Comparative Effectiveness Research Prioritized

BY JOYCE FRIEDEN

WASHINGTON — As with so many other things, when it comes to performing comparative effectiveness research, more is better, according to speakers at an Institute of Medicine meeting.

But more of what? That was the thorny question addressed at the meeting, convened in March by the institute's 23-member Committee on Comparative Effectiveness Research Priorities. The meeting was held to seek advice from various stakeholders on how the federal government should spend the $1.1 billion in stimulus money allocated for comparative effectiveness research (CER).

One concept kept coming up over and over again: Focus on conditions that are widespread and cost a lot of money.

Committee chair Dr. Harold C. Sox emphasized that the committee's work was just beginning. "This is an information-gathering process," he told the audience. "It's a time for the committee to listen and take what we hear under advisement as we formulate our recommendations. We're early in our process."

He added that "it would be a mistake for anybody to infer any conclusions or drift in the direction of the committee's thinking by any questions the committee members may ask the speakers. We will be asking probing questions—just don't try to read something into it."

Once the committee finalizes its recommendations, it will write a report that will be scrutinized by a group of experts. The committee will be held accountable for responding to the criticisms of the reviewers, said Dr. Sox, editor of Annals of Internal Medicine and a past president of the American College of Physicians.

The committee's report on CER priorities is expected to be finished by July.

In a related effort, the Department of Health and Human Services recently named a 15-member Federal Coordinating Council for Comparative Effectiveness, which the department says will help the DHHS, the Department of Veterans Affairs, the Department of Defense, and other federal agencies use the stimulus money "to coordinate comparative effectiveness and related health services research."

In addition to various agency representatives, the council includes Dr. Ezekiel Emanuel, who is serving as a special adviser for health policy at the White House Office of Management and Budget.

At the IOM meeting, the committee heard from dozens of speakers, each delivering a 3-minute talk advocating CER priorities. Ideas varied widely, from urologic diseases to the best way to use electronic health records. But one concept kept coming up over and over again: Focus on conditions that are widespread and cost a lot of money.

Dorothy Jeffress, executive director of the Center for Advancing Health, did not name specific conditions but said that "priorities for CER should be on high-volume and/or high-cost conditions for which there exist significant variation in practice and multiple treatment or diagnostic options."

Teresa Lee, vice president for payment and policy at AdvaMed, the lobbying group for medical device makers, suggested that "chronic disease management and health care–associated infections represent significant research opportunities. Examples of [chronic diseases] include diabetes, asthma, and major depression."

Children's health care also came under discussion. Christopher Fox of the American Association for Dental Research made the case for including dental caries among the CER priorities. Dental caries are preventable. "We're spending $76 billion and yet enormous health disparities exist," he said.

"We're not getting the right preventive services and treatments to the right people at the right time."

Mary Jean Schumann of the American Nurses Association said that CER should "address the full spectrum of interventions, including prevention, alternative therapies, and watchful waiting," whereas Kitty Ernst of the Frontier School of Midwifery and Family Nursing asked that expanded use of midwifery services be considered as a research priority.

Dr. Mohammad Akhter, executive director of the National Medical Association, asked the panel to consider many of the same issues other speakers mentioned, but also noted that his group has "trust issues" with government research funding.

In an interview, Dr. Akhter said he wondered whether the ulterior motive behind CER was cost savings. Government efforts often purport to be about improving patient care, but then turn out to be something else entirely, he said. For example, peer review organizations started out being concerned about professionalism "and then they became punitive. . . . We should know what the aim of all this is. Is it just about saving money?"

That sentiment was repeated by other speakers. "The health of the public should trump business interests," said Dr. Ted Epperly, president of the American Academy of Family Physicians. "We should look at clinical effectiveness, not cost-effectiveness," said Ms. Lee of AdvaMed. "Cost-effectiveness is an important priority, but comparative effectiveness research should be done in an impartial fashion," said Dr. Jack Lewin, CEO of the American College of Cardiology.

But one person had a slightly different take: "Our industry believes comparative information on cost is equally important," said Carmella Bucchino of America's Health Insurance Plans. "If one intervention is marginally better, we still want to know how much more we're paying for that benefit."

The makeup of the IOM committee was the subject of some controversy. After a group of 20 public interest, patient advocacy, and consumer groups complained in a letter that the panel had only one consumer representative, two more were added. ■

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