AcademyHealth
25th Annual Research Meeting
Session I: 25th Anniversary Founders Panel
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Robert J. Blendon: Hi. Bob Blendon. Put simply, this is both a personal honorific thing, I think, for the group and something we hope that for start purposes, we will have some lessons learned for people who build research institutions and programs in the future.

My colleagues here came together and allowed me to describe the rationale in my own way. But basically, 25 years ago, a distinguished group from very different research backgrounds got together and believed because they have very strong commitment that science could alter health systems regardless of what the background was, a belief that research could really matter. And that they needed some sort of an association for what was seen as still a fragile field not often recognized by many universities, difficult having funding and needed some identity and came together and formed what is now AcademyHealth.

What we want to use the time together is to ask people, as we go around, some lessons learned about the building of not only the academy and the association behind it, but each one of the people here had an extraordinary [audio glitch] at research firms in building entities over the last 25 years that had a

huge impact on this field and having lessons for people that might be very useful. So, the aim of this is going to be go around and give people in formal remarks about four, five minutes apiece aimed at lessons that they would like people in the audience to take away from the experiences.

By choice, I was requested to lead, again, in four, five minutes to remind people that 24 years ago, I was asked to kick off the first annual meeting and I made a small number of points and I promised my colleagues I will do this as shortly as possible. I was asked to repeat this and the bottom line 24 years later was, I wanted to make the point that the field we are in was not going to look like biomedical research years later. It was a very different type of field.

And there were three reasons. One is the treatments that we found often were very, very controversial. Uwe Reinhardt is in another room and is telling you for the 50th time, one person's price is another person's income. So this was going to be a very controversial field. Two, the research we do benefit populations but it does not benefit millions of individuals as they see it. So as the field went on, we would be short of what are called grateful patients. And just finishing work for the American Cancer Society -- they have four million volunteers, we do not.

Thirdly, this type of research, when the findings would just take years to be implemented, a new clinical treatment can be in a hundred centers within a few months. The fact that health insurance actually benefit people's health could be 20 years, and before [indiscernible] so that led to something different. We needed an analogue and I threw out something at the time - there were so many former deans and chairs here - which we just called it a series of area studies, or urban studies, environmental studies, foreign policy studies and I just made quick points that they had a certain set of behavior about them that was worth thinking about.

One is the distracting thing that what are called area studies -- most of the research follows public policy. It actually does not lead it. You go to war in Iraq and you study the Iraqis; you enact Medicare and you study Medicare. It is just the whole history of this that the large part of research is done after Congress makes a decision.

Secondly, the actual change - and the people in this panel are incredible at this - are actually made by experts in these fields, not by research. Most decision-makers can never remember reading the research; they remember hearing the people here talk to them about it, so it is a unique characteristic.

And just the last point is that the public that supports these kinds of fields is actually not interested in the field

at all; they are interested in particular problems and they change their mind frequently. So if you are building a field, you have to build a capacity that is geared up to the fact that tomorrow's problem was not today's problem.

That is basically all we have to say and I missed one point and I will just mentioned this because it affected this association and field very much. And we did not know it then and now; that is we finished a period - and if we wanted General Larive [phonetic], Ron Brownstein was senior political writer for *LA Times* - of the most politically partisan period in one of the periods of U.S. history.

And it is a very simple point I want to make about this. During the last 20 years, the two parties could not agree on the role of government in health care. As a result of the inability to agree on that, they could not agree on the role of health services research. If you do not know what the government does, you should be able to agree easily on what the government should do with the research that is found. And actually, the almost loss of appropriations, the attacks have to do with not the quality that the research that was done but the question about in a world where parties cannot agree on what government should do on health care, what should health services researchers -- quit. That is all I have to say 24 years later and what we are going to do is honor and give a

chance for people's insights who are so critical in the development.

So the first, and I think most people are aware of this, Clif Gaus took on the first presidential role, took over developing this. We kidded this morning about talking to a meeting of 300, Clif talked to a meeting of 12. So let me turn over this. He was sort of the parent among parents of this and Clif is going to set a frame for some lessons learned and then I'm going to move it around my colleagues, and then we are going to open up for people for questions. Clif?

Clifton R. Gaus: All right, thank you. I think I will convene the board meeting now. Okay. We [cross-talking] --

Robert J. Blendon: Just one quick -- I knew he -- can we hear Clif on the back? We are okay? Can you hear him?

Clifton R. Gaus: All right?

Robert J. Blendon: Yes? Okay.

Clifton R. Gaus: Can you hear me? Okay.

What I'm going to do in about five minutes is just give you background as to why we got together and really formed the organization; what was going in those days. I had been in government for almost 10 years, mentored by Dorothy Rice of the Social Security Administration [cross talking] --

Male Voice: Speak to your mic.

Robert J. Blendon: If you speak into it.

Clifton R. Gaus: I will hold it. Is that better?

Male Voice: Move closer.

Clifton R. Gaus: I will hold it. I moved from Social Security Administration to HCFA, very successfully built a pretty large health service research program in HCFA. And at the same time, the National Center for Health Service Research was growing. And around the '80s, I left and the change of both administrations and federal budgets really brought upon the health service research committee some serious budgeting concerns. And essentially, the health service research budgets were on the table for cutting.

And I was at Georgetown University at the time and started to shop around with my friends, my colleagues, the idea of forming an organization of health services researchers, but also an organization that really dealt with the user community as well and kind of created a home for basically researchers interested in the same field. We had economists, sociologists, appraisers, researchers, et cetera, all doing work in health services but they had no home. And so the real goals at that time was build a home for health service research and let's take on some of the budgetary issues and particularly in the federal government around health service research.

There were two risk takers that I want to acknowledge in those early years, this was in the very early 1980s. One of

them was Bob Blendon. Bob stepped up to the plate when we really needed it. We had no money. We had a small meeting, at University of Pennsylvania, of research centers, all whose budgets were on the table for cutting but they all thought the idea was great. I called up Bob - Bob was Vice President of Robert Wood Johnson Foundation at the time - and I said, you know, "How about $50,000 to form this association?" Bob said, "Well, unfortunately, Dave Rogers and I can only sign a check for $25,000, how is that?" I said, "I will take it." And that literally, that RWJ, in a very nimble and quick way, put the money on the table to make it possible for us to organize.

The second risk taker was Alice Hersh. As many of you know, Alice passed away at a very young age and tragically. Right after we got the money, I needed to find somebody to do all the hard work and the ground work, and Alice had been a graduate student with Stuart and even though we had no promise of long-term salary - had maybe, at the best, six months' worth of a salary in the bank - Alice agreed to come. And actually, she was, as much as any of the board here, had it behind the actual creation of the organization and saw through the first annual meeting which I'm sure some of the other folks will talk about and how we actually pulled off a meeting with 300 people in Chicago. Alice would be very proud if she saw us all here on the stage today. This was her dream and 25 years later, I

do not think anyone could have imagined that the organization would have had as much impact as it has in the field had as much impact this one has. I hope some of the fellow prior board members here will talk about some of those impacts.

Stuart was in HEW when I started my career. He was struggling with the National Health Insurance bill at the time, the Kennedy-Mills Bill and he remembers how little data we had about the doctors who are co-insurance [sounds like]. You want to comment on that Stuart?

Stuart H. Altman: Is this working now?

Robert J. Blendon: Can we hear Stuart in the back?

Male/Female Voices: No.

Stuart H. Altman: How does it work now?

Well, looking around this group, I had the distinction of being the only one that had absolutely no background in health service research which made me uniquely qualified to follow Cliff, and the reason why is that, as Cliff pointed out, I found myself in 1971 in a fairly senior policy position in the government and realized we did not know what we were doing and turned to Cliff and to Dorothy - I see Dorothy sitting there, Dorothy Rice - and started to ask all these kind of basic questions on what we knew and what we did not know. And it led indirectly -- the RAND experiment had begun even before that

under OEO but they were just really basic understanding that we did not know.

And so two things -- first of all, it was my office that began to push at the government level the idea that we needed to really expand the base of people who worried about (a) providing independent, objective analysis; and second, we needed to develop a database. Most of the information we had, really, was pulled together from bits and pieces, and with all due respect to what came out of Social Security, it was basic data and you needed to know more.

And so when Cliff came to me after several years of having done that, he said, "We really need to get this going." He could not have found a more willing supporter of his model than me. And we were fortunate I had moved on to Brandeis at that time and we were one of the research centers of then HCFA so we had a few dollars to kick in. But the important thing was that there were tremendously complicated policy issues that were being made on the fly with absolutely no information behind it. Sometimes the world has not changed all that much. We say it all too and --

One last thing I will say because I really want to hear my colleagues as well - one of the problems we have right now is our success and that is, now, every side of every political issue requires health services research. And so to the extent

that this field can play a role, it needs to carry on the objective analysis group. And, unfortunately, all too often, segments of our communities [audio skips] and as a result, we are on every side of every issue which makes for a lot of jobs, but it does not necessarily make for good policy. So one of the things that I am the most proud of, of this organization through the years, it has stood for independent, high-quality, objective research. As we look into the future, we need to keep doing that. So thank you for --

Robert H. Brook: Let me follow the conversation. Bob, can I follow up with RAND because Stuart raised the issue of the sort of the critical role of the RAND study?

Robert J. Blendon: That is going directly to the CIA according to the [laughter].

Robert H. Brook: That is a problem of RAND I think.

I was going to make two or three comments about this. First of all, the thing that makes all the difference in the world is when institutions want to cooperate. That is still extraordinarily rare in our field. Both success and failure of this field is the willingness of people across institutional lines to cooperate. What made RAND such an exciting place to be was that UCLA was a full partner. And what made UCLA so exciting in this field was that RAND was a full partner. And that required the regents, the chancellor and everybody else to

agree. To those of you that do not know, RAND is, in essence, a teaching hospital of UCLA. I mean, it has the same status.

We tried to replicate that model because RAND now exists in a few other cities and I can only tell you there is not a single place yet in this country or a single other academic institution that is willing to actually say that that is a model that is worth doing. And I think that is a huge mistake and one of the things that we could solve. I do not know how much you want me to comment about now but you want me to use up my two minutes?

I'm going to say a couple of things. One, the last 25 years because of the people up here, we have actually been able to get all the easy work done. When we began the health insurance experiment, nobody knew how to measure health in the policy study. Now, nobody would even question whether you can measure health. There are a few psychometricians running around that want to spend another $4 billion trying to measure a little bit better, but the bottom line is we are 99 percent of the way. Nobody really knew how to apply economic modeling to health care very well. Now, again, we are at a stage where there is not much more to do with the econometrics or statistics in this field. When I began and when people began up here, nobody could measure quality of care. We can measure quality of care.

So we are leaving the new generation at this moment with all of these tools so that can be used to provide objective information to help make better policy decisions. The question, really, at the moment is: Can we change that culture of using this information? How do we want to do it?

I am a little bit fearful. I look through the 2,200 registrants for this meeting. I think I identified two that come from the for-profit sector. I am all the way on the right or my right, at least. I asked some of my clinical scholars that come into the program, "Any of you Republicans?" When was the last time I hired a Republican? I have not hired a white male in a long time that is Protestant but when do I hire a Republican, white male or anybody as a health service researcher? I'm serious. I mean, if we really are going to bring this country along, and produce subjective information, how do we make this a field that has equal participation from both the right and the left? I'm a little bit sad that we were not able -- one of the outrageous things I said - I have said a lot of them - was I wanted to billionize ARC and in its previous name -- actually people looked at me and thought I was nuts. They had a good reason to do that. We have not achieved that goal of trying to produce a billion dollars into that kind of an agency even today and that is a big mistake and a big problem.

And last, I think we are going to have to figure out, now that we have all the tools and the information, how we really are going to go about making change? I would ask this audience: Will the basic scientist make women immortal before or after we have universal health insurance? I mean, which will come first? When 40 years ago, we began the RAND Health Insurance Experiment, the president was not going to sign off on this study because he said it is going to take 15 years to get the results and by then, we will have National Health Insurance, why do we need them? Just do as Bob says - study it after it occurs. What is going to occur first now? Are we going to really have health insurance for everybody? What do we need to do? I would suggest two things. One, I think it is incumbent upon us not to just continue to talk with each other. One, we have to talk with communities and try to increase and change health services research methods to really include community-based participatory research methods.

And then lastly, I have been saying things that I might as well say them since I am now old enough that it is not -- I am not going to get another position in life, but if I could do one thing, I would bet dollars for doughnuts that we will have no health policy change by the year 2010. And by that time, all physicians in the country are to treat everybody and their staff in Congress and in the Executive Branch, whoever wins, as

if they had no insurance, that the only way we are going to actually produce a change and force Washington to do something is to actually treat the decision-makers and their families as if they had no insurance. Would that not be a fun experiment to do and I would be happy to let Bob do the public opinion poll right away [laughter].

Robert J. Blendon: Larry Lewin.

Lawrence S. Lewin: I really have respect for everybody on this panel and not least of which was Stuart [audio glitch]. But I have to disagree with Stuart in one respect and that is, he said he was the only one who had nothing to do with health services research and I probably was even further away than he was. As a management consultant involved in working with states and institutions on implementing, I was especially moved by what I heard this morning on his talk. I thought about implementation of science is very appropriate.

So why was I involved in founding this organization if I was not a health services researcher? Well, at the time I was dealing with a very difficult issue. I had a contract with the then NCHSR to run a series of meetings for state and local officials on how they could make use of health services research in making policy. And the rationale - Rob Fordham was the father of all of this - was that the way you get people to use information is to learn how to make decisions and if we

could teach them about how policy is made, maybe they will find information helpful.

And so we had these week long workshops and the biggest challenge we faced was that bridge between policy and research. And as my colleague, Jack Needleman, once said, "A policymaker asks a question; the researcher reformulates it to adapt to the data and the methodology at hand, and when he or she is done, the policymakers are often left with an unanswered question". So bridging that gap, getting policymakers and health services researchers to talk to one another was really a major challenge that we were facing at the time.

So when we sat down together to figure out what this organization should look like, one of the disputes we had - and it was a very hot dispute - was whether this should be an organization of health service researchers or of health service researchers and users. And the arguments on both sides were very strong. The compromise that we came up with was that, "Yes, we would include users and policymakers, but we would also have methodology workshops." And I'm proud to say that I was the one who first recommended, as a non-methodologist, that we had this -- it was my way of trying to win the point.

But I have to say that of the things that I have observed at these meetings, those methodology workshops have really proved to be wonderful and it has taught me a very important

lesson and that is, if you have a membership organization, you have to do more than say to people, "We are here. You should support us because what we are doing is important." You have to give something back to them. And I think that what this organization has given back to its participants, to its members, not only in methodology and understanding of what one another is doing but also to create a career field as well as a voice on the Hill, has been extraordinary. I'm very proud to have been associated and when I looked out from this stage this morning at 2,400 people, seeing that there are plenty of representatives, I have to tell you, big difference. Thank you.

Robert J. Blendon: Barbara?

Barbara J. McNeil: [Speaks away from the microphone] my assignment asked me to think about what it was like to take some of the early thoughts about the creation of this organization and to translate them into the establishment of a department in a medical school. And the idea here was that this organization was started in 1983 and a few years after that, Harvard Medical School decided that it was time for physicians to interact more directly with policymakers in terms of both research and subsequent decisions.

So I think my message from that would be the following: we have now established a department that has about 22 fulltime

faculty who sit in the same place; there are 12 others who are associated with us but do not sit in the same geographical area. And I would like to say the following. I do not think my remark should be construed as a lesson in history but potentially as a lesson in future planning because everybody around this table will soon pass on to greener pastures - red or blue, depending - and we will be replaced by people in this audience, or people elsewhere in the meeting. Or other groups of health policy researchers will be found in the country.

I want to say, therefore, a little bit about what I think the recipe is for success in building a research group that has a rich portfolio, and some of the criteria that I would give are obvious. First of all, you should hire very talented people. No question about this. And they should represent multiple disciplines - obviously economists, sociologists, statisticians, physicians -- those are pretty clear, no-brainers.

The other part of it though, I think, is the following. Such individuals should be nice. And I think that is really important because [cross-talking] -- yes, that was one of the classes from kindergarten, because -- what was the name of that book -- *Everything I Learned in Kindergarten*. That was one of the lessons because everything that -- if we are going to make any advance either locally or nationally, it is because we have

done collaborative research, bringing together our colleagues from multiple different disciplines and people are not going to want to work with us unless we have a nice collaborative way about us. So smart is important, multi-disciplinary is important, but nice is really important. And I cannot emphasize that enough.

The other thing I would say - I was talking about this at lunch today with somebody - is in establishing a group, I know that it is the habit of physicians frequently when they take new jobs to say, "I'm going to take that job only if you give me five positions, and x million dollars, and 600 more square feet per year." There is a huge laundry list and I actually think that is the wrong way to go.

I think in some sense we should be in the pay-for-performance mode in building a research enterprise, and that leaders of such groups should be given new positions, new space, new computers, new whatever, conditional upon their success. So I personally would be the first one to scrap any kind of big offer letter with 16 different lines in it that get negotiated back and forth over several months.

The other thing I would say is -- and this applies to researchers individually and in a group and in a department. I think over the next few years, we do not know which way the world is going. Bob has mentioned that, Larry, Stuart,

everybody and therefore, we have to be absolutely flexible in what we do. We have to take on any kind of project that comes our way even if it might seem a little bit tangential because we never know what leads are going to come out of that that will lead to insights in some way and then some arena in the future.

That is it.

Robert J. Blendon: Bill? The balance with two different schools is terrific.

William P. Pierskalla: Well, a couple people have mentioned how they came out of different areas. Well, I'm quite a maverick in this group, too. My background is engineering and mathematics and business. And I do not really do health services research in the context of this society; although, I was there at the beginning. As I recall the beginning and Cliff mentioned this a little bit, those of us who were running centers, and I was running the Leonard Davis Institute, we had a million dollars a year coming in from the National Center for Health Services Research under a grant, in our case, to do management-based research. The other one is from our policy base. And that was facing extinction because, as I recall, the national center budget was going like from $50 million to $25 million in one cut. And we were basically all out of that money. I mean, we would have been in business,

maybe, but we were all out of that money. And we had to do something about it and we said we have to unite because we cannot fight it individually. We have to do it collectively. And in fact, we did and we were very successful. And Alice Hersh played a monstrous role. I mean, she was just amazing how she helped shepherd that.

And so another thing, I want now to talk about Alice. I was the first treasurer of this organization [audio glitch] in -- nominally, treasurer. Alice did everything and she took care of all the money, she made sure everything happened and it was just amazing.

Now to get back to some of the comments that Bob asked about. I would like to differ to two colleagues, too, Bob Brook and Bob Blendon. We have not solved all the problems. As I recall, in the late '70s, I got involved in doing research in health-related areas. What was the biggest issue? Costs were rising at twice the rate of the CPI; we were already at 9 percent of GDP; and it was going up at this phenomenal level, and what could we do about it. Minnesota tried to a grand experiment in HMOs. Most of Minnesota was being pushed or jumped or something into HMOs; we had to cut cost.

In New Jersey, the Secretary of Health - I cannot remember her name, Joan [phonetic] somebody - looked up to Yale and Bob Fedder [phonetic] up there was talking about DRGs. He said,

"We can use DRGs to manage things better and cut costs through better management." She looked and said, "I can use it to cut my payments." And sure enough, she put DRGs in around 1982, '83 and she did cut costs, went to Maryland and then all of a sudden HCFA picked it up and went all over the country.

We do not know how to control costs. We are still in the same problem. Only now, we are talking 16 percent of GDP versus 9 percent. We have not even dented that problem although prospective payment helped. HMOs helped, although we did away with HMOs in the last few years because the better way is to retreat than to try to fight the system, controlling and rationing care because basically HMOs and managed care was rationing care in some way or another.

So we solved a lot of problems, I agree, and Bob said quality. When we were doing quality back in the early '80s, we would talk about quality and you would get to the physicians and they would say, "You cannot measure quality. We know quality, we do quality. You cannot measure that." It was a little bit like beauty. How do you measure beauty? Well, that has changed. We measured them and we do a pretty decent job and it is getting better all the time.

Finally, the other way I'm a maverick a bit is I work on management problems as distinct from policy problems. I get a great deal of satisfaction working with hospitals and physician

groups and nursing groups and so on, trying to solve the problems they have. Sometimes it has policy implications like one of our members in the audience here, Joanne Levy, and I worked on a project to try to figure out how West Virginia could have more physicians working in rural areas and because they were spending a lot of money on physicians and getting virtually no benefit out of it.

But I like to work on problems personally and one thing I noticed is, a little bit missing in our organization here is that we are not working on the kind of problems that turn me on and which are, for example -- which I'm getting involved in now -- we have a lot of vets coming back, men and women, from Iraq and Afghanistan with multiple concussions and traumatic brain injury, how can we build a system through the DoD and the VA to make sure that these people get the treatment they need over the course of their needs, which can be quite long. In fact, some of them may never ever come back to full recovery. How can we build a system that really cares for these people? That is sort of the level I work in. I'm not at the policy level but I applaud the policy level. Do not get me wrong, we have to do that or we do not see any change at the higher plane.

That is all.

Robert J. Blendon: A quick apology from the chair here, since these are long-term household words. It is Bill

Pierskalla, University of Pennsylvania, Barbara McNeil from Harvard Medical School. Again, just the apology of not making sure that we have recognized for that [sounds like].

Let's do Ed Hughes, Northwestern.

Edward F. X. Hughes: Correct [sounds like]. It is great to be here and we were asked to think about three or four things that either we had learned at building institutions that we could share [background whisper] provided -- can you hear me?

Male Voice: No.

[Cross-talking; speakers speak away from the microphone]

Edward F. X. Hughes: Thank you for your indulgence. Well, it is not just the CIA after you, too.

We were asked to either provide a prospective on lessons learned from building successful institutions or about the field itself. And what I thought I would like to do is make three points about the field itself over things out of zero over 25 years and things I hope could be observed over the next 25. But I also want to make a little kind of footnote to history. Cliff is absolutely correct in describing how this organization began. It was at the University of Pennsylvania, I was at the meeting that took place, but I want to speak for the Midwest, that some of us came from that hallowed part of the nation, with independently original ideas. We also needed

an organization. And that was what made it so exciting, that we all came - I mean, not all of us but a number of us did - with the idea something had to be done, that there really was a need in the country -- not that there was a need in the country, there was a universe of mostly then young-but-not-so-young people committed to this field.

I was asked: How did I choose to go into the field? I did not choose to go in this field. The field found me. I was in it. And there was no field. We were doing what we thought was right and I was in the same spirit of being just having my decision to become a physician. The goal was to help people. And I thought this was the way you could help the most people. And, Bob, I'll disagree in the most charitable sense that this field does benefit individuals. You do not see the individual but unequivocally the work will be done. Quality, decision-making, managed care - it benefits individuals. That is why we have been so successful and so important.

So three points that I think are worth reflecting. And what is interesting is, implicitly, one of them has been stressed already - the first one I'll make. The second one has been stated three times, which I thought was remarkable. The third one has not really been mentioned and I'll be very proud to end with that.

The first is the positiveness and Bob said how successful we have been. This field has been enormously successful. And when we started, one of the things we had to overcome in that meeting was defeatism. There were those that, "Well, we cannot accomplish." It was learned helplessness for so many years trying to do stuff without really achieving. But I kept saying among others, "We can do things." And we did it. Bill was talking about quality, what we did about managed care, Harold Luft's work, John Wennberg's work which has revolutionized how we think about geographic variations.

What is exciting now is that, let alone, let's say the national health insurance work but we are now getting more and more to help people make decisions about their own health care and I think a major frontier is essentially behavior. How do people adhere to diabetes regimens? How do we get them to be aware of those issues, that that frontier of individual health responsibility, accountability - extremely important - psychology and all the stuff will come there? And so I will also support the notion that I do not think we have solved problems necessarily but we have made enormous advances. And like many other great fields, the best years are still to come.

Point number two. This was made by Bob as also made by, I think, Stuart and that is, it is critical that this field remain empirically driven. Bob used the word "objective". I

will argue over this. I have been disappointed. I think this organization has not been empirically, [indiscernible] driven but has been more inclined to certain ideological physicians than others. And I think its future will remain strong and vibrant to the extent to which it is, again, empirically-driven, research-driven, and not trying to figure out how do we support a certain position, but what does the data show? What is the most efficient way for our society to pace our resources to provide the insurance bond that you speak of, et cetera? But we cannot be ideologically-driven. This is very important.

And coming from business school, I can speak with a certain perspective that the American business community is enormously important in our future. And by the way, they value healthy workers. That is why the large employers are not dropping out of providing health insurance. They value healthy workers. And they represent for us, whether we are aware of it or not, an enormous user community. We have been accepted there. They look to us unequivocally.

And lastly, and this point I do not think has been brought out before, but I think it is enormously important and it has been a guiding source of inspiration for me as I have matured through my career, and that is the issue of sustainability. I heard a CBO staff person speaking recently about health care costs. There was not a syllable in his presentation - however

empirically and methodologically rigorous - that somehow these dollars were related to keeping people healthy and making them better. We have achieved in this nation during the 25 years of our existence, the single most remarkable reduction of cardiovascular mortality in the history of the world.

It is amazing how many of us are alive. I think it was 25 years previously there were people on this stage who would not be here today if it were not for the advances of medicine over this period of time. There is nothing more precious than human health. I do not care what the output of society is. Steve Jobs will make an announcement tomorrow about the new generation of the iPod and the stock price of what went down in the market. Who cares -- at one level?

But yet think about how many people care about it. There is nothing more precious than human health. The notion that spending is too much in this nation is not appropriate - I will argue. Sure, we want comparative [sounds like] -- we want to spend the money on what is most effective as compared to effective research. To me there is no problem at all if we are spending 16 percent of GDP in health care, 17, 18 or 22. When we get to 85 percent, we can sit around and talk about it. But let's not be defeatist at all. We are in the most important business that this nation is in; we are doing the most precious

thing that any society can do. Let's be enormously proud of it.

Thank you very much.

Robert J. Blendon: Ronald Andersen, UCLA.

Ronald M. Andersen: All right?

Male Voice: Yes.

Ronald M. Andersen: Oh, great.

Male Voice: Just do not mumble much. Sit next to Bob.

Robert J. Blendon: This is and was a tough group. Let's be honest.

Ronald M. Andersen: I wanted to talk about the early work in National Health Survey Research and what it has contributed and how it has changed and how that perspective might value and help young researchers. There are a lot of good friends and people out in the audience. No offense, but I do not know how many really young researchers we have here.

We could be celebrating not only the 25th anniversary of the Academy, but in fact the 75th anniversary of National Health Surveys and their impact on health services and research and policy and practice. That really is kind of startling when you think about it, maybe not so much to many of us here but to a lot of young folks who could not imagine that there is anything relevant that happened in health services research 75 years ago.

I think the Academy needs to emphasize here - more so than we have - this tradition for younger researchers to learn about the achievements as well as the limitations and mistakes that were made, to help build what really I feel is a proud tradition for the future. I feel strongly about the import of that tradition as I was thrown into the middle of it as a 24-year-old, all but dissertation to direct the national survey of medical care use and expenditure in 1963. And I went to NORC to interview for this job, and Jack Feldman, who was a research director and the original methodologist of a series of foreign national surveys done by NORC and HIF for the Center for Health Administration Studies at Chicago, said to me, "Ron, this is not like studying cardiac farmers in Indiana" -- where I had spent the last three years. I suppose he was suggesting that this was a limited-number-of-people study being studied and maybe not so many people know about them or necessarily care about them. He said, "The nation will look at your results and compare them with other sources," like some of the stuff Dorothy Rice was producing at the time, "so your results need to be sound and accurate." So to try to compensate for my lack of experience, I really started running scared as a 24-year-old. I tried to immerse myself in this tradition that had gone before. And the previous work and results that had been

published, they were my bible. And some of the people who had done that work were my mentors and my confessors.

And I just want to share with you and think about a little bit of this tradition and why it might be important for more of us to know about and learn from it. We go way back to the CCMC studies done in 1928 to 1931. They interviewed 9,000 families in 17 states, the District of Columbia, and Odin Anderson talked about this being the first effort where reformers turned to the systematic collection of what then was the best they could come up with as national data to look to changes in the health care system that might benefit us all. And they used public health nurses; they interviewed six times over a 12-month period, these families, and went from 1928 to 1931. They tried to verify conditions; they talked to physicians about diagnosis; they tried to talk about the cost but the physicians did not want to talk about cost. And they were the first to document.

This is still going to sound familiar: 10 percent of the families were responsible for 41 percent of the cost. This was the first time we had evidence of that kind of information. The result was a recommended prepayment community-wide planning and - what was the third thing I want - oh, group practice. None of that came into being but there was a format that generated a lot of interest in and consideration. On the other

hand, there was no systematic sampling and they did not interview African-Americans because they did not think the methodology was appropriate to gather information from that population group.

So then we go on to '35, '36, we have the public health service doing a national health survey of 700,000 households. They thought there was safety in numbers. That was in urban areas. And they did 37,000 surveys in three rural states to get information from rural areas, and they did include African-Americans. And they felt with those numbers, they could make systematic estimates about various kinds of diagnoses, the various kinds of diseases in the country, to use for planning purposes. Now, they did not again do systematic sampling but they got the idea that more degrees of freedom were better than less degrees of freedom.

And nothing much happened except we still have plans on the board for national health insurance as we have had most of the time since the '30s -- and then the four national surveys funded by the drug industry. Can you imagine the first two at the Health Information Foundation with NORC doing the work? This is the drug industry involved. And Odin Anderson was the research director of those first two. They got down to about 3,000 households and they did the first national probabilistic sampling frame that was done for any studies. And it came out

of the health care field. It was just a marvelous beginning, and not only produced data to compare with data from other kinds or sources such as the Bureau of Health Statistics.

It was tremendously politically charged. They showed disparities in insurance coverage and expenditures and use by income. By that time, 40 percent of the low-income had insurance compared to 60 percent as a country as a whole. And again, 10 percent of the people were responsible for 41 percent of the cost.

Robert J. Blendon: I have to say thank you, Ron, just because I promised in blood when we started here that we would [cross-talking] --

Ronald M. Andersen: Let me just summarize the sale [sounds like] of --

Robert J. Blendon: I see Dorothy Rice looking at me, "Yes, we are going to summarize."

Ronald M. Andersen: -- that we went through a series of national studies and involvement. NCHS started to do the National Health Survey in '59, AHRQ with an emphasis on utilization and extent and health care. AHRQ started to do the national expenditure surveys. We worked with [indiscernible]. RWJ came on board, emphasized the access to care. Blendon and his colleagues supported the study. National studies have

access to care, which it provided tremendous information I think, to use.

Granted we have a lot of problems, but we have made a lot of progress. And I think much of this data has contributed. And I think it is all related to what happened in the past and I feel quite passionately that many of our younger folks do not know about this tradition. And sometimes they are reinventing things that frankly go back as far as the CCMC studies. And so I think that is something that we really need the people and traditions in the studies that have been done that can help them and support them to do even more now.

Robert J. Blendon: Gordon DeFriese, North Carolina.

Gordon H. DeFriese: Thank you very much. I do not know if everybody can hear me, but I really feel quite honored to be among this group of people here. As you could tell, they are much older than I am, so they have all been very helpful to me and my career. When we met in that conference room out at the Rand Corporation in 1983, I felt very honored to be there. I had already been directing a center for about 10 years - actually a little more than 10 years - and we were one of the first five centers funded by the old NCHSR. But then we all had to face the music when they de-funded these centers and then that was when they said, "Gordon, have we got a job for

you. You can become the director of one of these unfunded centers."

Anyway, I was in my second round of funding from whatever they were called then, NCHSR, and we had met out there in Los Angeles and some of these people I had not actually met at that time. But all of them I had heard of, of course, then they all became friends. I will say that there was one thing that was very distinctive about that group and that is, that there were very few real doctors in this group, people who really took care of patients. Bob, of course, is a distinguished physician who was vice-chair of the Department of Medicine in UCLA, Jerry Attrition [phonetic] as well, really well-trained in medicine at Hopkins and so forth, was the first clinical scholar and actually set the model in place that the RWJ then began to implement in the early '70s. Ed had been trained in surgery and really was not practicing at that point. He was at the Kellogg School at Northwestern. And Barbara is a radiologist and has always been clinically active as far as I know, and of course, she is one of the youngest in this group as well. But basically, we were not -- and Phil Lee [phonetic] was there but you know, he had not been practicing for quite a while although he had already been in at least one administration, in a fairly prominent place, and of course, he has had several lives. And he has been in several of these. But basically, we did not

have very many clinicians. And we learned fairly quickly that if we were really going to do anything in this area, we really needed to speak to clinical medicine and dentistry and nursing, et cetera.

But starting with medicine, to begin with, the Robert Wood Johnson Foundation deserves a tremendous amount of credit for perceiving the value of a training program like Commonwealth had run before, that would enable us to bring into this field a cadre of young clinicians who really knew about and cared about these non-biological aspects of health and medical care. And you know, RWJ did try it later with both nursing and then, at our place, we ran a program in dentistry where we trained them at both Harvard and UCLA, but we coordinated it out of Carolina. Basically, they backed out of nursing and dentistry eventually and downscaled the clinical scholarship for physicians, but if you look at that program, it really made the whole field of general internal medicine and general pediatrics a good part of community-based psychiatry. If you look at the VA program - and I see Shirley sitting out here - we have clinicians all through the VA system who have been trained in this area of research who now know how to do it. And the mental health services research community would not be there were it not for a lot of these kinds of people.

So in terms of implementation and getting ideas out there, what we did was essentially we saw a lot of this whole field come alive around the basic notions of health services research. People like Mitch who were running these centers at Kaiser actually were creating an environment within which non-clinicians and clinicians could work together to study these issues, so in North Carolina we tried to replicate that. We tried to make it really attractive for clinical people to want to work in an environment like this with weird people like sociologists and anthropologists and economists and other people, lots of lawyers and other kinds of people getting involved.

And so these centers, as they blossomed around the country, became very interdisciplinary kinds of places where the questions were more important than the discipline you brought to study them. And so we began to put these things together in a way that I think was really quite exciting.

And also I think, going back to this morning's presentation by our keynote speaker, our chairperson, if we think about what she had to say to us about implementation, we have been working on these issues for many years. And out of these centers, have come not only a number of programmatic strategies for dealing with health [audio glitch] but programs like ones that we also ran in our own state and now, in several

other states where health policy units were created that were outside the university, that were in between the university and health policymakers. And I think that health services research has really been like the basic launching pad for so many things in the field.

Gordon H. DeFriese: And of course, the name of the journal was a negotiated thing that Carl White forced the American Hospital Association to name the journal *Health Services Research* instead of the *Journal of Hospital Studies*. And I think that Carl White has become a really good friend. And many years later was the professor for people sitting on this panel including Bob Blendon. But Carl White could sense years ahead what terms were really going to be important and how we should frame this thing so that we could take advantage of it and now we all benefit from it. But I feel particularly blessed by being around such a group of people all these years and I'm also very honored to be a part of this discussion today.

Robert J. Blendon: Mitch Greenlick -- we will say Kaiser Health [indiscernible] but also the Oregon legislature.

Merwyn R. Greenlick: Thank you, Bob. When I first entered politics, I was told by one of my mentors, an ex-governor, ex-cabinet member --

Robert J. Blendon: Can you speak up, Mitch?

Merwyn R. Greenlick: Yes, I can speak up; I can probably get to the back of the room without the mic. Is the mic on?

Robert J. Blendon: Yes. It should be, yes.

Merwyn R. Greenlick: I was told by my mentor that you are always supposed to say, "I want to make three points," it does not matter how many points you are going to make. And sometimes I lose count but I want to make three points.

First point, Larry Lewin and I were on two sides of -- the Association of Health Service Research was going to be an association for the producers of research or for the users of health services research. And I was trained - in the early '60s - at the same time that Professor Andersen was trained to be health service researcher. We were really in the very first generation of people trained specifically in the field of health services research, Ron at Purdue and me at Michigan.

Our mentors had come into the field in a very different way, through sociology as both, I think, your mentor and mine did or economics or administration or some other way. And when people came out of those other professions, they had an intellectual community to belong to. It was the intellectual community of sociology where you had the big arguments or your structure functionalists or whatever, and the economists or your econometrician or an institutional economist, but they had a community to belong to.

What I always missed was a sense of community as a worker in the field of health services research. And why I was so interested in starting this organization was to build that sense of community among health services researchers. And I clearly recognized we need to be talking about both the user and the producer but I was focusing on that in a sort of a selfish way because it was sort of lonely out in Portland. I mean, I had 300 people working for me but in terms of the field, it was lonely and I really wanted to build this intellectual community that we have built over the last years. And you look out in that audience and that community is really there and it was very exciting. And I'm really happy to see that it is not an issue so much anymore. We do have a community and it is a healthy community and it is a vibrant community and it is very important.

Now I want to make the first point, or is it the second point? In the mid-80's, the early '80s, it came to me that what was the Center for Health Services Research or the later whatever it was called, was de-funding, there was a lot of problems and Blendon was everything it could to keep the money in there. But it struck me at that point that those of us that want to do health services research needed to translate it in a different way in order to survive the field. And based on the Willie Sutton principle which I'm sure you all know, you ask a

bank robber why he robbed banks and he said that was where the money was, it struck me that we needed to find a way to translate health services research in a way that could be funded in the NIH where they lost as much money in the cracks as there, you know, in the sofa.

And NIH as the health services research organization, whatever it was called, had to fund. And I started translating the research questions I had so that -- it related [sounds like] to cancer or heart disease or whatever. And it was a little tricky; the name of my center at that time was the Health Services Research Center so whatever I did, it always went to the Health Services Research study sections where they got approved but where there was no money. I mean, they wore funding at the top 0.05 percent at that point. So I had to change the name of the institution to the Center for Health Research.

Now, why I am making this point and I got very successful in translating health services research questions to be funded by the Heart Institute or the Cancer Institute or the Aging Institute or NIDA, for example, which I have been a part of over time. The reason I raise that is I look at the program for tomorrow morning and there is a program of NIH talking about its health services research agenda. I think that is an amazing change and I really think the folks here and the

organization had something to do with that change. And it is obvious that you cannot translate the bench research from NIH into the clinical area and out into the field without the kind of work we have all done. So that was an extraordinary sign - to see that.

Third, I want to make my second point which is -- I want to leave one in case I need to make a --

Male Voice: Can I make one?

Merwyn R. Greenlick: Yes, but not mine [indiscernible due to laughter]. You have to reserve some time.

Robert J. Blendon: I'm counting.

Merwyn R. Greenlick: The third point is sometimes, this field is very personal and the notion that we do not have grateful patients. But what we do have, particularly those of us that have worked in the demonstration area, I mean, I started the first home health agency and a managed care program in 1968. I started what was probably the first pre-paid Medicaid program that I managed. It was actually the second; Sam Shapiro started the first with the Old Age Assistance Program in New York. But those of us that have literally done projects that have affected the lives of thousands feel that sense. They do not know that what we had to do with it but we know what we had to do with it and that is very satisfying as we look back. And it became particularly pointed to me as an

individual, and I did this in the context of now being in the legislature but at a personal level. I understood how important some of the work we have done.

We have talked about care in the last year of life, and we talked about this 10 percent that uses [sounds like] 60 percent. I found myself in the position personally. I was diagnosed with lymphoma in the end of the 2005 session, a kind of nasty version of it and I found myself in what my oncologist thought was my last year of life. But it turns out it was not my last year of life because of the chemotherapy agents that were developed by research, that are still being developed by research, and the ability of my health care provider to pour out about $150,000 into my care over what would have been my last year of life and it turned out not to be. And I am now two-and-a-half years past that and I began to understand what this last year of life means in a very different way.

I had a similar experience and I want to end with this because Bob Brook made a point that I think is the important one. I had a great two years. I also fell, knocked the pads off both my knees and I was laying in the road waiting for an ambulance to come, knowing I could not straighten my legs, I was figuring it was probably something wrong. And started asking myself, where was I going to ask the ambulance driver to take me? And I figured out where I was and then I said, "Well,

I'm doing that because I have health insurance." What if I did not have health insurance? And here I was, laying in the street, turned out it was 30 minutes but you know, things got a little screwed up in the system and playing what would have happened if I did not have health insurance.

Now, I told the story gaveling in my first meeting as Chair of the Health Care Committee of the Oregon House of Representatives. And then redoubled my interest in how we have to continue to move as CCNC did. And I have been in that same generation you are. I have read all three, two of those reports because they were sitting in the library in Michigan -- how all of our lives are affected as individuals by the work we do and it seems to me that is the satisfaction that we all derive.

The health care system is not something that happens to somebody else, and the improvement our research has to the health care system is not just something, it is helping those people and those other people; it is helping all of us. And our involvement in health services research becomes very personal when we understand those kinds of consequences. So I have been very happy to share the past quarter of a century with my colleagues here and with the whole community we now have of health service researchers because the field has emerged in that way.

Robert J. Blendon: Thank you. It is a very special, personal moment in that people here can ask some extraordinary people their backgrounds, questions, you may never have them exactly assembled together this way so we are hoping to take any questions from the community here for all or any head [sounds like] specifically. I believe we have mics somewhere in the audience. Is that belief based on statistical evidence?

Marsha R. Gold: I'm not sure I have this question formulated well enough for this panel but I wanted to pick up on Ron's comment about data --

Robert J. Blendon: Just so we know who you are, just tell everybody --

Marsha R. Gold: Oh, I'm sorry. Marsha Gold, Mathematica Policy Research, and I did hear a lot of those things when I was in training and found them useful and do wonder why people do not always know them today.

But anyway, I want to pick up on Ron's comment that the survey data gave us so much capacity and one of the challenges that I see looking at organizational change - massive changes - that right now, there is no data; that is the equivalent of that. And we end up in a situation where we often think, well, how do we get the right treatment to the right patient through the right doctor? But it happens through a system, it happens to an organization, it happens to a culture with a set of

values. Taking off where Bob Brook said that, you know, we have done a lot, we have done some of the basic measurement, where do people go next? I would be interested in people's thoughts on how we do address some of the tougher questions of health services research that involve not just individual access and its effects but how we get our institutions to move in ways that do the things that our other research shows are good for people?

Robert J. Blendon: [Indiscernible] do you want to respond? Larry?

Lawrence S. Lewin: I think it raises an interesting question that goes to the name of this organization. As you look at what persuades people to change policy, a lot of it has to do with a lack of conviction about how people will respond, whether it is physicians responding to payment systems or individuals responding to incentives for taking care of themselves. And part of the problem is I think we tend to think of health services research as having to do with the care delivery system. So I'm not suggesting that the organization change its name, but I think the concept of focusing on health and the health of the community and all that affects that particularly from the standpoint of how individuals respond to incentives, particularly to care for themselves, is an important area that I think is going to get a lot of attention

in the future. And I'm not sure that health services researchers think of that as being central to the field.

Robert J. Blendon: Bob, again?

Robert Brook: I'm going to take this a little differently. I could not agree more with the comments that Mitch made about that. We are people with health insurance that talk about and work on trying to help other people get it or people that know how to get high-quality of care because we think we can beat the system and then do research to help other people that do not have the same connections that we have. So I'm going to take a crack at this a little differently.

I think we have to have a new contract with the American people. You just cannot have a right for health insurance; you have to have a responsibility. And we have to reverse this notion, this nonsense of privacy and security of data so that everyone who gets health care - and we all get subsidized health care - have to allow their data to be used in a way that will advance medicine whether at the organizational level, doing a survey, just like you have to participate in the census, just like you have to take a driver's test to drive. I think we have to change and hopefully, in the next political window, this rights-and-responsibility issue if we are going to make any progress whatsoever.

The second thing is I think we are shooting ourselves in the foot. We have moved funding - it has been true in every administration but more in this administration - so that we allow them to tell us that we cannot actually produce information that is funded by taxpayers in the public domain. I think we have a serious problem and I hope going forward, the young people in this group will coalesce this organization and demand that information work done under government contracts and grants actually has to be made public as opposed to be hidden. And I think we are partly responsible for this because we are all in this kind of a survival mode, still, of "If we do not get it and then do it, then we do not eat and if we do not eat, then our families does not like us very much." So I really believe that we are going to have to do some serious changes beyond just take advantage of the new political window, [audio glitch] window that is going to open up, see if we can change health policy.

Robert J. Blendon: Other questions?

Male Voice: Question, Bob, on your left.

Robert J. Blendon: Yes, we need an introduction to the [indiscernible].

Carolyn M. Clancy: You wanted me to stand here so we could move the camera from the panel to the questioner I think to portray interaction. First I wanted to say --

Male Voice: You want to repeat that?

Carolyn M. Clancy: Yes. I'm Carolyn Clancy from ARC. I wanted to say thanks to all of you for doing this. I think that for all the challenges we have ahead, I bet that back in Chicago in the early meetings, you did not really envision a meeting this huge with more and more young people coming in every year, so thank you very much for that.

I also had a comment/question. So my suggestion actually is I'm hoping that before you leave this meeting that you might all get together and put in slips of paper into a time capsule - I'm quite serious - that we could look at five, 10, for how many years out. And one issue in particular I would love to see you address, which I do not think is subject for a glib answer is: What does this future look like? You are all got into this, thinking that this was academic institutions and think-tank-like organizations doing this stuff and bringing the information to policymakers in a world where there is more and more data available from health care delivery even from various aspects directly affected by policy.

I think a real question, taking Maggie's [phonetic] challenge about implementation very seriously this morning is she would be focused as much on building that kind of capacity. Or do we simply end up funding the people who thought to do that? So there is no right or wrong answer, but I look forward

to opening the time capsule from when this distinguished group got together and made predictions about where we ought to be in the future.

Thank you.

Merwyn R. Greenlick: Bob, can I take a shot at that?

Robert J. Blendon: Sure, absolutely.

Merwyn R. Greenlick: I think Carolyn has really put a finger on an important point and from a legislator's perspective. We are very clearly going to be pushing the institutions in our state into making state-wide data available from all the health care that is delivered. We have a small state, we have 3.5 million or so people but there is no question, the collaboration among the health care delivery system is going to be forced from the purchaser's perspective and the state is the most important purchaser that we have. We are going to demand that. We have created quality institutes with the help of ARC and the Commonwealth and RWJ, and there is no way that we are going to continue to put the kind of money into the delivery system we put from the legislative perspective without being able to do what Bob demands; without being able to make sure we had the data that really allows us to assess what is going on, and to force the kind of quality improvement in the health care system that we as researchers

know can happen if we have the data and the will to make it happen.

And I think the future is that across the states, we are going to be developing the political will to make this kind of information available in ways that it has never been available in the past. Twenty-five years from now, it will look extraordinarily different. We will be able to access the data in the health care system and we will be able to change the way care is delivered in the community because we will have the information and the political will to do that.

Clifton Gaus: Let me add something to this also. Bob Brook and Bob Blendon will remember that our mentor always asked, "What was the denominator?" And today, I do not know that we made a lot more progress in this country. And in building those databases with very good denominators, Kaiser Permanente is clearly the leader in that regard. There are, in terms of a cross-section of our population, many health plans that have continuous data - inpatient, outpatient - mined from claims and able to do lots of things with it but is not shared with anybody. And the Medicare program stands out still, 40 years later, as the one program that has a denominator and that has made that data available to the research community and you think about what we have done with that, and the power of that.

And so, Carolyn, I do not know who we are speaking to about this but if we could do one major thing, you know, to push forward the knowledge of what we are doing, would be to get a truly national -- even if it is not a hundred, 200, 300 million people -- a national representative sample of total utilization and a denominator to it. We all dreamed 30 years ago the National Health Insurance would do that. But certainly that has not happened and whatever plan we enact in the future probably will not have that single source of data. So the research community does need to address that and put all the force we can into forcing the owners of the data out there to both share it better and get better data.

Robert J. Blendon: A group that I work with just had a very interesting meeting on electronic medical records and the potential that electronic medical records, that however slowly we are evolving to the point that they will be available in fairly large amounts and the capacity of electronic medical records to provide that kind of information. I mean, it will not be perfect information. We were debating the gold standard of clinical trials on the one side, observational data that comes out of claims on the other. But the electronic medical records are much better than the observational stuff that comes out of claims. While it will not be perfect and it will

violate certain statistical properties, it is going to be a very powerful force.

And one of the things that I think Barbara brought up and I'll speak for Barbara because she is so shy, is she said in many respects, we lack the methodology and the technique, that we are still using techniques that were developed maybe in the 1920s. Barbara gave us credit; I think she went as far as the 1970s. And I think if anything, the research community needs to develop a new set of techniques to make use of these data. And we cannot keep on relying on old techniques. But that data will become available.

Allen Dobson: Al Dobson, Dobson/DaVanzo. Bob, this is primarily to you. You know as much as anybody [indiscernible-speaks away from the microphone].

Robert J. Blendon: I cannot hear you. I do not know very much about mics, though.

Allen Dobson: It is on. How is that? Is that on now?

Al Dobson, Dobson/DaVanzo, and a question primarily to Bob Blendon. You know as much as anybody in the country about how people think about health care. We have all these folks at this conference that know all these technical things, but it seems like there has to be a bridge between the folks out there and the people at this conference with their technical stuff before we can move [background noise] the basic question, all

the rest of our basic questions. How do we cover all those uninsured? Obviously, we have not done it the past 20 years Do you see any way at all we can make a bridge such that folks get it as we get it that is the right thing to do?

Robert J. Blendon: The bottom line is yes.

Allen Dobson: Thank you, Bob.

Robert J. Blendon: So I would not be with my colleagues for 25 years if I did not believe that was possible. I surely would not have stayed with this type of research I do if I did not have some face to do this. I want to slightly change just the answers since you asked me versus my colleagues.

Research -- we do not have a lot of is understanding the basis that people who actually make decisions about these issues, use on how they make decisions. And for instance, in other fields, take foreign policy. We actually know more about how Congress thinks about choices in foreign policy than we do about our area. We know about what we know, we know the facts that we actually do not know how legislators and Congress weigh evidence. And the importance, after 25 years, is we produce information for decision-makers who we often do not understand. And so if you ask me what I would do here, is have a somewhat better understanding -- so there is a whole field of research in foreign policy. When is it important to Congress, how they find it, what the constituents have to have, when the polls

matter on foreign policy -- all these were done by academics. They are not done.

And you can have some understanding about the nth power of what types of information and events. But I feel we do not know this. We know something about clinicians, use that information, but actually not decisions in the other -- and if you are asking me what I would add to what we know is a better understanding of who the user is and what are the constraints. At breakfast this morning, Mitch talked about he had to learn a whole new life in the legislature. It was a different world even though he was saying the issues are the same. Well, that is measurable and researchable to have a better understanding of who uses and for decisions and under what circumstances.

In terms of the American public, our colleague-cum-foreteller [sounds like] people know very, very well, always quotes Winston Churchill, that they will try everything. And ultimately, after they have tried everything they will actually find the right thing to do. So I have confidence we will actually get there but I [indiscernible] committee where -- let me just take a couple more questions.

Deborah K. Walker: Hi, Debbie Walker. I'm not sure if I'm a health services researcher. I started in as child development, I mean up [sounds like] to associates now, with the Public Health Department. And I'm very curious to ask you

guys a question about how you thought of the health services research related to public health at the beginning and today. I served as the immediate past president of the American Public Health Association, 135 years old. If we are going to produce health, only 10 percent of health comes from what the medical care system is doing. Some of you alluded to this; that is why I'm raising this question. So I would like to say, necessary but sufficient. You could have the best universal, quality, evidence-based health care system and we still will not produce population health. And that is going to take - I'm a behavioral scientist -- that is going to take multiple components, multiple sectors like we know with tobacco.

So here is my question. You all have really done a great job at health services research. How do we now -- or do you see the future embracing more of a public health social determinants model of health where we really can come together in a bigger way to do that? Because I always have looked at this organization and I love these meetings as well as I like all the other meetings as being really focused on one part of that question. So I see that as the challenge, moving forward, to be able to integrate all that you have done and much more of that framework community-participatory, multiple components, and all the social determinants that produce health because it is not just medical care.

Male Voice: You know, I think, obviously from my comments that I completely agree. And I thought a lot about this. In fact, I'm working on a paper now on how HHS might be reorganized to get a focus more on the health of Americans rather than the health care delivery system. And one of the major changes and focus that will be necessary here is that we have traditionally thought of ARC, and now increasingly NIH, as being an area of lobbying and concern. But CDC is a very, very big part of this picture as well. And CDC to some extent is part of the problem because while they give money out to the states, they do not do a lot of research on -- now, RWJ is doing a lot now in terms of trying to invest in the public health system by setting standards for performance and all the rest. I think the years ahead are going to see more of that partially through the RWJ efforts and partially because what we have learned is that efforts of preparedness have shown us that it is not just the yearly preparedness for the public health system is lacking, it is the entire system. And there are organizations working on this. But I think that it is important that we bring CDC into the picture here as well as the leadership of HHS to broaden the focus to include mental health as well as public health.

Merwyn R. Greenlick: Bob, I would like to make a point of that, if I might. The interesting issue relates to what Bob

just said a moment ago. The critical public health issues are mostly political issues rather than scientific issues. The two most bruising challenges I had in the last session as chair of the House Health Care Committee was a fight over fluoridation of the water system and a fight over an increase in tobacco tax which I was interested in, not because it funded health care but because it would reduce adolescent smoking. In both cases, the argument had nothing to do with reality. The fluoridation issue, we were attacked by the right and the left. The Sierra Club using the worst kind of junk science that you can imagine attacked it, as well as the radical right attacking it because we were interfering with the life of their children or something. And the tobacco company brought - in little Oregon, in a market of 3.5 million people - $13 million in the campaign, again, full of lies, and spent $13 million defeating an $0.85-a-pack cigarette tax. So when we start getting into the public health issues, we have a whole different set of decisions that we have to be involved in and most of us are not very well prepared as researchers to deal with those issues. So we need to be involved with dealing with them as public advocates, I think.

Female Voice: [Indiscernible - speaks away from the microphone].

Male Voice: Yes.

Robert J. Blendon: Yes, I think your point is well taken. I think the single-most important thing we can do as a nation to improve the health of the nation, to improve the urban public school system and the cultural problems associated with people not going to school and staying in school. And I think that a future for health service research frontier is making that link because that is where the social investment has to go.

Gordon H. DeFriese: I'm Gordon. I think that this is an excellent question that you have raised. I think that if we think back to where we were 25 years ago when this organization started and we were meeting to try to figure out what to do and why, I think that most of us were pretty desperate in those days for funding of any kind to keep this field going. We even told the main national organization and federal agency greatly threatened by and therefore, our future. And so we were not really so concerned about a lot of the issues so much as we were how to keep the field alive.

Now, I think when I came to this meeting and I got here, I got my program this morning and started looking through it, I was astounded how many sessions are on the topic of obesity. And it is not just on health care delivery but on the problem of obesity in our society. Three of us here on a panel in Israel will be meeting in a couple of weeks and one of the

things that is going on there is "Healthy Israel 2020" is being planned very much like healthy people. And one of the things they think we have done here is figure out how to figure out the cost and effectiveness of public health interventions which we have not done very well. But they want to learn from us but where we have to share with them if what we did in medicine and dentistry and so forth, but what they want to know is how do you do this in tobacco cessation and other kinds of things. So I think that there should be or does need this kind of attention. But if we look at this program for this meeting, it is a very different program than we ever imagined 25 years ago. And I think in that regard, it does address some of the kinds of issues I think you raised which are very important.

William Pierskalla: I would just like to second that. I really do believe that the transformation is there and the young people are there and we have not kept up to them. I never would believe that one of my clinical scholars in the year 2008 would be addressing the question: How do you provide clean, cool drinking water to schoolchildren in urban Los Angeles, not in an underdeveloped country. There are no standards, there is no ability to get it, there is no fountain that works, and if you culture the fountain, the bottom line is that it looks like a toilet bowl. So the question is how do

you do this? We are already there, I think. I think how to encourage that is very important.

I think there are couple of points that have been missing in this conversation, though. And I think part of that is our arrogance. We all do come from academic backgrounds, a large part of us in some science way. And we believe in methods and tools. And how do you get somebody, an average American, to understand what produces health and what is the health care system if there is not a single lecture, course or textbook that anyone as a schoolchild reads about it? As far as I know, this subject is not even covered.

Mitch went into the legislature. He knew something - at least I think he knew something - about both health and health services research and health systems, but by God, in the state of California there is not one single physician in the legislature. And I do not know how many of those people, if you actually did 101 of anything, understand even the basics about how the delivery of health care systems works or the production of health, and so one of my questions is to really think about doing that last [sounds like].

We are doing an experiment. We are taking PhD-RAND statisticians and we are going on into the community and trying to figure out how they can relate to them and teach them what a number is. How do they use numbers in making a case? I mean,

the gulf between our researches and where people are is so great now over methods that we really have to disrupt this mechanism and try to get communication to be far better than what it currently is.

Robert J. Blendon: I want to honor my commitment to my colleagues that we would break at this time. I want to thank everybody. It is not normally the panel; it is for their contributions over 25 years. As someone who gave that first [indiscernible] address, I can tell you that I never envisioned a field with this size, scale or importance. Those of you at universities know this has become a major centerpiece of research policy from undergraduates to every professional school. It is extraordinarily due to many people in this audience and the many people in this panel for you, for them, and I agree with my colleagues, the lives we have actually helped. I thank very much for people who participated.

[Applause]