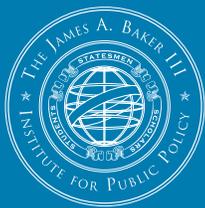


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IN THIS ISSUE

The study “The neglected purpose of comparative effectiveness research” appeared in the May 2009 edition of the *New England Journal of Medicine*. The authors, Aanand D. Naik, M.D., and Laura A. Petersen, M.D., M.P.H., are both from the Houston VA Health Services Research and Development Center of Excellence at the Michael E. DeBakey Veterans Affairs Medical Center; the Clinical Services and Health Policy Core, John M. Eisenberg Center for Clinical Decisions and Communications Science Center at Baylor College of Medicine; and the Section of Health Services Research, Department of Medicine, Baylor College of Medicine in Houston, Texas.



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HEALTH POLICY research

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Can the Obama administration’s investment in comparative-effectiveness research yield improvements in health care for the average patient?

Yes, according to Aanand D. Naik, M.D., and Laura A. Petersen, M.D., M.P.H., but only if the renewed investment in comparative-effectiveness research (CER) includes a commitment to funding studies of how to best implement these findings into practice.

On Feb. 17, 2009, President Barack Obama signed into law an initiative providing \$1.1 billion to support research on the comparative effectiveness of drugs, medical devices, surgical procedures and other treatments for various conditions. Industry and free-market advocates have expressed concerns about the role of cost-effectiveness analyses within CER and subsequent government intrusion into doctor-patient decisions.

Despite such controversy, most agree that although the federal government provides a large amount of funding for research, the translation of this investment into practice — enabling new laboratory discoveries to reach patients’ bedsides — is frustratingly slow. Furthermore, much of the government’s research funding that goes toward randomized clinical trials to evaluate the efficacy of new drugs, devices and treatments is carried out within highly controlled environments. Doctors are most concerned about the relative benefits and harms of one treatment as compared with another for their particular patient, but randomized trials are seldom designed to answer these types of practical questions. Therefore, health policymakers and health insurers and providers are increasingly interested in the information that could be obtained from studies of the comparative effectiveness of different treatments for specific conditions.

Surprisingly little attention has been paid to what we believe is the most critical question facing CER: Will its results significantly improve the quality and safety of the health care received by the average patient? Policymakers and research funders, such as the National Institutes of Health, often assume that the final steps in the translation of clinical research

— the decision to act on new medical evidence and its implementation in routine care — are seamless and automatic, whereas we know that changing the behavior of physicians and patients is difficult.

Therefore, we also need evidence-based methods for discovering and describing how the findings of clinical trials and CER can be efficiently implemented and incorporated into routine practice. Harnessing the promise of CER by ensuring the efficient and effective implementation of its findings in practice requires substantial investment and planning that will involve health care providers, patients and other local stakeholders.

Above all, the Federal Coordinating Council for Comparative Effectiveness must remain mindful that the primary goal of CER is to enhance the translation of new medical discoveries into safe and high-quality health care for all Americans. This goal can be achieved only if our renewed investment in CER includes a commitment to implementation research. The creation of a CER initiative focused on developing and disseminating effectiveness reviews is an essential, but not sufficient, step toward the routine provision of safe, high-quality health care to all Americans.

The views expressed in this article do not represent those of the Department of Veterans Affairs or the Agency for Healthcare Research and Quality.

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