

Framework for Health Services Research Policy for 2008

The overarching problem: Health care in the United States has the potential to improve people's health dramatically, but often falls short and costs too much.

The importance of information: The best health and health policy decisions are based on data and scientific evidence. Better information can ensure the rapid diffusion of scientific innovations, sound health policy, and health system efficiency.

The contribution and promise of health services research: Health services research provides the data and evidence needed to make decisions and develop policies that optimize health care financing, delivery, access, and outcomes. It provides policymakers, practitioners, and other decision makers the necessary tools to make health care:

Affordable, by decreasing cost growth to levels sustainable by individuals and the country.

Efficient, by decreasing waste and overpayment and monitoring cost-effectiveness of care.

Safe, by decreasing preventable medical errors and adverse drug events, monitoring public health, and improving health system preparedness.

Effective, by monitoring and evaluating health programs and outcomes and improving implementation of evidence-based innovations as part of routine health care.

Equitable, by eliminating disparities in health and health care according to ethnicity, gender, and geographic location, as well as socio-economic and insurance status.

Accessible, by connecting people with the appropriate health care they need when they need it.

Patient-centered, by increasing patient engagement in their care, as well as their satisfaction with the care they receive.

For examples of ways in which health services research has helped contribute to these important objectives in rural health, child health, and public health, among others, please see Appendix I.

Policy to Promote Value and Accountability in Health Care

Americans expect value for their health care dollars. They also expect accountability, or a process by which value can be demonstrated and monitored. Industry has contributed to these expectations by investing in methods for promoting value and accountability, such as outcomes monitoring and quality improvement. In health care, investment in scientific innovations has not been matched with the corresponding investment in value and accountability. Without this funding, we will be unable to take full advantage of our investments in biomedical research.

Proposed Priorities

We suggest the following “cross-agency” priorities for the Department of Health and Human Services (HHS) and other public and private health research agencies to foster the availability, quality, and timeliness of research to meet evolving health and health care needs.

- **Advancement of Innovation and Knowledge:** Many of the sentinel studies that have changed the face of health and health care in the United States— John Wennberg’s Dartmouth Atlas documenting geographic variation in health care delivery and outcomes, for example—are the result of ingenuity on the part of investigators who believed their ideas had the promise to clarify a phenomenon, improve methods and measurement, or make an otherwise unmanageable policy problem manageable. Yet the last few years have shown a dramatic decline in the number of, and funding for, grants that support such investigator innovation. We need greater investment in new and competing grants to rejuvenate the free marketplace of ideas. Public policy should ensure that all agencies funding health services research spend at least as much on new and competing grants as on earmarked intramural research and targeted, extramural contracts. To expand the knowledge base and discover new ways to improve the health system, these agencies also need to invest in new methods to answer increasingly complex policy questions and in new translation approaches to move research innovations from the bench to the bedside.
- **Fair and Transparent Access to Information:** The nation cannot advance to a place where evidence informs policy and practice if access to information is limited unnecessarily. Recently, limitations have been imposed on permissible research uses of federal data, and restraints have been imposed on the publication and disclosure of the results of research. Public policy should ensure that population health data, as well as data generated by federal health care programs, are made public, and that all public data sets are made readily available to researchers who enter into agreements that ensure privacy, security, and compliance with applicable human subject research requirements. Policy should also ensure transparency in data access, data use, and publication policies and prohibit the imposition of excessive prior restraints on the publication of research.
- **The Next Generation of Health Services Researchers:** The field of health services research has experienced an erosion of investment in its data and methods, but also its researchers, as evidenced by the recent decline in the number of, and funding for, training grants. Researchers who are seeking advancement in their new careers require evidence of independent scholarship, including K-Awards, RO1s, and other

grants. Failure to fund such grants adequately may result in losing early career researchers to research fields with more support. In addition, health services research careers are jeopardized by current constraints on research funding, data availability, and publication rights. If left unchecked, these declining investments in graduate education could threaten the field's capacity to address public and private sector research needs for information. The return on investment in graduate students and new researchers will only be realized if the funding infrastructure expands to support them throughout their early career development.

- **Broad-Based and Adequate Funding for Comparative Effectiveness Research:** Comparative effective research—where pharmaceuticals, medical devices and medical procedures used to treat the same conditions are evaluated for their relative safety, effectiveness, and cost—has great potential to improve health care quality and patient outcomes while ensuring that consumers receive the best care at the best value. Congress should increase and expand the sources of funding for conducting and coordinating a wide spectrum of comparative clinical and cost effectiveness research, including systematic reviews of existing literature, analysis of administrative data and clinical registries, and pragmatic, prospective, head-to-head trials. Doing so would ultimately help patients, providers, payers, and policymakers make rational choices about new and existing health services. Since the findings of the research would benefit all people, its sources of funding should be broad based. Independence and scientific integrity should be emphasized.
- **Accountability through a Coordinating Council for Health Services Research:** An advisory council comprised of federal sponsors of health services research (e.g., AHRQ, CDC, CMS, NIH, VA, DoD, etc.), private foundations, researchers, business leaders, and consumer advocates should be created to develop a standard definition of health services research, collect and display the results of health services research conducted by the federal government, and suggest an annual health research agenda. The Secretary of HHS should be required to report on the amount and types of health services research being conducted across agencies. The Council would report to the President and Congress annually on the contributions and priorities for research to improve the performance of the U.S. health care system. This report would provide an important mechanism for targeting research and demonstrations to address critical health issues.

Appendix I: How Health Services Research Informs Public and Private Decision-Making

Child Safety

Using the Partners for Child Passenger Safety (PCPS)—an ongoing child-focused, real-time, crash surveillance system established with the State Farm Insurance Companies in 1997—Flaura Winston (Children’s Hospital of Pennsylvania) found that only 25 percent of children between 3 and 7 years of age were appropriately restrained in crashes; children in seat belts alone were at a 3.5-fold increased risk of serious injury. Winston’s analysis of PCPS data led to the rapid adoption of belt-positioning boosters as the appropriate form of restraint for children once they’ve outgrown car seats. Appropriate restraint by children in this age group has doubled and child fatality is at its lowest level ever.

Coverage

During 2004 and 2005, a team of Urban Institute researchers led by John Holahan found that an individual health insurance mandate or an employer mandate combined with an individual mandate could yield universal coverage with a relatively small increase in government costs relative to Massachusetts’ gross domestic product and current health spending. Holahan’s series of research papers framed the debate over health care reform in Massachusetts: the landmark insurance mandate legislation passed in early 2006 reflected many aspects of the policy options and analysis contained in this body of work.

Health Care Financing and Administration

Arlene Ash’s Medicare-funded research led to the development of Diagnostic Cost Group (DCG) models and more generally, facilitated the adoption of risk adjustment tools in health care financing and administration. The DCG models are designed to reward health plans for providing excellent care for sick people while limiting incentives for “cherry picking” healthy patients. CMS chose the DCG model to stabilize Medicare against risk selection in its managed care plans. Variations of these models have been adopted by state Medicaid programs, private insurance companies, and large employers, as well as public payers abroad. And virtually all proposals for health system reform now assume robust risk adjustment at various levels of health services delivery.

Obesity

Eric Finkelstein (RTI International) used data from the late 1990s to find that obesity is responsible for up to \$92.6 billion in medical expenditures each year; approximately half of obesity-related health care costs are borne by Medicare and Medicaid. A 2002 study by Roland Sturm (RAND) found that the effects of obesity on a number of chronic conditions were larger than those of smoking or problem drinking. Since then, obesity has been escalated to the top of the list of health care priorities, and policymakers have appropriated funds for federal agencies to fund health services research that encourages people to understand the effects of diet and exercise on their health.

Patient Safety

A 1998 study led by David Bates (Brigham & Women’s Hospital) found that computerized order entry of prescriptions at Brigham & Women’s Hospital reduced medical error rates by 55 percent; rates of serious errors fell by 86 percent. Thanks in part to this groundbreaking work hospitals around the country are installing their own computerized physician order entry systems. In fact, The Leapfrog Group—a large national coalition of more than 100 public and private organizations that provide health care benefits—includes computerized physician order entry as one of the safety standards it encourages hospitals to adopt.

Rural Health

Stephen Mick (Virginia Commonwealth University) and colleagues examined rural hospital performance in the late 1980s and early 1990s and found that activity typical of urban hospitals is beyond the capacity of most rural facilities and recommended that a new federal approach would be required to preserve rural acute-care services. This work helped form the intellectual basis for Medicare’s highly successful Critical Access Hospital program, which was designed to improve rural health care access and reduce closures of hospitals that provide essential community services.

Workforce and Outcomes

In 1997, Jack Needleman (UCLA) and Peter Buerhaus (Vanderbilt University) analyzed more than six million patient discharge records from 799 hospitals in 11 states and found that patients in hospitals with fewer registered nurses stay hospitalized longer and are more likely to suffer complications, such as urinary tract infections and upper gastrointestinal bleeding. This research established a causal link between the nursing shortage and outcomes, and helped move the nursing shortage into the public’s eye and onto policymakers’ radar. In 2002, Congress passed the Nurse Reinvestment Act to increase the domestic supply of nurses.