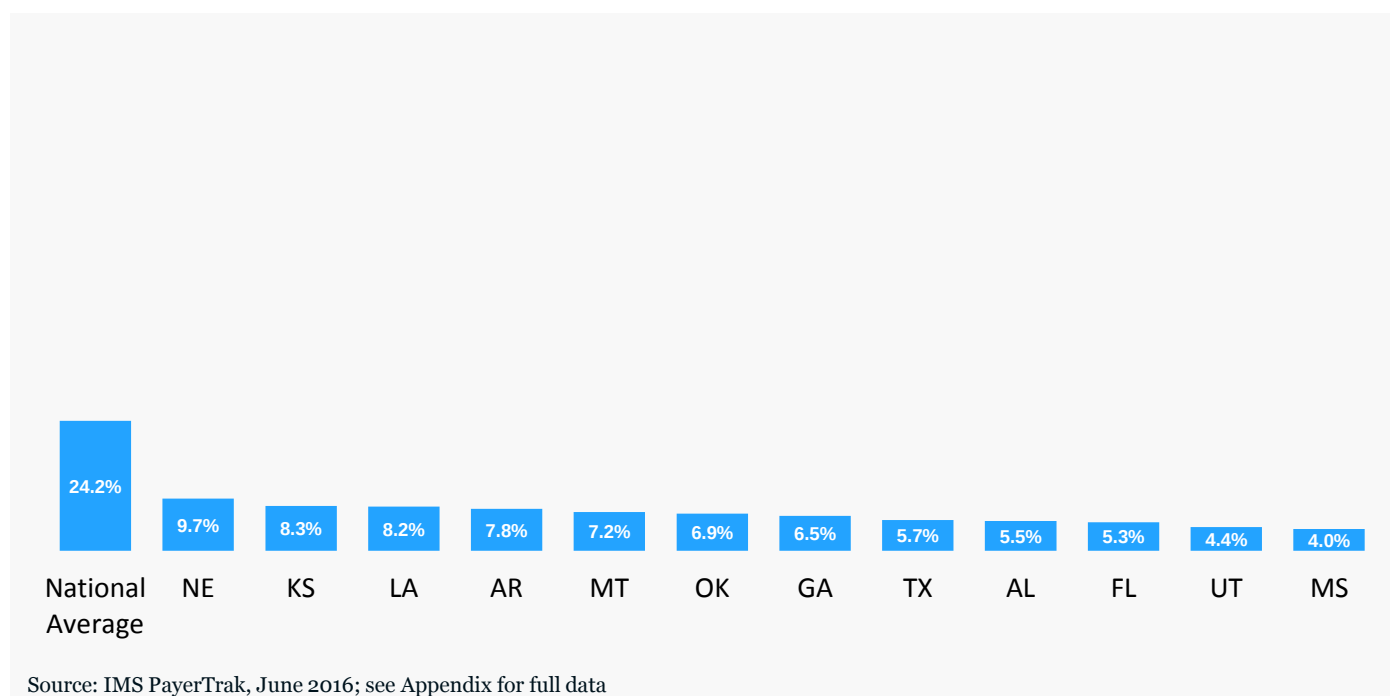


- In Vermont, Medicaid funding is used by patients filling 68.1% of total buprenorphine prescriptions.
- Seven additional states have more than 40% of prescriptions funded by Medicaid.
- A total of 20 states (including the District of Columbia) exceed the national average level of Medicaid funding of 24.2%.
- All eight states are Medicaid expansion states.

Chart notes: Medicaid is a combination of FFS Medicaid and Managed Medicaid.

Medicaid accounts for less than 10% of buprenorphine prescription payments in twelve states

Medicaid Payment Share of State Total Prescriptions

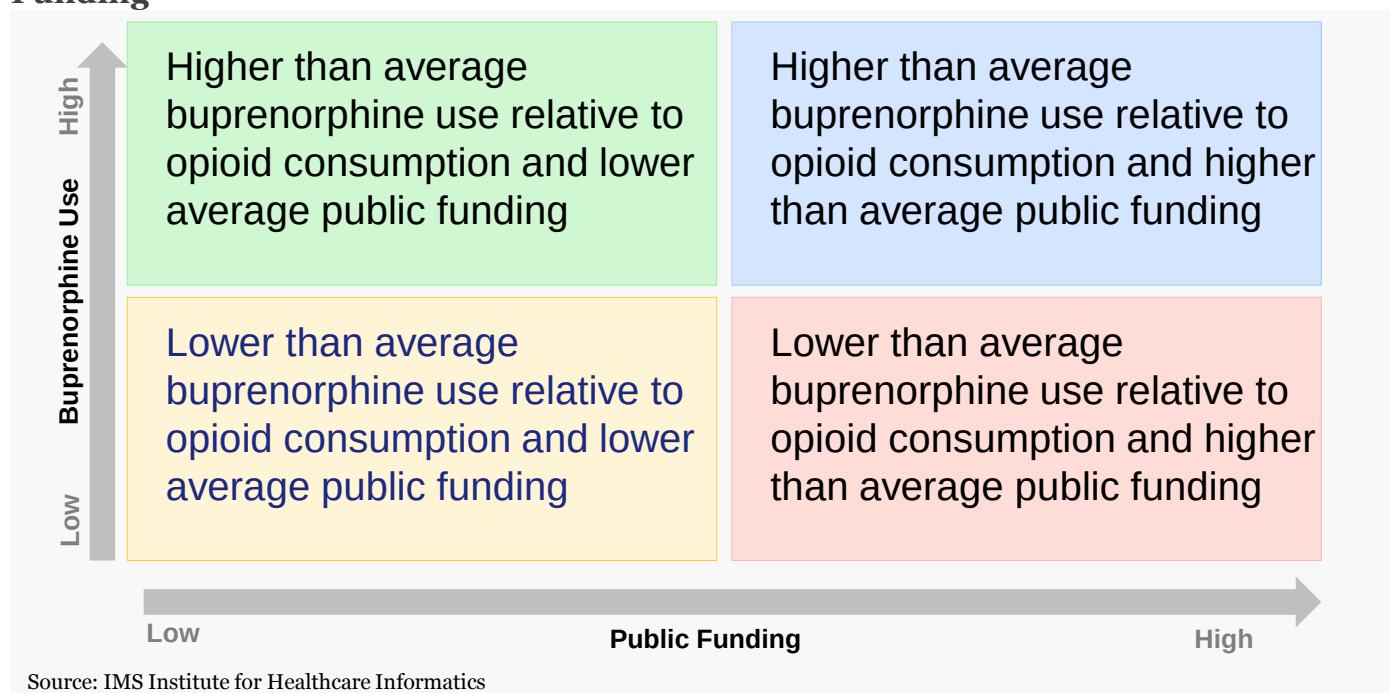


- Thirty-one states have less than the national average level of buprenorphine prescription coverage through Medicaid
- Only two of the twelve states where Medicaid accounts for less than 10% of buprenorphine prescription payments are Medicaid expansion states - Louisiana and Montana.
- Mississippi has the lowest level of public payment funding, with 4% of prescriptions filled through Medicaid.

Chart notes: Medicaid is a combination of FFS Medicaid and Managed Medicaid..

States can be compared based on their buprenorphine use and public funding

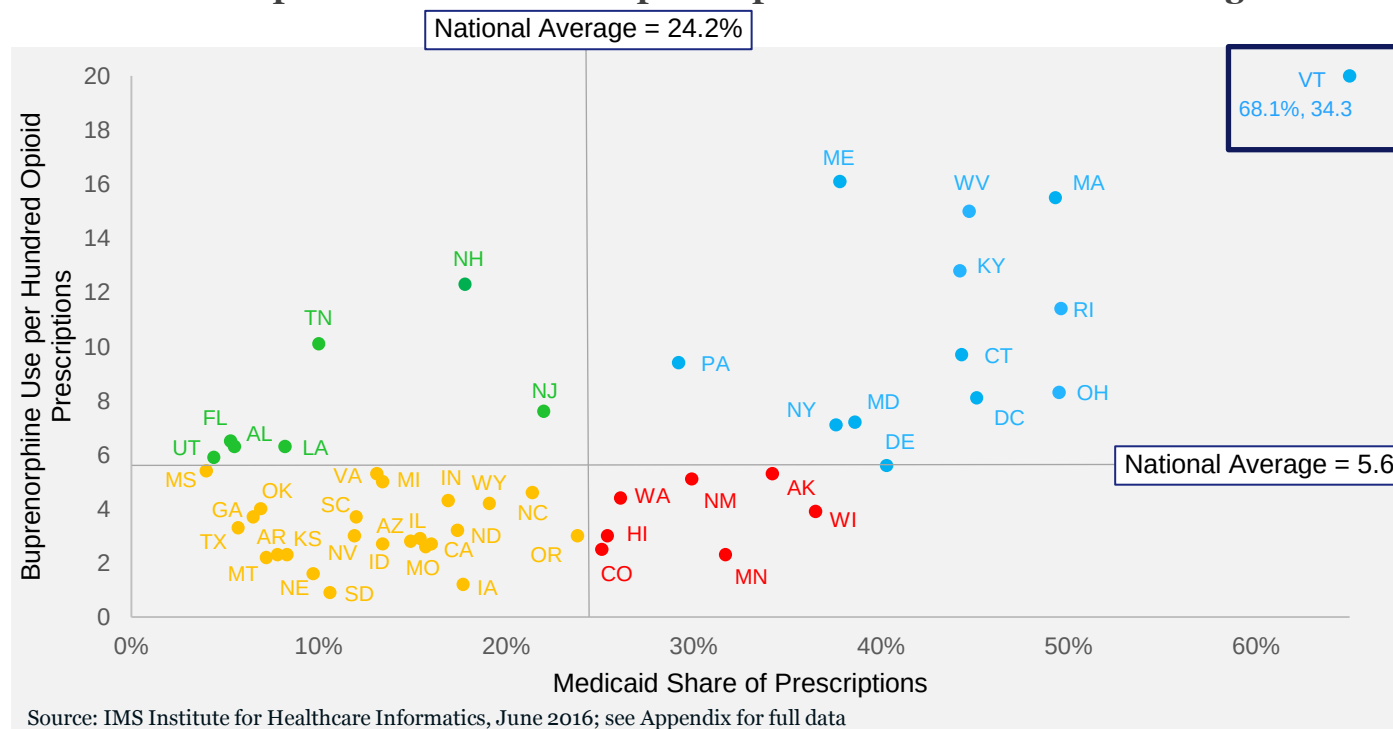
Framework for Comparing State-Level Relative Buprenorphine Use and Public Funding



- States can be compared in terms of the extent to which buprenorphine is used in absolute terms or relative to prescription opioid use
- A further comparison of the level of public funding for buprenorphine through Medicaid can also be used to differentiate state-level programs
- Together, these comparisons can yield a segmentation of states based on relative buprenorphine use and public funding levels

States exhibit a wide level of variation from national averages in both the use of buprenorphine relative to prescription opioid use and funding for these medicines

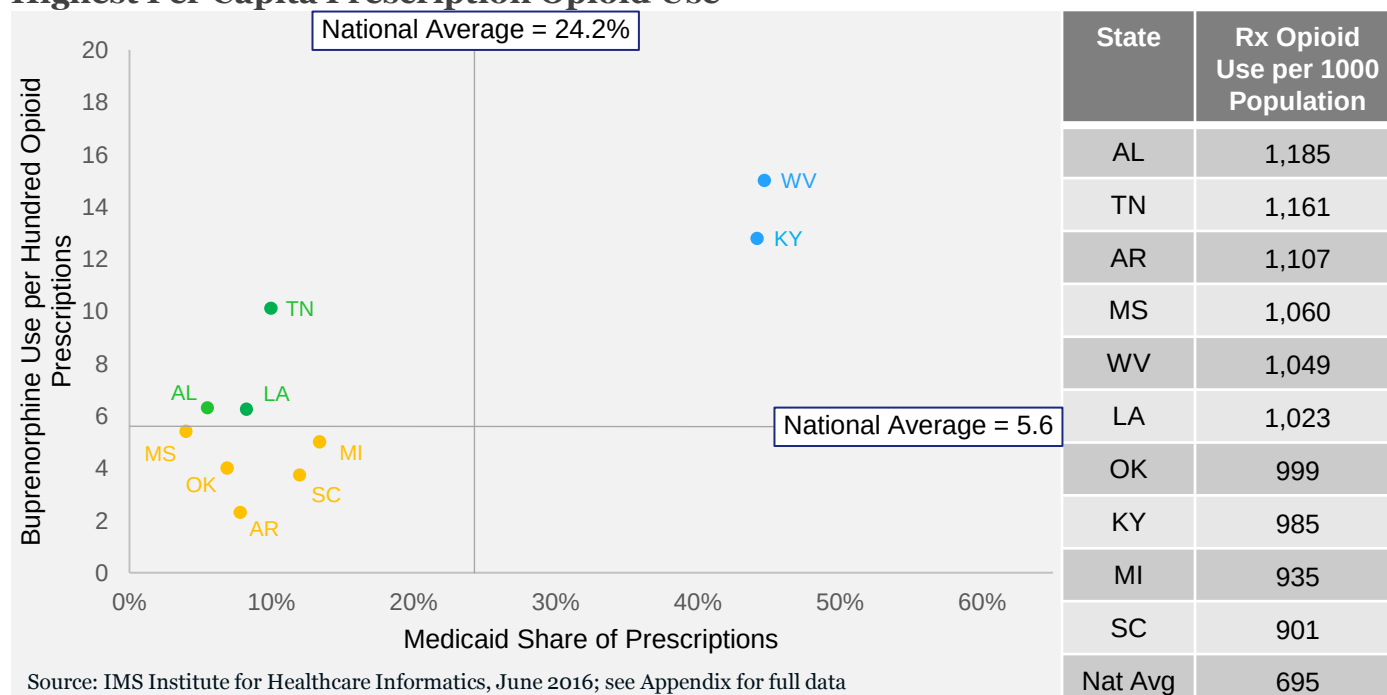
State Level Comparison of Relative Buprenorphine Use and Public Funding



- **13 states** - including VT, OH, RI and MA have higher than average rates of buprenorphine use relative to prescription opioids and a greater role of public Medicaid financing for these recovery medications
- **7 states** - including TN, NH and NJ have higher than average rates of buprenorphine use relative to prescription opioid use despite public financing playing a smaller role than the national average
- **24 states** - including MS, GA and TX have lower than average rates of buprenorphine use relative to prescription opioid use and public financing plays a smaller role than the national average
- Vermont is an outlier with 68.1% Medicaid share of TRx and 34.3 buprenorphine prescriptions for every 100 opioid prescriptions. This level of use is more than six-fold higher than the national average and the level of public funding is 2.5 times higher.

Most of the states with the highest levels of opioid consumption have below average levels of buprenorphine use and public funding

Comparison of Relative Buprenorphine Use and Public Funding in States with Highest Per Capita Prescription Opioid Use



- Of the 10 states with highest per capita opioid use, the volume of buprenorphine use per hundred opioid prescriptions varies from 2.3 in Arkansas to 15.0 in West Virginia
- 8 of the 10 states with highest per capita opioid use have less than the national average levels of payment for buprenorphine prescriptions coming from Medicaid
- AR, OK and MS have both relatively low buprenorphine and public funding for these treatments

Appendix

1. State Details – Sorted Alphabetically by State

State	Drug Overdose Deaths	Rx Opioid use per 1000 population	Buprenorphine use per 1000 population	Buprenorphine use per 100 Rx Opioid use	Share of TRx			
					Commercial	Medicaid	Medicare	Cash
AK	124	566	30	5.3	49.5%	34.2%	6.7%	9.6%
AL	723	1,185	75	6.3	69.0%	5.5%	7.0%	18.6%
AR	356	1,107	26	2.3	64.0%	7.8%	4.6%	23.6%
AZ	1,211	693	19	2.8	67.8%	14.9%	6.2%	11.1%
CA	4,521	466	13	2.7	60.1%	16.0%	8.8%	15.1%
CO	899	618	16	2.5	58.6%	25.1%	7.8%	8.5%
CT	623	611	59	9.7	44.3%	44.3%	8.1%	3.3%
DC	96	665	54	8.1	39.4%	45.1%	11.0%	4.5%
DE	189	797	45	5.6	49.7%	40.3%	4.1%	5.9%
FL	2,634	623	40	6.5	71.1%	5.3%	5.7%	17.9%
GA	1,206	769	28	3.7	74.4%	6.5%	6.3%	12.9%
HI	157	442	13	3.0	54.0%	25.4%	7.1%	13.6%
IA	264	667	8	1.2	63.9%	17.7%	8.9%	9.5%
ID	212	752	20	2.7	65.4%	13.4%	9.9%	11.4%
IL	1,705	615	18	2.9	67.5%	15.4%	7.5%	9.6%
IN	1,172	867	38	4.3	65.7%	16.9%	7.6%	9.7%
KS	332	848	20	2.3	73.5%	8.3%	7.4%	10.8%
KY	1,077	985	126	12.8	40.1%	44.2%	5.9%	9.8%
LA	777	1,023	64	6.3	70.5%	8.2%	5.7%	15.6%
MA	1,289	570	88	15.5	35.1%	49.3%	13.3%	2.3%
MD	1,070	638	46	7.2	48.4%	38.6%	6.5%	6.4%
ME	216	705	114	16.1	45.7%	37.8%	12.6%	3.9%
MI	1,762	935	47	5.0	65.6%	13.4%	8.8%	12.2%
MN	517	522	12	2.3	49.8%	31.7%	10.3%	8.2%
MO	1,067	844	22	2.6	62.9%	15.7%	9.0%	12.4%
MS	336	1,060	57	5.4	63.7%	4.0%	4.5%	27.8%
MT	125	683	15	2.2	66.8%	7.2%	7.3%	18.7%
National Average		695	39	5.6	57.1%	24.2%	7.3%	11.4%

Source: IMS PayerTrak, IMS National Prescription Audit, June 2016; Centers for Disease Control and Prevention

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State	Drug Overdose Deaths	Rx Opioid use per 1000 population	Buprenorphine use per 1000 population	Buprenorphine use per 100 Rx Opioid use	Share of TRx			
					Commercial	Medicaid	Medicare	Cash
NC	1,358	854	40	4.6	58.5%	21.4%	7.6%	12.5%
ND	43	608	19	3.2	57.4%	17.4%	4.9%	20.3%
NE	125	720	11	1.6	63.8%	9.7%	10.6%	15.9%
NH	334	626	77	12.3	62.3%	17.8%	11.1%	8.7%
NJ	1,253	538	41	7.6	63.2%	22.0%	6.6%	8.2%
NM	547	657	34	5.1	53.0%	29.9%	8.0%	9.2%
NV	545	816	24	3.0	69.3%	11.9%	4.5%	14.3%
NY	2,300	504	36	7.1	50.1%	37.6%	7.3%	5.0%
OH	2,744	828	69	8.3	37.0%	49.5%	6.1%	7.3%
OK	777	999	40	4.0	72.7%	6.9%	5.0%	15.5%
OR	522	758	23	3.0	57.0%	23.8%	10.9%	8.4%
PA	2,732	795	75	9.4	51.2%	29.2%	5.9%	13.7%
RI	247	663	76	11.4	34.7%	49.6%	13.8%	2.0%
SC	701	901	34	3.7	71.0%	12.0%	6.8%	10.2%
SD	63	666	6	0.9	64.5%	10.6%	14.8%	10.1%
TN	1,269	1,161	118	10.1	63.7%	10.0%	6.1%	20.3%
TX	2,601	573	19	3.3	77.1%	5.7%	7.6%	9.6%
UT	603	719	42	5.9	72.5%	4.4%	5.7%	17.4%
VA	980	655	35	5.3	68.3%	13.1%	6.3%	12.3%
VT	83	596	204	34.3	21.2%	68.1%	9.0%	1.6%
WA	979	667	29	4.4	57.7%	26.1%	7.3%	8.8%
WI	853	668	26	3.9	48.0%	36.5%	7.6%	7.9%
WV	627	1,049	158	15.0	42.1%	44.7%	6.0%	7.2%
WY	109	655	28	4.2	61.2%	19.1%	6.4%	13.3%
National Average		695	39	5.6	57.1%	24.2%	7.3%	11.4%

Source: IMS PayerTrak, IMS National Prescription Audit, June 2016; Centers for Disease Control and Prevention

2. State Details – Sorted by Drug Overdose Deaths

State	Drug Overdose Deaths	Rx Opioid use per 1000 population	Buprenorphine use per 1000 population	Buprenorphine use per 100 Rx Opioid use	Share of TRx			
					Commercial	Medicaid	Medicare	Cash
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OH	2,744	828	69	8.3	37.0%	49.5%	6.1%	7.3%
PA	2,732	795	75	9.4	51.2%	29.2%	5.9%	13.7%
FL	2,634	623	40	6.5	71.1%	5.3%	5.7%	17.9%
TX	2,601	573	19	3.3	77.1%	5.7%	7.6%	9.6%
NY	2,300	504	36	7.1	50.1%	37.6%	7.3%	5.0%
MI	1,762	935	47	5	65.6%	13.4%	8.8%	12.2%
IL	1,705	615	18	2.9	67.5%	15.4%	7.5%	9.6%
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NJ	1,253	538	41	7.6	63.2%	22.0%	6.6%	8.2%
AZ	1,211	693	19	2.8	67.8%	14.9%	6.2%	11.1%
GA	1,206	769	28	3.7	74.4%	6.5%	6.3%	12.9%
IN	1,172	867	38	4.3	65.7%	16.9%	7.6%	9.7%
KY	1,077	985	126	12.8	40.1%	44.2%	5.9%	9.8%
MD	1,070	638	46	7.2	48.4%	38.6%	6.5%	6.4%
MO	1,067	844	22	2.6	62.9%	15.7%	9.0%	12.4%
VA	980	655	35	5.3	68.3%	13.1%	6.3%	12.3%
WA	979	667	29	4.4	57.7%	26.1%	7.3%	8.8%
CO	899	618	16	2.5	58.6%	25.1%	7.8%	8.5%
WI	853	668	26	3.9	48.0%	36.5%	7.6%	7.9%
LA	777	1,023	64	6.3	70.5%	8.2%	5.7%	15.6%
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NM	547	657	34	5.1	53.0%	29.9%	8.0%	9.2%
NV	545	816	24	3	69.3%	11.9%	4.5%	14.3%
OR	522	758	23	3	57.0%	23.8%	10.9%	8.4%
MN	517	522	12	2.3	49.8%	31.7%	10.3%	8.2%
AR	356	1,107	26	2.3	64.0%	7.8%	4.6%	23.6%
MS	336	1,060	57	5.4	63.7%	4.0%	4.5%	27.8%
NH	334	626	77	12.3	62.3%	17.8%	11.1%	8.7%
KS	332	848	20	2.3	73.5%	8.3%	7.4%	10.8%
IA	264	667	8	1.2	63.9%	17.7%	8.9%	9.5%
RI	247	663	76	11.4	34.7%	49.6%	13.8%	2.0%
ME	216	705	114	16.1	45.7%	37.8%	12.6%	3.9%
ID	212	752	20	2.7	65.4%	13.4%	9.9%	11.4%
DE	189	797	45	5.6	49.7%	40.3%	4.1%	5.9%
HI	157	442	13	3	54.0%	25.4%	7.1%	13.6%
MT	125	683	15	2.2	66.8%	7.2%	7.3%	18.7%
NE	125	720	11	1.6	63.8%	9.7%	10.6%	15.9%
AK	124	566	30	5.3	49.5%	34.2%	6.7%	9.6%
WY	109	655	28	4.2	61.2%	19.1%	6.4%	13.3%
DC	96	665	54	8.1	39.4%	45.1%	11.0%	4.5%
VT	83	596	204	34.3	21.2%	68.1%	9.0%	1.6%
SD	63	666	6	0.9	64.5%	10.6%	14.8%	10.1%
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National Average		695	39	5.6	57.1%	24.2%	7.3%	11.4%

Source: IMS PayerTrak, IMS National Prescription Audit, June 2016; Centers for Disease Control and Prevention

3. State Details – Sorted by Total Medicaid Share of Prescriptions

State	Share of TRx			State	Share of TRx		
	Total Medicaid	Managed Medicaid	Fee for Service Medicaid		Total Medicaid	Managed Medicaid	Fee for Service Medicaid
VT	68.1%	3.3%	64.8%	ND	17.4%	8.7%	8.7%
RI	49.6%	43.6%	6.0%	IN	16.9%	15.6%	1.3%
OH	49.5%	47.1%	2.4%	CA	16.0%	2.6%	13.4%
MA	49.3%	36.4%	12.9%	MO	15.7%	1.5%	14.2%
DC	45.1%	14.0%	31.1%	IL	15.4%	9.3%	6.1%
WV	44.7%	35.9%	8.8%	AZ	14.9%	14.6%	0.3%
CT	44.3%	4.8%	39.5%	ID	13.4%	2.7%	10.7%
KY	44.2%	43.8%	0.4%	MI	13.4%	3.3%	10.1%
DE	40.3%	36.4%	3.9%	VA	13.1%	10.3%	2.8%
MD	38.6%	3.4%	35.2%	SC	12.0%	10.6%	1.4%
ME	37.8%	1.7%	36.1%	NV	11.9%	7.1%	4.8%
NY	37.6%	33.0%	4.6%	SD	10.6%	0.9%	9.7%
WI	36.5%	4.7%	31.8%	TN	10.0%	4.6%	5.4%
AK	34.2%	6.7%	27.5%	NE	9.7%	2.9%	6.8%
MN	31.7%	24.0%	7.7%	KS	8.3%	4.1%	4.2%
NM	29.9%	28.2%	1.7%	LA	8.2%	7.7%	0.5%
PA	29.2%	28.3%	0.9%	AR	7.8%	3.0%	4.8%
WA	26.1%	19.9%	6.2%	MT	7.2%	0.6%	6.6%
HI	25.4%	22.8%	2.6%	OK	6.9%	0.3%	6.6%
CO	25.1%	5.7%	19.4%	GA	6.5%	3.9%	2.6%
OR	23.8%	19.7%	4.1%	TX	5.7%	4.7%	1.0%
NJ	22.0%	21.2%	0.8%	AL	5.5%	0.8%	4.7%
NC	21.4%	1.4%	20.0%	FL	5.3%	4.1%	1.2%
WY	19.1%	12.5%	6.6%	UT	4.4%	0.3%	4.1%
NH	17.8%	8.5%	9.3%	MS	4.0%	2.8%	1.2%
IA	17.7%	9.9%	7.8%	National Avg	24.2%	16.4%	7.8%

Source: IMS PayerTrak, IMS National Prescription Audit, June 2016; Centers for Disease Control and Prevention

About the Institute

The IMS Institute for Healthcare Informatics leverages collaborative relationships in the public and private sectors to strengthen the vital role of information in advancing healthcare globally. Its mission is to provide key policy setters and decision makers in the global health sector with unique and transformational insights into healthcare dynamics derived from granular analysis of information.

Fulfilling an essential need within healthcare, the Institute delivers objective, relevant insights and research that accelerate understanding and innovation critical to sound decision making and improved patient care. With access to IMS Health's extensive global data assets and analytics, the Institute works in tandem with a broad set of healthcare stakeholders, including government agencies, academic institutions, the life sciences industry and payers, to drive a research agenda dedicated to addressing today's healthcare challenges.

By collaborating on research of common interest, it builds on a long-standing and extensive tradition of using IMS Health information and expertise to support the advancement of evidence-based healthcare around the world.

Research Agenda

The research agenda for the Institute centers on five areas considered vital to the advancement of healthcare globally:

The effective use of information by healthcare stakeholders globally to improve health outcomes, reduce costs and increase access to available treatments.

Optimizing the performance of medical care through better understanding of disease causes, treatment consequences and measures to improve quality and cost of healthcare delivered to patients.

Understanding the future global role for biopharmaceuticals, the dynamics that shape the market and implications for manufacturers, public and private payers, providers, patients, pharmacists and distributors.

Researching the role of innovation in health system products, processes and delivery systems, and the business and policy systems that drive innovation.

Informing and advancing the healthcare agendas in developing nations through information and analysis.

Guiding Principles

The Institute operates from a set of Guiding Principles:

The advancement of healthcare globally is a vital, continuous process.

Timely, high-quality and relevant information is critical to sound healthcare decision making.

Insights gained from information and analysis should be made widely available to healthcare stakeholders.

Effective use of information is often complex, requiring unique knowledge and expertise.

The ongoing innovation and reform in all aspects of healthcare require a dynamic approach to understanding the entire healthcare system.

Personal health information is confidential and patient privacy must be protected.

The private sector has a valuable role to play in collaborating with the public sector related to the use of healthcare data.

IMS INSTITUTE

FOR

HEALTHCARE INFORMATICS

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