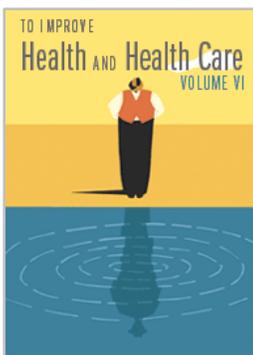




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**To Improve Health
and Health Care,
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Edited by
Stephen L. Isaacs and
James R. Knickman
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Editor's Introduction

The managed care revolution that swept through the health care industry in the 1990s was seen as potentially threatening or beneficial to some of the Robert Wood Johnson Foundation's most important goals. On the one hand, there was the possibility that capitated payments (set fees paid per person regardless of the amount of care provided) and discounted reimbursement mechanisms would impede access to, and reduce the quality of, care. On the other hand, there was the possibility that by focusing on prevention and coordinating care, managed care would improve access and quality.

Because of the importance of these issues, in the early 1990s the Foundation staff considered mounting a prospective "evaluation" to better understand this national experiment in market-driven health care reform and its effect on access, quality, and cost. The staff believed that such an evaluation could determine where the Foundation might be helpful in guiding or compensating for the managed care revolution. More important, a careful assessment of the impact of health-system change could provide useful information to policy makers.

To undertake this assessment, the Foundation funded, in 1994, the Health Tracking initiative and created the Center for Studying Health System Change to run it. So far, the Foundation has invested more than \$100 million in this ambitious program to help policy makers and the media understand the dynamics and effects of market-based health care.

This is not, of course, the Foundation's first involvement with managed care. In "The Changing Approach to Managed Care" in the 2001 edition of *The Robert Wood Johnson Foundation Anthology*, Janet Firshein and Lewis G. Sandy observed that the Foundation was an early supporter of the idea of managed care, then worked to improve standards for measuring and improving quality, and finally tried to smooth out some of managed care's rougher edges.⁵ Nor is this the first time the Foundation has attempted to use research findings as a lever for policy or program action; in Chapter Six of this year's edition of the *Anthology*, C. Tracy Orleans and Joseph Alper write about an effort to translate research into action in the context of tobacco-cessation programs.

In this chapter, Carolyn Newbergh, a freelance journalist specializing in health care, examines the Health Tracking initiative. She explores the changes in the health care system and how the Center and its collaborators used surveys and other research methods to discover how the changes were affecting access, quality, and cost. She also explores the effect on Health Tracking when the

consequences of the managed care revolution turned out not to be as dramatic as had been anticipated.

Newbergh does not shy away from exploring the difficult challenge faced by the Health Tracking initiative: to make its widely praised research findings available to the media and to policy makers in a clear and timely manner. This reflects the tension that sometimes appears between those doing research and those trying to communicate it. Resolving that tension is one of the keys to translating research into policy.

⁷ Firshein, J., and Sandy, L. "The Changing Approach to Managed Care." In *To Improve Health and Health Care 2001: The Robert Wood Johnson Foundation Anthology*. San Francisco: Jossey-Bass, 2001.

The handwriting on the wall in the early 1990s wasn't pretty. Like an ominous EKG, health care insurance premiums had been rising at a double-digit pace as health care costs raced upward. Employers struggling to cope with a slow economy made it clear that they couldn't continue to absorb the increase in premiums. At the same time, the number of uninsured people was at thirty-four million and counting. Economic prognosticators were pessimistic about how we would get out of this fix.

Meanwhile, the Clinton administration's ambitious plan to reform the health care system, with its emphasis on managed care and competition, flatlined into history. Instead, the country was left with a de facto reform that was to be carried out by the private health insurance market. What was about to ensue was a virtual experiment in letting market forces try to come to grips with the complex system of private health financing and delivery, primarily through the mechanism of managed care.

Managed care held out great promise for making sense of the private system by instituting cost-containment strategies such as capitation, which provided doctors and hospitals with a fixed sum of money for a patient's overall care. This created an incentive to do only what was necessary for good care and not waste resources. Managed care was expected to reduce overuse in the system, which often saw too many unnecessary referrals to costly specialists or lengthy hospital stays. Managed care was also envisioned as using integrated delivery systems of doctors and hospitals caring for a specified population, applying medical practices that proved most effective. It was also expected to lead to more preventive health care, since physicians now had an economic self-interest in preventing illness and chronic conditions.

But as managed care plans began taking the place of fee-for-service insurance, the media were reporting horror stories: pinched-off access to specialists by doctors acting as gatekeepers to care; patients waiting for authorization before setting foot in an emergency room; and so-called drive-through deliveries, as women were forced to leave the hospital the day after giving birth.

What was truly happening? Were unnecessary costs being trimmed away and were the headlines just symptoms of a few growing pains as managed care evolved? Were premiums coming under control? Were patients getting more mammograms and blood glucose tests, or were they receiving less and poorer-quality care while being denied access to doctors when they truly needed them? Were doctors and hospitals cutting corners on care to reduce utilization and make sure the capitation fee covered their bottom line? What was happening to the uninsured in this climate?

Answers to such questions were hard to come by, because no one was collecting timely, reliable data on the private health care market's fluctuations. Government studies were often too outdated to grasp real-time needs; what's more, they had a national focus and did not target the health plan approaches emerging in local markets across the nation. Reports from private health care industry groups and analysts were driven by business interests with their own agendas, and these were often proprietary.

This glaring information gap was recognized during the days when the Clinton reform plan still looked possible. Many wondered then how to keep watch on what would develop. But with reform actually being carried out in an ad hoc way and heightened concern about its effect on the care patients received, the need for accurate, current information became even more pressing. How would anyone know how a market-based system of health care was working if no one was keeping tabs on this national experiment? Without a thorough, timely, unbiased source of information, it looked as though health policy decisions would be shaped more by anecdotes that grabbed media headlines (of the "Muncie Grandma Dies After Being Denied Operation" variety) than by thoughtful evaluation of what was truly happening.

THE HEALTH TRACKING INITIATIVE IS BORN

It was against this backdrop of a yawning information gap and the expectation of revolutionary change that the Robert Wood Johnson Foundation decided to mount a large-scale research program in 1994. Known as the Health Tracking initiative, the program set its sights on extremely broad and ambitious goals: to follow and assess the changes occurring in the private health care system, primarily in managed care, and what they meant to people. Health Tracking would focus, over time, on patients' access to care and its quality and cost in the many diverse health care markets in the country. Its hope was to generate

high-quality objective data and analyses that would inform and thus guide the whole process of policy and organizational change.

This ambitious undertaking would have as its centerpiece the Center for Studying Health System Change, established in Washington, D.C., in 1995. The Center would oversee the Community Tracking Study, whose key element was a broad longitudinal survey of thirty-three thousand families in sixty communities, plus a national sampling. The locales, randomly selected to be representative nationally, would be revisited every two years to detect change and what it meant. The sixty thousand people to be interviewed over the telephone would be asked about their access to care, the medical services they used, their satisfaction, and their health status. The study would include two other surveys using the same communities: twelve thousand doctors would describe their changing practices and twenty thousand public and private employers would shed light on the kinds of health plans they offer and how much employees pay for coverage. Researchers would also conduct site visits at twelve of these communities for more in-depth interviews with up to ninety participants in a local private health care system—the major employers, health plans, safety net providers, hospitals, benefit consultants, medical groups, and consumers.

As it evolved, Health Tracking would add on a number of other outside “collaborative” studies to fill in the picture. In 1997, a study by RAND/UCLA would begin looking at access to substance abuse and mental health services in these communities. To better assess the quality of care being delivered, in 1998 a RAND Santa Monica study would start examining medical records in the twelve site-visit communities to look at a number of quality indicators. In 2000, a University of California, Berkeley, study would be commissioned to look at how medical group practices across the country manage treatment of chronic illness. The Foundation also added funding to provide small grants to encourage researchers in the field to use the data from the longitudinal survey, which is posted for public use at the Website of the Inter-University Consortium for Political and Social Research.

Collaborative Studies in the Health Tracking Initiative

The lead organization in the Health Tracking initiative is the Center for Studying Health System Change, but other organizations also play a significant role. The RAND Corporation, the University of California, Berkeley, the University of California, Los Angeles, and the Research Triangle Institute received approximately \$34 million to gather and analyze additional nationwide data about health systems change and its effect on health and health services.

The Community Tracking Study always intended to look at whether having a high level of managed care in a community makes a difference to people's health and the quality of medical care they receive. But this kind of research turned out to be so complex that it was spun off to consultants Beth McGlynn and Steven Asch at the RAND Corporation in Santa Monica. The study—believed to be the first population-based research that examines these critical questions—is expected to generate insights into who is at risk for poor health care and the kinds of measures that have been shown to improve quality. A sample of Community Tracking Study participants at the twelve site-visit locations are interviewed about their health histories, and their medical records are reviewed. The quality of their care is evaluated on the basis of more than one thousand indicators spanning acute care, prevention, and treatment of chronic conditions. The study takes into account income, insurance, age, gender, and geographic location.

In another study meant to fill in the picture of American health care today, a team of researchers at UCLA/RAND is examining how managed care and public policy affect access, quality, and cost of care for people with alcohol, drug abuse, and mental health problems. The Healthcare for Communities Study, led by Kenneth Wells, Audrey Burnam, and Roland Sturm, looks at a segment of the Community Tracking Study participants intensively, with an emphasis on the poor and those at increased risk for these behavioral health problems. This study is compiling the first nationwide database on the behavioral health services that are available through public health managed care programs nationwide. Among the findings so far: most people with substance abuse go without care, most children and teenagers with mental health problems get no treatment, and just 30 percent of depressed or anxious adults receive the care they need.

At the University of California, Berkeley, a team headed by Stephen Shortell is examining how organizing physicians into group practices or independent practice associations affects their use of care management approaches for patients with four major chronic illnesses: asthma, congestive heart failure, depression, and diabetes. This is the first national study to investigate this linkage. Among the care management techniques looked at are use of evidence-based clinical practice guidelines, care-management systems, and disease-management programs. The study interviews physicians' organizations across the country, going into more depth in five of the Community Tracking Study locations. It also talks to trailblazers in using care management approaches. The hope is that the study will identify both impediments to managing chronic conditions within a

The unbiased data the studies yielded could then be used for various purposes: to inform those responsible for health care policy at the local, state, and national levels about changes and when they might want to intervene; to dispel or confirm myths or anecdotes that too often drive health policy decision making, and to make a rich database available to the Foundation's own programs and health policy researchers everywhere.

This initiative seemed a good fit for the Robert Wood Johnson Foundation. The thinking was that creating better health care policy takes extremely good information. "Knowledge generation is a core strategy of the Foundation," said Foundation executive vice president Lewis G. Sandy. "The sharing of

information leads those in the system to new dialogues, understandings, and potential policy choices based on what's happening in the environment.”

To obtain such information, the Foundation had commissioned survey research in the past. Surveys conducted in 1976, 1982, 1986, and 1994 aimed at understanding the extent to which people had (and lacked) access to health care services. Every so often, surveys were done on how physicians' practices affected access and quality of care and the role of employers in private insurance. But it was hard to draw comparisons among these surveys because they examined different populations, were never linked, occurred irregularly, and were carried out by separate organizations with varying methods. Health Tracking was set up to eliminate those problems, by coordinating the studies and using the same communities and methods at regular intervals.

As envisioned, Health Tracking would be expensive (to date, the Foundation has committed more than \$100 million to it) and time-consuming. The Foundation never spelled out how long Health Tracking would last. Many involved at its inception say they imagined it would function for at least a decade. Devoting such a large amount of money to research was rare for the Foundation. However, it has made similarly large investments in a number of programs that didn't involve research, such as Fighting Back®, Covering Kids and Families®, Clinical Scholars® and Faith in Action.®

Any expensive, open-ended program, however, can invite criticism and even jealousy both from within and without, as this one has. Is it worth the money? Is it meeting the goals? The need to show results, to quickly find its place in the health care policy debate, has shaped Health Tracking almost from the start and continues to do so today.

THE INITIATIVE UNFOLDS

Recognizing that Health Tracking's effectiveness would depend on the credibility of the researchers who produced the work and the reputation of its organizational home, the Foundation approached Mathematica Policy Research, a respected consulting firm in Washington, D.C. To minimize startup costs and build on Mathematica's credibility, a new organization, the Center for Studying Health System Change, was established as a subsidiary of Mathematica. The Center began functioning in 1995 under the direction of Paul Ginsburg, a highly regarded health economist who had headed the Physician Payment Review Commission, which advised Congress on Medicare issues.

As its first endeavor, in 1995 the Center tested the Health Tracking concept through a pilot program, the Community Snapshots Project. Teams of researchers conducted local interviews and produced brief profiles or “snapshots” of health care developments in fifteen markets, selected to represent a range of regions, population sizes, and stages of development.¹

The Center’s first year of funding for the large-scale Community Tracking Study, also in 1995, went into planning the research design and startup. The Center contracted with a number of organizations to collect data: Mathematica’s survey group to conduct the household study; the Gallup Organization to interview doctors; and the RAND Corporation, through the research of Stephen Long and Susan Marquis, to study employers. The survey work began in the field in 1996. It took a full year to complete the sixty thousand interviews and three to six months more to put the information together so that it could be analyzed. This meant that a program funded in 1995 didn’t start generating reports until the fall of 1997—a relatively rapid pace for traditional academic research, but a considerable wait for a center aiming at research that would plug into present-day needs.

Under pressure to produce reports quickly that would give the Center a public presence, Ginsburg, in the fall of 1996, began writing annual reports on costs, which were culled from his analysis of various outside sources. He was the first to note that managed care was truly leading to an era of lower premiums—a finding that was at first viewed with skepticism but that later, as the trend continued, gained wide acceptance.

Once researchers feasted their eyes on the first survey’s data, they understood that they couldn’t begin to describe health system change because the findings couldn’t yet be compared with another period. “With a longitudinal study, you can’t do more than establish a baseline after just one survey,” said Robert G. Hughes, a Foundation vice president who helped spearhead Health Tracking. “The way the program is structured, the longer it goes, the more valuable the results will be.”

What the program could do with its first survey results was to show what was going on right then, and to start debunking myths that had emerged. It was able to demonstrate, for example, that changes in health care varied from community to community and that managed care was not evolving to the same level of sophistication and restrictions everywhere, contrary to what had been thought. It also published reports looking at health care issues such as the number of uninsured across the country and whether consumers believed their doctors would refer them to a specialist if they needed one.

Even with this output, however, the pressure on the Center to produce more and to raise its public profile continued. After the second round of the household survey, undertaken in 1998 and 1999, the Center did begin generating reports, which started flowing in 2000. The reports showed, among their other findings, that slightly more families had a choice of health plan than two years before, and that the number of low-income uninsured children getting onto private health plans hadn't changed.

But then something occurred that had not been anticipated. The rapid, fundamental health system change the Center was set up to monitor wasn't materializing as envisioned. A curious thing had happened as health plans imposed restrictions on patients and doctors around the country: they balked. Angry about seeking authorization for a referral to a specialist and not being able to see a longtime doctor who wasn't in their provider network, patients complained to their employers, the media, and their lawmakers. As a result, legislation was enacted by many states and the federal government to protect consumers' interests. For their part, physicians were distressed about losing autonomy and income and gaining a mountainous amount of paperwork, so they banded together against capitation and for better fee arrangements. Hospitals, too, felt that care and their bottom line were being harmed by managed care; many of them consolidated and were able to use their greater bargaining power to negotiate improved contracts with health plans. Moreover, employers, contending with a tight labor market and eager to use generous benefits as a strategy for retaining workers, pushed insurers to relax restrictions on seeing specialists and to give patients greater choice of physicians and hospitals.

By the late 1990s, the backlash against managed care was in full swing. Under pressure from so many directions, health plans loosened many of the restrictions they had established to contain costs and to manage care. They eased up on barriers to seeing a specialist, gave their members a wider range of physician and hospital networks from which to choose, and began negotiating contracts more to doctors' and hospitals' liking. They also lessened or eliminated the financial incentives offered to physicians to reduce costs (and, some argued, to reduce care).

This meant that the very beast the Center was created to keep watch over had transformed itself into more of a mild-mannered, household pet. Fundamental change in the system was not continuing to unfold. Even the much-touted idea of creating integrated health care delivery systems of physicians and hospitals who would tend to a defined patient population—and would use an evidence-based medicine approach to their care—was not taking hold quickly. Most consumers seemed to feel battered by change in this period, but they probably felt it more as what news accounts called the “hassle factor” over difficulty in getting a referral or authorization for treatment and dealing with the health plans'

bureaucracies.² Although, strictly managed care no longer threatened health care services, the milder version that had replaced it no longer held out much hope for stemming health care's rising costs.

Through its publications and conferences, the Center has been out front in describing the waning of tightly managed care and the concomitant rise in health care costs. In its September 2001 *Data Bulletin*, the Center was among the first to point out that premiums were on the double-digit rise again in 2001, up 11 percent—the highest increase since 1993—and would continue on this trajectory for some time.³ Many similar findings came out through other organizations (business groups, consulting firms, and the government) during the following winter.

Sure, the Center was an important voice describing this retreat from tightly managed care. But if managed care no longer represented significant change, the Center's reason for being seemed to grow more uncertain. This put even more pressure on the Center to show that it was informing the public policy debate.

COMMUNICATING THE RESEARCH FINDINGS

Once the Center began turning out findings, it (and the Robert Wood Johnson Foundation) learned the basic lesson that good research wouldn't get noticed without a well-oiled communications strategy. Communications would have to be given as much importance as the research itself if the Center were to become a resource for the outside policy world of local, state, and federal elected officials and their staffs; federal agencies working in health care; lobbyists; consumer groups; trade associations; advocacy groups; and academic institutes and think tanks.

Unfortunately, because of the way that the Foundation awarded the initial grant, the Center got off on the wrong foot in its public affairs operation. The original idea envisioned the Foundation itself handling all communications and being the voice of the Center. However, the Foundation later rejected this approach, and no money was allocated for communications when the Center was created. Many who were involved at the time say that the Foundation was uncomfortable with being so closely identified with the Center's findings, which might be controversial.

As a result, the Health Tracking surveys started out in early 1996 without having a public affairs approach in place. In fact, no funding was available for communications until July 1996, when the Foundation approved a \$1.6 million supplemental grant and the Center hired outside contractors to prepare some publications and plan other dissemination and outreach activities. But this was six months into the first

household survey, which was planned and carried out without sufficient emphasis on what would interest policy makers most. The Center's early journal articles and reports were criticized as wonky, dry, untimely, and not particularly relevant to the real world. At the same time, the Center was viewed as lacking in political savvy and out of touch with its audience's needs. Communication wasn't given its proper due until the decision was made in 1998 to hire an in-house communications specialist to coordinate a multifaceted public affairs approach.

Getting a grip on communications was critical because of the inherent tension between research and communications. Most researchers are by nature methodical, exacting, and cautious, and they are not inclined to rush their findings for the sake of publicity or informing the public. They often bury their findings late in a journal article after thorough analysis of statistics and previous studies. Generally, researchers are not of the rough-and-tumble political world, don't understand how it works, and don't put out feelers to see what people want to know. They achieve credibility by publishing their findings in peer-reviewed journals, which is valuable but time-consuming. For the Center, that added many months to the long process of generating results.

"So often with research, by the time it comes out, you're confirming the already known," one Washington health policy observer said. "It will have been written about in a less careful, less confirming way in the corporate press, but it's out there. And, in fact, a lot of decisions are made in the health care arena based not on careful data collection and analysis but on slipshod work."

Without a cohesive communications strategy, the Center missed opportunities to play a role in its early years, some say. One observer recalls that the Center sat on information that would have been pertinent to a congressional debate on uninsured children, saving it for a formal press conference the next week. "A more adroit operation might have said, 'We can tell you your numbers are off but we're not at liberty to comment further until our press conference,'" this observer confided. Someone else on the sidelines noted that the Center had to be pushed to think about how it could lend its voice to the Patients' Bill of Rights debate.

Once it hired public affairs specialist Ann Greiner in 1998, the Center focused on how to be relevant to its audience and reach out to it in a readable format. Greiner took soundings from policy makers about what they wanted to learn. Both she and Ginsburg worked with researchers as they designed their studies or looked at data to point out when something particularly interesting was lurking in a dense study.

To make its research more timely and useful, the Center began, in October 1999, to put out short takes on its findings in a four-page *Issue Brief* or a two-page *Data Bulletin* before a journal article is published. A number of journals agreed to this approach as long as the brief or bulletin mentioned where the subsequent longer, more complex article would appear. However, two of the nation's leading medical journals, the *New England Journal of Medicine* and the *Journal of the American Medical Association*, wouldn't go along with this approach.

Although the Center had employed these shorter publications before, it had never used them as a preview of a journal article. Doing so permitted the Center to gain recognition as a timely resource for health policy data.

Today, the Center puts out an *Issue Brief* or a *Data Bulletin* at least once a month and produces journal articles, *Community Reports* (from the site visits), *Tracking Reports*, and *Research Reports*. The Center also distributes press releases and briefs major news organizations before important findings are announced. It mounts well-regarded conferences three times a year on a current topic of interest and holds brown-bag lunches with policy makers to stay abreast of their interests and share the center's latest research findings. The Center remodeled its Web site (www.hschange.org), which provides easy access to a great depth of materials. Media coverage of the Center's work has steadily grown, with more than one thousand citations in news articles during 2001. Ginsburg has become a regular resource for news stories on managed care and health care costs.

The Center also addressed one of its key problems: that a longitudinal survey is, by its nature, slow and cumbersome and takes considerable time to produce results. Because these surveys depend on repeating questions over the years to pick up change, researchers can't add and subtract too many questions from a survey without losing the ability to draw conclusions over time. Although the Center has made some modifications to the survey, it has learned to rely on site visits to the twelve communities that are studied in greater depth as a way to be more timely and flexible. At these site visits, researchers can plug in questions about current issues on short notice. They essentially take the pulse of the community and pick up on new trends and changes they didn't previously know about. "We see things at site visits that we haven't expected," Ginsburg said. "Our researchers saw network provider instability at a site visit." Doctors or hospitals were dropping out of a health plan's network, leaving patients to scramble to find a new provider whose services would be covered, or to pay more themselves for a doctor outside their network. "That was something we didn't foresee," Ginsburg added, "but we saw it so clearly that we could publish something before many other studies even began to look at it."

Some of those active in health care policy say they have been bombarded by Center materials in the last few years, and they like what they see. “In the last two years, the Center has kicked up its public persona in a major way,” said Stuart Altman, a leading health policy expert and professor at Brandeis University’s Heller School for Social Policy and Management. “I notice this in the amount of materials that it puts out and the timeliness of what it puts out.”

Information coming out of the Center is now reaching a broader audience and attracting more attention, many said. “If I had to criticize the Center in the past, I would say the material it developed was not as user-friendly for outside organizations as it could have been,” said Ronald Pollack, executive director of the advocacy group Families USA and a member of the Center’s user advisory committee. “Over the past few years, the Center has really improved on that score very dramatically. Its materials are much more user friendly and it’s cited much more frequently in the media. Organizations like ours find it much more useful.” Within government, too, the change of approach has been noticed. “My health insurance staffers say the Center always has very well-written and easy-to-understand materials,” said Richard Price, who heads a section of the Library of Congress Congressional Research Service that fields health policy questions from members of Congress; these questions often concern a specific district or state. “They like these materials because they keep them informed about trends in health care costs across the country.”

Yet some staff members who support health-related committees said that the Center could do more to alert them about new research findings and reports. Others complained that the Center’s work was still too slow to be folded into current political debate or to be relevant at all.

“I think they do very high-quality work,” said David Nexon, staff director for health of the Senate Committee on Health, Education, Labor, and Pensions. “They could probably do a better job of publicizing what they do because it’s tough to get people’s attention up here on the Hill.”

From another perspective, a staff member for the House Energy and Commerce Committee, Patrick Morrissey, said, “We have found them less useful because although we generally get their papers, there’s not much follow-up.”

In 2000, the Center sharpened its mission statement and reinvigorated its public affairs strategy for the coming years. It set a relevancy test for research, clearly spelling out that the foremost audience is policy makers. The Center committed itself “to strategically managing and disseminating its research for maximum policy impact.” It set a goal of becoming the “leading health policy research organization

devoted to understanding developments in health care markets and communities and the effect on people's health care." It also specified that its research would concentrate on three areas: private insurance coverage and costs, access to care by the uninsured, and managed care and markets.

To further these goals, when vice president Peter Kemper, who designed the Community Tracking Study, departed in 2001, the Center brought in Len M. Nichols, a former principal research associate at the Urban Institute, who also advised the Clinton administration on health care reform. Outside observers praised his appointment as being on the money, bringing the Center cachet because he is politically astute, knowledgeable about health policy, and plain-speaking.

Nichols said he planned to identify the health policy issues that were likely to emerge over the next six, twelve, eighteen, and twenty-four months to help researchers stay relevant. He will work with Ginsburg and Richard Sorian, who replaced Ann Greiner as public affairs director in early 2002, on early design of study projects, and he will make sure that policy implications are clearly drawn from research before it's written up.

"My job is to open a window into our own research and the general health economic and policy research so policy makers can get all they can out of us," Nichols said. "Then they can go into a room somewhere and do the playing, make the final decision."

THE CENTER AND HEALTH POLICY

Five years into Health Tracking, is this major undertaking helping to produce better health policy?

Gauging the Center's influence on public policy decision making is complex. As many an organization that produces research has learned, the route it takes isn't easily traced; too many people read the information and use it in ways the authors may know nothing about. Having influence at all is tricky in a contentious policy environment of special interests and political ideologies, at a time when there is little passion for significant health policy legislation.

The Center can cite many instances when calling issues to the attention of policy makers has led to change or notice. Among them:

- After noting in a 1998 article published in the *Journal of the American Medical Association* that doctors who rely the most on managed care contracts provide less charity care, the Center was asked to present its findings to the Senate Finance Committee.
- In a 1999 *Issue Brief*, the Center showed that 20 percent of low-income people were offered health insurance coverage but didn't enroll because of the cost of their share of the premium. In

direct response, the Senate proposed bills that would offer either a tax credit or a subsidy for workers to buy insurance through an employer.

- The Center’s findings about the number of children who remain without health insurance, although they are eligible for the federally funded State Children’s Health Insurance Program, was cited by senators as they proposed spending money for outreach to families.
- Two communities—Greenville, North Carolina, and Lansing, Michigan—strengthened their health care safety net after the reports by the Center revealed serious inadequacies.

The Center has frequently helped sort fact from fiction—for example, by finding that:

- Slightly more employees had a choice of health plans in 1999 than in 1997, contrary to the prevailing thought at the time.
- Surgeries and use of in-patient hospital and emergency care were about the same for HMO patients and those covered by other plans.
- People held negative opinions about managed care at the same time that they were satisfied with their own health care, raising questions about how to understand the results of patient satisfaction surveys.

The Center’s work has appeared in more than two hundred of its own reports and journal articles, and the Website sees heavy traffic. Its publications have been praised as first-rate and its personnel as impressive. The information made available to the public has been requested ten times as much as any other Foundation data set. And in August 2002, *Modern Healthcare* listed Ginsberg among the “100 Most Powerful People in Healthcare.”

Certainly, these are auspicious signs, but do they indicate that the Center has arrived at its destination? Is it recognized as a major supplier of high-quality, nonpartisan information that contributes to better decisions about health policy, particularly in Washington? Is it influencing policy makers’ thinking?

Opinions vary, because these questions are difficult to answer. Perhaps the best yardstick for measuring the organization’s effectiveness may be how it’s regarded by the people it’s trying to reach: the media and the policy environment itself.

News coverage is important to putting the Center’s work on the nation’s radar screens. Policy makers are inundated with reports they will never get to read, and news stories focus their attention on topics that matter to the public. When Ginsburg tells the *New York Times*, the *Washington Post*, or the *Wall Street Journal* that health insurance premiums are rising 11 percent largely because of hospital-related expenses—as he said in September 2001—he is shown to be a reliable, trusted source of analysis. Not only the public takes note; so do elected officials and others who try to sway the public.

“I turn to the Center because it’s viewed as a credible source of information and nonpartisan,” said Ron Winslow, a *Wall Street Journal* reporter. “They come closest to doing the kind of work journalists do in terms of gathering information about various communities and making assessments. So I think their methods are interesting and their information is very accessible to policy makers and to journalists.”

Another Washington-based health reporter frequently relies on the Center for insight into “the economics behind the health care system mystery.” This journalist praises the Center’s output as top quality but laments that data are “not always as fresh as I’d like.”

Staff members for Senate and House committees dealing with health policy and those in the research support offices for Congress couldn’t recall instances when the Center’s work had played a significant role in a specific piece of legislation. But many said that they and others in policy channels viewed the Center as a worthwhile, important resource, particularly useful for an overview when a topic is first being considered.

The late John Eisenberg, who headed the Agency for Healthcare Research and Quality at the Department of Health and Human Services before his death in 2002, said that his office had found the Center’s studies informative; “Paul Ginsburg provides data of great value to policy makers that’s complementary and not redundant to information we’re collecting.”

The Center’s steadfast nonpartisan approach is an asset as well as a liability when it comes to impact, both staffers and advocacy groups said. On the one hand, the Center is producing sound, reliable information that no one else is—and it’s needed to understand health care change around the country. “I think of them as one of a handful of groups that are unbiased, without an agenda to push,” said one Congressional staff member. “You’d be hard-pressed to find anyone to say they’re putting on a particular spin or angle.”

On the other hand, not taking sides means that it’s harder to get press coverage, and that policy makers don’t look to you as often—and as a result, there may be fewer opportunities to be influential.

“Sometimes information that has a point of view makes it into the public policy debate, whereas information like this, which is more down the middle, doesn’t,” said another Congressional staff member. “This doesn’t mean it’s not as informative or not important to have the Center’s kind of

analysis. But when we're trying to develop a position or get quick support for a decision we've already developed, we tend to go to organizations that are more advocacy-oriented."

Staff members from a number of agencies said the Center's community survey data and market trend reports had found their way into their own reports—a sign that the Center's reach is expanding. "Our health insurance folks like these reports a great deal because they give them information no one else is providing, helping them understand very dynamic areas," said Richard Price, of the Congressional Research Service at the Library of Congress. "With this information, they're able to communicate analytically important information to members of Congress, the committee staff, and member staff."

Important trade associations increasingly issue news releases to highlight or respond to Center findings, and Center results are showing up in other organizations' own publications, which again suggests that the Center is gaining influence. "I find its products are fact-based," said Dr. Don Young, president of the Health Insurance Association of America. "The whole notion of being an early-warning system by looking at a select number of communities and doing it longitudinally is a very creative idea. Do we cite them, point to them as information on trends that are coming? The answer is yes."

Finally, being held in high esteem by other organizations suggests that the Center is finding its place on the map. "I think they're one of the few organizations that are really doing important work," said Karen Davis, president of the Commonwealth Fund. "The Center is up there with the top five or six places generating the important new information that's relevant to health policy issues."

THE FUTURE

The Center was created to track major changes in the health care system; because they never completely occurred, questions about the Center's continuing role remain. However, as the Center itself has documented, the times ahead are expected to be increasingly turbulent.

Today, the employer-sponsored health care system is at another crossroads, much like the one the nation faced ten years ago. A double-digit rise in premiums is again with us as underlying health care costs continue to swell with the advent of new technologies and the expense of prescription drugs and hospital care. The economy entered a recession in 2001, and seven million more people were uninsured. Employers, feeling the pinch, protested once more that they could not afford to cover health insurance premium increases. This time, managed care is in no shape to come to the rescue. It's not likely to resurrect any of the cost-containing tools that were once so unpopular.

All signs point to a shifting of costs to consumers. Ginsburg and others have documented the fact that consumers have already begun to pick up the tab in higher copayments for a doctor's office visit and prescription medication, and more of this will probably be seen. But if consumers continue to be forced to foot the bill for higher costs, as expected, more of them will undoubtedly find they can no longer afford their health insurance and drop it.

Given that managed care's retreat is leading to higher costs and that there is great uncertainty ahead, a number of people within and outside the Foundation say that this is not the time to back away from tracking. They argue that the Center's contributions so far have been substantial, and that its analyses will be just as vital as they were five years ago—perhaps even more so.

In the meantime, after the Center's strategic planning process, the Foundation and the Center began to cut the cost and size of Health Tracking. Families will be interviewed for the longitudinal tracking survey every three years instead of biennially, and other adjustments are being made in related studies, amounting to an estimated cost savings of 25 percent. With health system change occurring more slowly, the Center says that not much will be lost in checking with the communities on a three-year cycle—and researchers will appreciate the less hectic pace. But the site visits will still occur every other year.

"The health care system is in worse shape now," Ginsburg said. "We have just as big a problem as when we started, but we have one less strategy. We can't see more than a couple of years ahead about what direction health care might go, because sharp changes are likely to generate their own backlash. To have the infrastructure to study changes, and the baseline data to do so, is a huge advantage."

Notes

¹ Kaplan, M. and Goldberg, M. "The Media and Change in Health Systems." In *To Improve Health and Health Care 1997: The Robert Wood Johnson Foundation Anthology*. San Francisco: Jossey-Bass, 1997.

² See, for example, Durkin, B. "Taking a 'Hassle' Out of Health Care: Some Plans Cut Referral Requirement." *Newsday*, May 31, 2000.

³ Strung, B., Ginsburg, P. and Gabel, J. "Tracking Health Care Costs: Hospital Care Key Cost Driver in 2000." *Data Bulletin* (Center for the Study of Health Systems Change) no. 21, revised Sept. 2001.