

Stimulus Money and Health Care Research and Investment

On February 17, 2009 the American Recovery and Reinvestment Act (ARRA) – or, as commonly referred to in the media, the Stimulus Bill – was signed into law. The legislation allocates \$787 billion for federal stimulus spending in an attempt to curb the current economic recession. Of the total, \$150 billion has been allocated to health care (Figure 1). Health care represents the largest proportion of dedicated funds as well as the largest sector of the economy.¹ Thus, recovery and well-being of the economy is inexorably tied to the condition of the healthcare industry. The \$150 billion allotment is viewed as the jumping-off point for the Obama administration's healthcare agenda, which seeks to increase access to services while controlling cost. Because this will have both immediate and long-term effects for everyone in the nation, it is imperative for all to understand the broad health policy implications.

Over half (58%) of the health care stimulus funds – \$87 billion– will be devoted to states in the form of matching federal assistance for Medicaid.² The remainder of the health care stimulus dollars are pegged for three broad initiatives: comparative effectiveness research, health information technology, and increased funding (\$10.4 billion) for the National Institutes of Health.^{2,3} These three initiatives have the potential to profoundly affect healthcare policy and the future direction of the healthcare industry.

Specifically, the ARRA apportions \$1.1 billion for comparative effectiveness research, one of the more controversial funding initiatives.² Because comparative effectiveness is in its nascent stage in the United States, many have presupposed its implications and have a deep-rooted misunderstanding of this form of science. In its simplest form, comparative effectiveness research can be boiled down to the comparison of alternative treatments for a medical condition to determine the best overall treatment strategy.⁴

In practice, it is not this simple; there are many methodological and policy challenges. Foremost, researchers must determine the appropriate

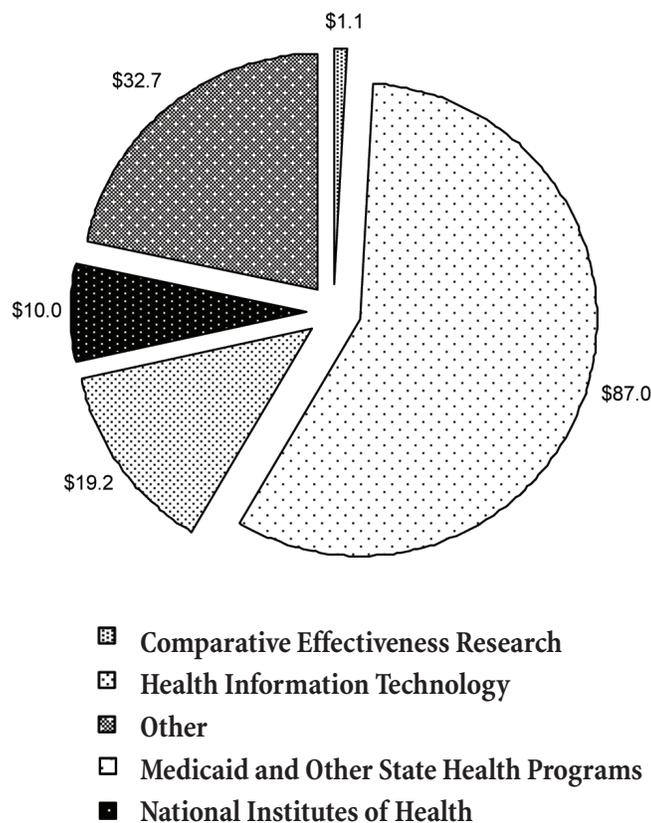
outcome measure for which to compare distinct or contrasting interventions. Another important component of comparative effectiveness research is economic evaluations of interventions. However, interventions which improve health outcomes do not always save money and, in fact, can be significantly more expensive than the current standard of care. As such, policy makers are forced to determine at what costs they are willing to fund interventions which improve healthcare.

While there are clear methodological and political challenges to conducting comparative

effectiveness research, it should not be discounted nor touted as the savior of health reform. Rather, when implemented as part of an overall evidence-based medicine agenda, comparative effectiveness research has the potential to curb rampant health care inflation and improve overall quality of care.

To oversee funding of comparative effectiveness research and to help alleviate the fear of the government using findings from this type of research to directly dictate medical coverage, the Federal Coordinating Council for Comparative Effectiveness Research (FCC-CER) was established

Figure 1: Allocation of Health Care Stimulus Funds (\$150 Billion)



on March 19, 2009. Comprised of a 15-member expert panel, the FCC-CER role is to submit reports to Congress on the comparative effectiveness research being conducted; it will not be able to mandate coverage or set healthcare policy.^{1,4}

The health care appropriation will also direct \$19.2 billion to healthcare technology and infrastructure investments with the ultimate goal of the implementation of an electronic health record for every person in the United States by 2014.² To achieve this goal, the funds will initially be used to provide incentives to doctors and hospitals to adopt the use of electronic health records.¹

The money will also be used to train workers in the use of health information technology and improve the security of electronic health records.

Finally, the legislation allocates an additional \$10.4 billion to NIH (approximately 1/3 of the current NIH budget), which must be spent in two years.^{2,3} Of the total, \$2.2 billion is dedicated to capital improvements of facilities, infrastructure and equipment to improve healthcare infrastructure and provide jobs as a way to stimulate the economy. The remaining \$8.2 billion is intended for peer-reviewed research grants.²

This tidal wave of money devoted to health care marks the beginning of a new era in health

policy, where costs are controlled and quality is demanded. Innovation is imperative, and novel ideas and approaches to solving the health care crisis are welcomed from all disciplines. In order to sustain lasting improvement, policy makers must remember to continue to invest in the nation's healthcare system after the stimulus funds expire. ■

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