Health Policy in Medicine: Inside the Beltway

Knowing What to Do: The Truth about Comparative Effectiveness Research

by Eugene Rich, MD, FACP

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Few will disagree that the US health care system is broken. In 2008 millions of Americans did not receive needed, highly effective health care. Millions more received unnecessary or even harmful services. The reasons are many and complex. Rising premiums, onerous co-pays, financially distressed employers, unavailable physicians, archaic payment systems, poor coordination--the list goes on. Only two facts are inarguably true about our health care crisis: One, 2009 will be worse; and two, better science can help us fix it.

The fact is, all too often clinicians and patients lack the strong research needed to back up the choices they must make at the bedside. Faced with an abundance of tests, treatments, drugs, and surgeries that might or might not offer their suffering patient a shot at better health, the physician must recommend SOMETHING! Unfortunately, some of those medical treatments may do more harm than good, but nobody knows which ones.

Why don't doctors have the evidence they need to know what works and what doesn't, and for which patients? Because the US has not made the necessary investment in this kind of medical science, known as comparative effectiveness research, or CER. To fix this lack, a $1.1 billion investment through the ARRA (the "American Recovery and Reinvestment Act") will get the nation started down the road towards better medical science and more effective care. But there are some very loud voices in Washington and around the country who don't want to see this effort be successful. They claim that CER amounts to "rationing" or even euthanasia! They accuse CER of merely being a way to deny patients needed care for reasons of cost, and that federal funding for such research will be biased in favor of the least expensive treatment.

But despite all the rhetoric, the "private sector" has no incentive to do all the research doctors and patients need to provide them clear answers to tough decisions. Why not? Consider the beleaguered pharmaceutical industry executive struggling to allay angry stockholder questions: "Why did you idiots put millions into a comparative study that just handed the market to our competition?" Bet his successor in the executive suite won't make that mistake again! What about the health plan leader fresh from a meeting with a large employer dropping their workers' health insurance because of rising costs: "You medical directors want me to raise our rates to pay for a $50 million clinical trial that takes 5 years to get results?" That conversation certainly won't go well! What are the other options for "creating a market" for comparative effectiveness research? Could enough Americans pay subscriptions for a "Consumers Reports of Comparative Effectiveness" to fund the billions of dollars of research needed to clarify what works? And if enough people did subscribe, would courts then forbid doctors from using this "copyrighted" research to inform the care of sick patients unable to afford the subscription?

No, the "market" cannot provide the research Americans need. Scientific evidence is a public good and federal research agencies are a proven national resource for producing great science. That's why the US has invested many billions in biomedical research at the National Institutes of Health. But for years political pressure from interested parties eager to market expensive and unproven new services has prevented substantial public investments in comparative effectiveness research. As a result the public good of research on "knowing what works" has long been woefully under-supported in the US.

There will always be some who reject the value of science in helping people resolve thorny problems and in making sense of a complicated world. This is not the American way, however, where our founders were children of the Enlightenment and where the embrace of science and technology transformed our world. It is sobering that there are so many 21st Century special interests eager to promote a new fear of good science. But America is now a nation where almost one fifth of our economy is health care, and spending on medical services has been growing faster than inflation for 30 years. So there are many powerful interests that profit from confusion. It's been said "one person's unnecessary surgery (or scan, or injection) is another person's paycheck." There are lots of potential financial "losers" when patients and clinicians can really know what treatment is best and can focus their attention on doing what is most effective.

It is time we rejected the anti science rhetoric. In its place, we must embrace the wisdom of another wise man, born 200 years ago, who said, “You can fool some of the people all of the time, and all of the people some of the time, but you can not fool all of the people all of the time.” We need more of the science that answers our health care questions, not less. Through publicly funded research on comparative effectiveness, Americans can begin to solve our health care crisis rationally and equitably.

P.S. For more information on this debate, see my recent article in the *Journal of General Internal Medicine* http://www.springerlink.com/content/b134717445673706/

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Comments from readers:

6/2/2009 - Bravo to Dr. Rich! (And, thanks for allowing comments.) CER is a critical component of HC reform, for both quality and cost control. And, yes, federal funding and regulation is the only way to successfully develop and implement clinical guidelines. Several years ago I proposed an "Apollo Project" to develop guidelines for the top 500 CPT/ICD-9 procedures, that would be federally-sanctioned and -mandated for Medicare coverage/reimbursement, with any deviation requiring clinical documentation, which would then be fed into a continuous, guideline-improvement process. Federally-sanctioned guidelines can also solve the malpractice "issue," by protecting physicians from any liability when the appropriate guideline is correctly implemented, even in the case of an untoward outcome. 21st century medical practice must view itself as a "science," rather than an "art," and reduce practice pattern variation wherever evidence (Levels I-III) allows. Brad Stephan