1997 AHSR Presidential Address

The New Environment for Health Services Research: Private and Public Sector Opportunities

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First of all, I want to thank Alice Hersh and the AHSR staff for making this past year very fulfilling for me personally, and for helping to advance the agenda for health services research, even in the face of an increasingly complex and changing environment, with real constraints on research resources. And I want to thank David Kindig for his friendship, advice, and help over the past year.

I'd like to talk to you today about the changing healthcare environment and the potential effects of these changes on the ways in which health services research is organized and conducted. In particular, I want to suggest that the exponential growth of managed healthcare brings health services research to the brink of great opportunity—a critical turning point in the evolution of our field.

This opportunity is embodied in two notions: the need for collaboration among various sectors of the healthcare system, public and private; and in the notion that research results must be applicable in the real world—in the health system—so that we improve the health of individuals and of enrolled populations, and ultimately of the entire population.

"Rapid change" has become the theme of healthcare in 1990s America, and all sectors of the healthcare arena are increasingly turning to health services research as a valued navigational tool—a tool for determining where we are and where we are going, and how best to get there.

In my experience with the CDC and HCFA, I know first hand the critical importance of health services research in decision making. Without it,

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the process of governing can degenerate into decisions that are made solely on bureaucratic whim, or in response to the pleadings of organized interest groups or in conformance with a specific political ideology.

The New Environment for Health Services Research

We need to conduct studies that lead to useful, actionable conclusions. This is a major challenge before the health services research community today. Will we be able to—and have the will to—consistently go beyond abstract discussions and aggressively participate in practice, by providing information that will eventually lead to improvements in the health of populations?

Will we answer peoples' questions about the most effective prevention options; the most effective health plans, doctors and hospitals; the systems of care that provide the greatest value, in terms of cost and quality of care?

What some view as turmoil in the healthcare arena I view as opportunity knocking for health services researchers and the organizations we represent. To seize the opportunity, health services research needs to overcome two basic obstacles, obstacles that sometimes seem embedded in the culture of research.

First of all, there can be a tendency to re-prove what is already established. For example, we don't need more studies to prove that biological harm results from smoking, or that nicotine is addictive. Rather, in this example, what we need is a better understanding of the psychological reasons people start smoking in the first place. I'm afraid the tobacco companies are way ahead of us there.

And second, the research community sometimes studies things that seem to have little practical value, such as a study I heard about that demonstrated that eating an extraordinary amount of walnuts can lower cholesterol over time—the obvious follow-up question being, "Who's going to ingest tons of walnuts?"

The bottom line is that health services research has to produce useful research—useful, for example, to individual healthcare consumers, useful to purchasers of healthcare services, useful to providers of healthcare, and useful to health plans. In my recent experience with Prudential HealthCare, we often had to make decisions quickly, often without complete information. We generally did not have time for long, detailed studies, but we often made use of some existing health services research. And Jeff Koplan and the team of Prudential researchers are demonstrating how to shorten the timetable for the production of quality, peer-reviewed, research results.

After we have results, we need to put the results of our work into forms that can be used easily by both public and private sector decision makers, and we need to distribute findings effectively to help assure that our hard work won't be sentenced to the three-ringed binder graveyard we all have in our offices.

A good example of something that worked well in this regard is a mammography study done in two Prudential HealthCare plans that explored the barriers standing in the way of women 50 and older having regular mammograms, and ways to break down those barriers. We found that phone interventions were more effective, and more cost-effective, than mail or other techniques. The study resulted in a mammography screening manual jointly designed by Prudential HealthCare's Research Center and the CDC, which is being tested now and will be available widely throughout the country soon.

A more basic challenge for health services research is charting the research agenda. Change is happening so rapidly that the world can be radically different when a study is completed compared to when it starts.

An example of this challenge is the current debate over the primary care physician gatekeeper. If one were to start a study today—to determine the best access for a patient in a managed healthcare setting to primary care physicians and specialists—by the time the study is complete, the marketplace will likely have already determined what it wants through trial and error. The need decision makers have right now for cutting-edge information would have passed.

Managed Healthcare and Health Services Research: Opportunities for Collaboration

Much of what I am talking about is based on my own managed care experiences, but managed healthcare is at the core of today's basic changes in the healthcare arena. More than 150 million Americans are enrolled in some form of managed healthcare plan, a number that will continue to grow—especially as more Medicare and Medicaid enrollees move to managed healthcare.

However, the role that managed healthcare will play is by no means without challenge. Managed healthcare is driven by the marketplace. It cannot survive unless it is giving the marketplace what it wants, which is access to quality healthcare at a reasonable cost. I believe that the present backlash against some aspects of managed care, together with the varied response of health plans, will yield additional forms of healthcare organization and delivery.

We may not yet fully appreciate the strength of the backlash and the rise in the call for consumer protection legislation at the federal and state level. We may not have properly anticipated the reactions of physicians to loss of autonomy and professional control (not to mention the decline in their real incomes). What is certain is the move away from individual, fee-for-service medicine.

What is not certain is what will be the successful future models. In fact, what we now call "managed care" is an increasingly heterogeneous amalgam of arrangements and activities. But managed healthcare plans have an increasing interest in studying health outcomes and effectiveness among their enrolled populations, because the marketplace is continuing to demand value in healthcare.

This growing and welcomed market pressure for demonstrable value has motivated many managed health plans to try to enhance the quality, appropriateness, and effectiveness of healthcare services through improvements in all aspects of the health plan process—clinical practice, patient outcomes, service delivery, access, information systems, organization, and financing. And that translates into a growing demand for health services research.

Four years ago, I helped found The Prudential Center for Health Care Research, marking an important step for Prudential HealthCare toward integrating health services research into practice via the health plan. The Center's mission is to produce information and methods to enhance the quality and effectiveness of Prudential HealthCare and managed care nationwide.

What I found was that health services research in a managed care setting offers several advantages. The very nature of the managed care philosophy represents a *system* to deliver care that was not available in the traditional fee-for-service marketplace. Such a system offers a more convenient and coordinated environment in which to conduct research.

Indeed, the data required to manage care effectively are the same data that are required to do health services research, and defined membership populations can offer excellent study targets, with real denominators. A plan's information systems can provide access to a wealth of defined population data. And depending on a plan's membership migration experience, there is the possibility of tracking trends and follow-up.

Let me make a parenthetical comment here. We have to recognize that natural cultural tensions can exist between the private sector and the academic and public sectors when it comes to health services research. Motivations can be different—the stereotype is that public research organizations are interested in broad-based research to improve the overall health of a population, while

private sector organizations are interested in quick research hits that can improve their bottom line. But I believe that these two cultures are much closer than these stereotypes indicate. In an important respect, we all want the same thing—a healthier population—and capitation gives health plans and providers strong incentives to practice prevention.

Interests within the diverse health services research community are converging. Because of this convergence, I believe there is substantial opportunity for powerful collaborations among managed health plans, public agencies, and academic institutions. We need to come together as a research community that is growing in diversity but sharing the common goals of addressing and solving specific problems in our healthcare system.

There is already a record of successful relationships. Prudential HealthCare, for example, is collaborating with Harvard Medical School; United HealthCare with the Universities of Minnesota, Pennsylvania, and Washington, and Johns Hopkins; Health Partners with the University of Minnesota and Mayo Clinic; and Group Health Cooperative of Puget Sound with the University of Washington. Other studies are being performed in collaboration with government agencies such as the CDC and AHCPR, the Agency for Health Care Policy and Research.

If I may give you a bird's eye view of managed healthcare by using my former employer as an example, consider some of the studies Prudential's Research Center is doing, which involved collaboration with public agencies and academic institutions:

1. *A Study of Prenatal Care in Medicaid*—with a broad coalition in Memphis, with state and local governments and community groups, to improve prenatal care for women in Tennessee's Medicaid program;
2. *A Mammography Intervention Guide*—which is the study and manual developed with the CDC that I mentioned earlier;
3. *A Study of Cardiovascular Diseases*—with Harvard Medical School and other health plans, funded by AHCPR, to evaluate the quality of care delivered to patients with chronic cardiovascular diseases enrolled in managed healthcare plans; and
4. *An Evaluation of Literacy Among Seniors in Medicare*—with Case Western Reserve and Emory to explore the relationship between literacy and the health of Medicare enrollees in a managed healthcare setting.

These collaborative efforts represent a win-win situation for everyone: public agencies and academic institutions get to extend their reach and

capabilities by tapping the population and data sources and overall resources of managed health plans; and the plans get access to the tools that help them deliver value in healthcare.

A Research Agenda: Putting Results into Practice

Now let me focus our attention on the future. What do we, as a field, need to be studying to foster this collaboration further? I believe we can put together a specific, near- and medium-term research agenda that the marketplace would find applicable to real world needs. Let me suggest ten points:

1. *Physician Compensation.* We need to look at how physicians are paid and how this influences care and services provided, including preventive services. Obviously, this could address how physician compensation arrangements affect quantity and quality of healthcare.
2. *Corporate Decision Making in the Healthcare Sector.* It's important to understand how the corporate structure affects the delivery of care; how physicians and corporate executives interact with the healthcare organization and one another; what impact the stock market has on healthcare delivery in publicly owned organizations; and what if any differences there are in the healthcare delivered by for-profit and not-for-profit healthcare organizations.
3. *Risk Adjusters.* We need to answer questions about payment arrangements. For instance, on a macro level, should we risk-adjust capitation as a whole on a prospective or retrospective basis, and if so, could that lead to adverse selection? What are the best measures—claims data or a survey of patients and health status? On a micro level, should payments to providers be risk-adjusted, and if so, might that lead to reducing payments to physicians the more effective they become, creating a disincentive to excel? How can that be overcome?
4. *Population-Based Health Services.* The public *and* private sectors are running parallel in their interest in population-based health services research. Are the tools typically utilized in managed healthcare, such as utilization review procedures, adequate to achieve change across populations? What are the best disease management and health promotion designs to help influence outcomes? What are the other ways of influencing health, beyond healthcare services, and how can they be made effective? What are the best measures of outcome across health plans and communities?
5. *Healthcare Workforce.* As access issues continue to heat up, we need to improve our understanding of the role of various types of healthcare workers

to broaden the reach of the system, especially in urban and rural areas where there can be a shortage of physicians. This is especially important at a time of dramatic change in the overall physician marketplace, and of the impact of informatics and telemedicine.

6. *Benefits Modeling.* Instead of trial and error, the marketplace would value knowing which benefit packages are most effective and efficient in producing positive healthcare outcomes.
7. *Children's Health.* A hot topic now is health coverage for America's millions of uninsured children. There would be value in researching the best way to extend benefits incrementally to them. Realistically, we need also to look at the tough question of whether this country should have a smaller benefit package for a greater number of children, or a larger benefit package for fewer children. Which arrangement would have the best healthcare outcomes? Which is the nation willing to afford?
8. *Private Data Issues.* We need to resolve issues of privacy and confidentiality of individuals, and of the proprietary interests of organizations with healthcare data and information. This is a topic of major interest to AHSR, and you will be hearing more from us on it soon.
9. *Joint Funding and Operation of Research Activities.* As I have explained, there has been an explosion of private sector involvement in health services research. With this has come a major new funding stream. While I was at Prudential HealthCare, we developed productive partnerships with Barbara McNeil and her colleagues at Harvard, plus useful collaborations with other academic units. But there are limits to what individual private sector entities can and will do—and we need to explore ways to enhance joint funding and research activities, perhaps a national pool of industry funds jointly managed by AHSR and the American Association of Health Plans.
10. *Setting the Public Research Agenda.* The public sector leaders, from CDC and AHCPR to HCFA and NIH, need to work much more closely together. Especially now they need also to work with the private sector, to develop a national research agenda that is relevant for the new century.

Conclusion

I realize, of course, that important work has already been done in these areas—and that together we are continuing it now. But all of these issues have something in common: they represent the massive change in healthcare

today, and therefore an equally large opportunity for health services research, now and in the future.

But even in the midst of a sea-change in healthcare, the basic *function* of health services research has not wavered, nor do I expect it will: we must document the current status of healthcare and its many facets, and we must demonstrate what works in healthcare. And the basic *mission* of health services research continues: we still must pursue ways to enhance the health of individuals and of populations.

What is changing is the system itself—and we must have a valid navigational tool, fully engaged in all aspects of the health system, conducting studies that lead to useful conclusions that can be implemented for meaningful change.

For a health system that at times seems in real disarray, and as we somewhat uncertainly enter a new century, I say . . . *take heart* . . . because *Health Services Research is That Pre-Eminent Navigational Tool. Opportunity knocks at our door!*

Thank you for a truly rewarding year. It has been my pleasure and honor to serve the health services research community through this great organization.