



Analysis

Commentary: Knowledge is not always power

BMJ 2010; 341 doi: <http://dx.doi.org/10.1136/bmj.c4217> (Published 23 August 2010) Cite this as: BMJ 2010;341:c4217

Nicholas Mays, professor of health policy

¹*Department of Health Services Research and Policy, London School of Hygiene and Tropical Medicine, London WC1H 9SH*

Nicholas.Mays@lshtm.ac.uk

Tunis and Pearson describe the objections raised by critics to the inclusion of comparative effectiveness research as part of President Obama's health reforms and the concessions made so that the Patient-Centred Outcomes Research Institute could be included in the final legislation.¹ Despite (possibly because of) the compromises made, the authors believe that the new institute "will prove to be enduring and highly influential." Their belief seems to rest on the following frail foundations:

- The institute is outside government and has a wide range of governing stakeholders including drug companies, private health plans, and medical professional bodies
- Its research priorities will be based on what patients, clinicians, and payers want to know
- It will have half a billion dollars each year to spend on these priorities
- The results of its studies cannot be used to establish coverage or reimbursement decisions or make explicit recommendations to guide clinical or health policy decisions
- The research commissioned by the institute cannot focus directly on the costs or value of treatment.

Seen from outside the United States, it is hard to understand why Tunis and Pearson are so optimistic. The very features of the institute that appear to have been necessary for its legislative passage seem to guarantee its relative powerlessness. Clearly, the institute will undertake much illuminating primary research on the (comparative) effectiveness of a wide range of healthcare services. However, the limitations of its remit and authority are huge, and it is arguable whether lack of knowledge is the main obstacle to improving the (cost) effectiveness of US health care.

Firstly, it is hard to see how its disparate governing stakeholders will reach a consensus and stick to it except in the most uncontroversial areas. Secondly, the institute has no "teeth" in its own right. It cannot require (public) payers to pay exclusively for (cost) effective interventions or even make recommendations in this regard. As Himmelstein and Woolhandler commented, "Without an

enforcement mechanism, stepping up comparative effectiveness research cannot overcome drug and equipment makers' promotion of profligate care."² The institute will simply report the findings of its studies, presumably as widely as possible. Thirdly, although there is some evidence from the US that public reporting of effectiveness and quality of care can influence providers (hospitals in the main) to start or enhance certain activities, it has little or no effect on patients' choice of providers.³ There is too little evidence available to tell whether public reporting improves clinical outcomes. Fourthly, in the current financial climate, its inability to report on cost effectiveness seems to guarantee its marginality in public policy terms. Measurement and research are not sufficient to achieve high quality, more cost effective care. They have to be linked with other features of the system such as financing, regulation, market structure, and governance.⁴

Notes

Cite this as: *BMJ* 2010;341:c4217

Footnotes

- [doi:10.1136/bmj.c3615](https://doi.org/10.1136/bmj.c3615)
- Competing interests: The author has completed the unified competing interest form at www.icmje.org/coi_disclosure.pdf (available on request from him) and declares no support from any organisation for the submitted work; no financial relationships with any organisation that might have an interest in the submitted work in the previous three years; and no other relationships or activities that could appear to have influenced the submitted work.

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