

# News

## DIVISION

UNIVERSITY OF MINNESOTA  
School of Public Health

## Finance and Incentives in the U.K. National Health Service: Some Emerging Lessons

Seventh Annual Minnesota Health Services Research Conference Keynote Address

University of York professor Peter Smith discusses key challenges to U.K. health policy. His research highlights the differences and surprising similarities of the U.K. and U.S. health care systems and suggests how researchers can best influence policy.

Peter Smith's work has greatly influenced policy in the United Kingdom. His research has led to the development of a national capitation formula used in the U.K. health care system. The work of his team at the University of York has been highly influential in the development of the performance measurement and reporting initiatives currently being implemented in the U.K. National Health Service. "In my work, I'm concerned with bridging the chasm between research and policy," he says.



Peter Smith is a professor at the University of York, where he leads a research team in the Centre for Health Economics. He also advises national and international agencies, including WHO and the World Bank.

and pharmaceuticals. The structure of the NHS is broadly popular and has remained relatively unchanged. Less than twelve percent of the population chooses to be privately insured.

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### Overview of U.K. Health Care

The U.K. National Health Service (NHS) provides universal coverage, which is mainly free and funded by national taxation. Budget holders are geographically defined primary care trusts (similar to U.S. style HMOs) that have charge of populations within their boundaries. General practitioners often act as gatekeepers, controlling access to specialists

# From the Division Head

**A**s I write these lines, the President has just issued an ultimatum to Saddam Hussein. Hopefully, by the time Division News goes to press, the conflict will be over. We are also living with concerns about budget cuts, affecting both the University of Minnesota and the health care issues that many of us study and care deeply about. Minnesota Governor Tim Pawlenty has announced significant cuts to many areas of state spending, including the University.

As yet, we do not have a clear picture of the impact of these cuts on the Division of Health Services Research and Policy (HSRP). We do have a firm commitment from the administration and School of Public Health Dean Mark Becker that cuts will not affect commitment to our academic programs.

On the health front, state budget shortfalls appear to threaten safety net health programs, with threats to the access and quality of care for many Minnesotans. Given the war and the economic goals of President Bush, it does not appear that relief will come from the federal government either. The good news is that Congress finally passed a budget for fiscal year 2003, giving many of our

funding sources clarity about their spending authority for this year. We hope the federal government continues its support of health services research, which can assist in improving the quality of care and the delivery of care in this country.

Despite the grim budget news, HSRP has some good news to report. Applications for all three of our degree programs are up substantially over last year, and the quality of the applicant pool is quite high. Our revamped M.S. program is meeting the needs of both the students and the sponsors. Page 3 highlights the activities of two of our M.S. student interns. We hope to expand the program in the coming years to meet growing demand.

The Seventh Annual Minnesota Health Services Research Conference, held on March 4, was a great success, with substantial attendance and great interest in the presentations. The health services research community in Minnesota is very much alive and well.

One of the benefits of age and experience is the ability to weather the downs as well as the ups in the economy, and to see some of the challenges facing us at the University as an opportunity for improvement.

All of us in HSRP will be working with our colleagues in the School of Public Health, the Academic Health Center, and the University to continue to offer exceptional educational programs and to engage in cutting-edge research. We appreciate the help and support of our many alumni and friends as we undertake these challenging tasks. ■



—Susan Bartlett Foote, J.D., M.A.



## Training Program Connects Students to Top Researchers

HSRP's M.S. program prepares students for dynamic careers by offering them the opportunity to work in top health care organizations and state agencies.

Playing a significant role in the newly revamped M.S. curriculum is the Health Services Research Training Program in which students work at health care organizations and state agencies. In addition to working with top Twin Cities researchers and analysts, students earn a salary plus fringe benefits. They also qualify to have half of their in-state tuition paid.

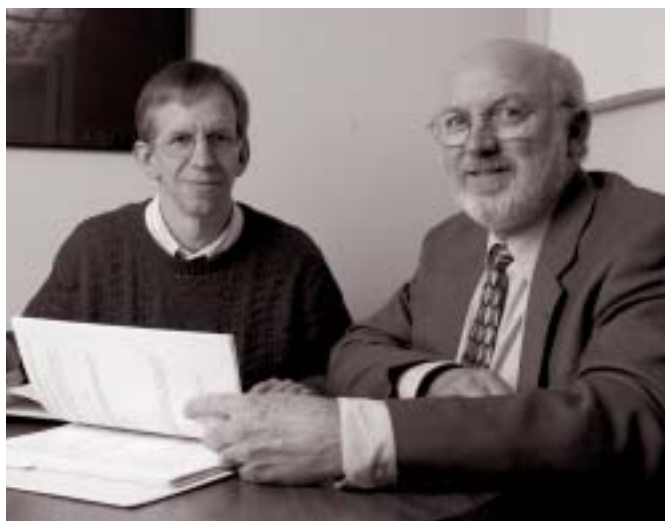
Here are profiles of two of the seven 2002-2003 training program participants.

### Park Nicollet Institute

Kirk Allison is working in the Health Research Center at the Park Nicollet Institute, a self-governing subsidiary of Park Nicollet Health Services.

His current projects include developing a database that tracks the progress and research compliance of more than 100 studies. For background he attends meetings of the Protocol Review Committee, which reviews the technical merits of research proposals; the Research Committee, which addresses general research issues; and three Institutional Review Boards, which address the protection of human subjects in research.

Allison, whose Ph.D. in Germanic Studies concerned literature, medicine and ethics, says his work at the Park Nicollet Institute allows him to combine his interests in ethics and quanti-



Kirk Allison and David Knutson

tative analysis. "Issues of ethics such as informed consent and compliance greatly interest me," he says.

"Kirk brings a level of knowledge that enhances the scholarship of our projects," says David Knutson, director of health systems studies. "His role here has evolved. He's working as a senior investigator on developing a unique database. It takes a quality researcher to do that."

### Hepatitis C Resource Center, Minneapolis VA Medical Center

Working as a research assistant for HSRP professor Judith Garrard led Veena Choudary to the Health Services Research Training Program. She and Garrard are serving on an evaluation team for the Hepatitis C Resource Center at the Minneapolis VA Medical Center.

Choudary, who is also a doctoral student in pharmacy at the U of M, is helping to evaluate materials for hepatitis C providers across the national VA network.

"Working on evaluating outcomes and survey design ties directly to what I'm learning in the classroom," says Choudary. "What's most exciting is seeing how this work can directly influence public health policy."

"Veena is very insightful and has contributed greatly to improving clinical systems for patients with hepatitis C," says center director Samuel Ho, who is also an associate professor of medicine at the U of M. "We appreciate working with someone so creative and motivated." ■

Judith Garrard, Samuel Ho, and Veena Choudary



## Faculty Brief Minnesota State Legislators on Health Policy

On January 24, HSRP, along with the National Institute of Health Policy (NIHP), sponsored a health care policy briefing for members of the Minnesota State Legislature.

The non-partisan, private briefing offered a neutral forum for legislators to put health care issues in their proper context and to consider policy strategies for Minnesota.

Sen. David Durenberger, chair and CEO of the NIHP, offered a framework for discussion. Professors Susan Bartlett Foote, HSRP division head, and Lynn Blewett, gave an overview of the U.S. health care system. HSRP professors Bryan Dowd, Robert Kane, and Rosalie Kane also presented, as well as administrators from the Minnesota Department of Finance, Minnesota Department of Health, and University of Minnesota Academic Health Center.

“With a major portion of the state deficit attributed to rising health care costs, health care is sure to be a top agenda item for the legislature this year,” says Foote. “I’m pleased that we can offer our expertise to legislators as they approach the challenges of health policy development.” ■



Above left: HSRP professors Susan Bartlett Foote and Lynn Blewett with Daniel McLaughlin, NIHP executive director, and Sen. David Durenberger, NIHP chair and CEO. Above right: HSRP professor Bryan Dowd presents “Private Health Insurance and Public Policy.”



Left: HSRP professors Rosalie Kane and Robert Kane give an overview of long-term care in Minnesota.

## Students Invited to ‘Impress the President’

HSRP students Rachel Halpern and Lisa Griffin Vincent were invited to participate in “Impress the President: Public Engagement and Research Initiatives - A Student Expo,” an event showcasing exceptional students at the University of Minnesota. The February 26 event was attended by University of Minnesota President Robert Bruininks, as well as the University community, state legislators, and the general public.

Halpern presented “Product Differentiation in the Medicare+Choice Program: Beneficiary Choice at the Product Level, 1999-2000” in a poster session. Vincent participated in a roundtable discussion with President Bruininks. ■



Ph.D. student Lisa Griffin Vincent addresses University of Minnesota President Robert Bruininks during a public roundtable discussion of research trends and innovations. She was one of 20 University students chosen to participate in the discussion.

## Robert Veninga Becomes Director of Executive Program in Public Health Practice

HSRP professor Robert Veninga has been appointed as director of the Executive Program in Public Health Practice.

Last year, the School of Public Health established the program in response to the needs of health care and human services professionals with advanced degrees who are interested in expanding their knowledge in public health.

“Public health issues—bioterrorism, foodborne illness, vaccinations, environmental health, occupational health, the epidemiology of heart disease, AIDS and obesity—are at the forefront of the nation’s consciousness and impact the practice of health care daily,” says Veninga. “There is no better time to study public health and apply learning to the practice of health care.”

The Executive Program in Public Health Practice is designed for working professionals. Many courses can be taken online and others can be taken in a concentrated three-week Public Health Institute offered every spring.

The program’s flexibility allows students to continue working in their current positions while earning the credits necessary for a Master’s Degree in Public Health (MPH). The curriculum is tailored to individual academic priorities: every student has a focus area and a faculty advisor with expertise in that particular discipline.

“This program will have a great impact on addressing the shortage of public health professionals,” Veninga says. “It offers key training for physicians, veterinarians and others with advanced degrees, as well as for professionals in the human services arena who want to understand the exciting developments in public health.”

Veninga will be responsible for recruiting and advising executive students. He will collaborate with curriculum advisors throughout the School of Public Health and will develop relationships in the community to foster student field experiences.

Veninga has been a central figure in providing leadership training for the



School of Public Health and has published four books and more than 90 articles on occupational stress, organizational change, and career renewal. He was the first recipient of the Leonard M. Schuman Excellence in Teaching Award and is a member of the University of Minnesota’s Teachers Hall of Fame.

*For more information on the Executive Program in Public Health Practice, contact Robert Veninga at 612-625-7459 or venin001@umn.edu. ■*

## HSRP Participates in National Cover the Uninsured Week

HSRP professor Lynn Blewett and HSRP student Sarah Verville participated in one of hundreds of events across the United States during Cover the Uninsured Week. The March 11 event, “Ethics vs. Economics” featured a discussion of health, policy, and academic professionals. The discussion compared the moral imperative health professionals share to provide care to all people with the troubles of an economically flawed system.

Co-chaired by former Presidents Gerald Ford and Jimmy Carter, Cover the Uninsured Week is an unprecedented campaign to raise awareness of the the 41 million Americans who lack health insurance. ■



“Ethics vs. Economics” panelists (from left) Macaran Baird, professor, Family Practice and Community Health, University of Minnesota; Sarah Verville, HSRP student and part-time faculty member in the School of Dentistry, University of Minnesota; Jeff Spartz, administrator, Hennepin County Medical Center; Jeffrey Kahn (moderator), director of the Center for Bioethics and professor in the Department of Medicine, University of Minnesota Medical School; HSRP professor Lynn Blewett; and Jeevan Paul, community physician, Model Cities Health Center.

Under Tony Blair's administration, health care has become a top political priority. Policy makers have committed to large increases in health care expenditures, with the goal of hitting the European average by 2005. But concern that the extra money isn't making a difference persists. "Our problem in the United Kingdom," explains Smith, "is not containing expenditures but deciding on how best to increase expenditures."

Smith has identified three key U.K. policy issues that suggest how critical it is for policy to recognize the importance of good research: health disparities and capitation payments; primary care incentives and gatekeeping; and performance measurement and reporting.

### **Health Disparities and Capitation Payments**

Risk adjustment, which has existed in the U.K. health care system since 1976, does not address the problem of 'unmet need' or associated health disparities. "Despite more than 25 years of capitation-based funding, there remain large health disparities in infant mortality, disability rates, and life expectancy," says Smith. These disparities fall around criteria such as social class, sex, ethnicity, lifestyle, and genetic factors.

In response to these disparities, the U.K. has recently adopted a new risk adjustment criterion that, Smith notes, has shifted the emphasis from reducing access inequalities to reducing outcome inequalities. How much greater the funding gap should be is up for debate. But an interim solution attaches a capitation payment to each year of life lost under the age of 75 for certain avoidable causes. "At less than

one percent of the overall health care budget, this is certainly a small amount," says Smith. "But the amount is set to increase to one billion pounds, with the purpose of targeting low life expectancy."

**"Our problem in the United Kingdom is not containing expenditures but deciding on how to best increase expenditures."**

When considering health disparities, policy makers must ask a critical question: How much health of the overall population are people prepared to sacrifice in order to reduce health disparities? For Smith, this is where research should help shape policy.

Smith's team developed a study in which ordinary citizens were asked to trade off total health gains against reductions in health disparities. These citizens were told that the rich live five years longer than the poor (78 as opposed to 73), and they must choose either to give two extra life years to both rich and poor or give zero to the rich and four years to the poor. If they chose the latter they were asked to say how much less than four years they would be prepared to give to the poor.

The median respondent would trade off total health gains to get just six months improvement in life expectancy for the poor. For the rich, the median respondent would need a two-year life expectancy improvement to trade off total health gains. Similar responses were obtained when defining the groups as "healthiest" and "unhealthiest."

"These findings indicate considerable willingness to target deprived populations," says Smith. "But there is great variation in preferences among the population we surveyed." Regardless of how much a population is willing to target health disparities, he says two key challenges remain: identifying effective interventions to reduce disparities, and designing incentives so that adjusted capitation payments are spent appropriately on the interventions.

### **Primary Care Capitation and Gatekeeping**

In the United Kingdom, primary care plays a key role in promoting quality and containing expenses. General practitioners, numbered at roughly 45,000, are independent contractors with the NHS. The general practitioner contract is a mix of capitation, deprivation payments, and quality incentives. Last month, a new contract was announced. Developed in negotiation between government and providers, it puts an emphasis on clinical quality, with 50 percent of income determined by quality incentives.

From 1991 to 1998, the government gave general practitioners the option of becoming fundholders. In the fundholding system, general practitioners received budgets from the NHS to purchase routine elective surgery and prescriptions. By 1997, 50 percent of all general practitioners had chosen to become fundholders. In 1999, fundholding was abolished.

The specific timeframe for fundholding creates what Smith calls a "natural experiment" in which fundholding incentives can be studied to determine if they were effective in capitation and

gatekeeping. He notes that fundholding incentives were often relatively generous, that surpluses could be spent on services for patients, including capital investments, and that 'overspends' were met by the health care authority. "This is a very gentle form of fundholding," he says.

Smith's team compared fundholder and non-fundholder admission rates for emergency and non-emergency services and found that the fundholding system reduced non-emergency referral rates by about five percent. Smith explains: "Even with very modest incentives, voluntary gatekeeper fundholding secured reductions in referrals, with earlier fundholders securing larger reductions than later fundholders." He also notes that, in addition to decreased waiting periods, fundholding resulted in distinct quality advantages. In short, Smith's findings suggest that policy makers may have abolished an effective initiative.

### Performance Measurement and Reporting

Currently engaging both U.S. and U.K. policy makers is performance measurement and reporting of health care. In the U.K. acute hospitals have been ranked according to key indicators, most of which address the hospital system's biggest quality related problem: patient waiting periods. Each hospital is awarded zero to three stars, based on the points given to each indicator. "This is a politically based rating system, not a scientific one," explains Smith. "But it's legitimate because this system is based on policy."

The performance rating system, although it doesn't have what Smith says are the most appropriate indicators, has brought undeniable improve-

ments to U.K. hospitals in the aspects that are measured. The consistent media coverage of these ratings has influenced the worst hospitals to make changes. "CEOs of the worst rated hospitals who didn't bring up their ratings in six months have been terminated or have left their position," he says.

Smith has led a more scientific approach to performance by developing a set of indicators and then examining how much performance is attributable to health care organizations in terms of region, district, or small area. Smith's team developed the study along 14 performance indicators in four main areas: health status, clinical quality, efficiency, and access to health care.

**"We have an enormous amount to gain from sharing international work."**

"We found large variations in the extent to which performances can be attributed to health care organizations," says Smith. In the health status category, mortality is an indicator that is not attributable to health care organizations. At the other end of the spectrum, waiting times, an indicator in the access category, are highly attributable to organization. Smith says managerial incentives should recognize this variability, and decision makers should recognize that small area organizations (populations less than 10,000) have more influence on performance than regional or district organizations.

Smith says this performance analysis has made great progress in measuring what had been elusive aspects of

health care. "Now we need to understand what's causing these variations," he says. "We also need a greater understanding of the properties of performance measures. Then we can design incentives in light of these properties."

### Conclusion

An overarching challenge to health services research, says Smith, is the "hyperactive" nature of policy makers. They often do not take the time to evaluate initiatives, as with the fundholding case. Although they are poor at commissioning and nurturing research, Smith says policy makers do have a great hunger for evidence, and they respond to high quality research, even if it has uncomfortable implications.

"The goal is evidence-based policy," he says, explaining that researchers need to anticipate policy priorities and understand better how to influence the policy process. "In this regard, we have an enormous amount to gain from sharing international work."

*A PowerPoint presentation of Peter Smith's keynote address is available for download at [www.hsr.umn.edu](http://www.hsr.umn.edu). ■*

### MINNESOTA HEALTH SERVICES RESEARCH CONFERENCE

Now in its seventh year, the Minnesota Health Services Research Conference brings together Minnesota's health services research community for a day of scholarly presentations and discussions. The goal is to establish a dialog among all those doing health services research in Minnesota.

This year's conference, held in Minneapolis on March 4, was coordinated by HSRP and 13 sponsoring organizations.

# Twenty-Five Years of Cost-Utility Analysis

## What Have We Learned?

The Health Services Research Seminar Series hosts national and international experts who discuss their work to promote dialogue on issues surrounding health services policy and research.

Recently, Harvard professor Peter Neumann discussed his study of 530 original cost-utility analyses. His findings suggest that we're often not researching the right topics, which may help explain why cost-effective analysis is overlooked by decision makers.

Cost-utility analysis is a type of cost-effective analysis in which health effects are measured in terms of quality-adjusted life-years (QALYs) gained. These analyses have become increasingly popular in the last twenty years, but at the same time policy makers have questioned their usefulness and credibility.

To understand this paradox Harvard researcher Peter Neumann developed and analyzed a database of 530 published cost-utility analyses (CUAs). The database was constructed through an extensive search for original English language CUAs using databases such as MEDLINE, HealthSTAR, and CancerLit for the years 1976-2001.

Once investigators identified articles using medical subject headings or keywords—such as “QALY,” “quality-adjusted,” or “cost-utility analysis”—two trained readers independently audited each article, abstracted its methods, and determined how well it met recommended protocols for reporting and discussing findings. They also recorded a subjective overall quality score for each article on a scale from one (low) to seven (high).

“The database shows that both the frequency and quality of CUAs have increased over the last 25 years,” says Neumann. While CUAs from 1976 to 1989 averaged from one to four per year, studies since 1990 have steadily increased from 15 studies per year to 90 studies in 2000.

“Are the methods of CUAs improving?” asks Neumann. “Yes, year by year, researchers are increasingly following recommended reporting protocols.” His team also found that the quality of analyses was higher in general clinical journals and in journals that publish a larger number of CUAs.

The database shows which interventions can save society money or give good value for money. Topping the list of cost-saving interventions are certain immunizations, as well as seat belt use, motorcycle helmet use, and voluntary exercise in 35-year-old men. Cost-effective interventions, which don't save money but give good value for money, include restricting cigarette



Peter J. Neumann, Sc.D. is an associate professor of policy and decision sciences in the Department of Health Policy and Management, Harvard School of Public Health. He is deputy director of the Program on the Economic Evaluation of Medical Technology there.

sales to minors, providing anti-depressants to patients with major clinical depression, and treating hypertension for older adults.

Less cost-effective interventions include dialysis versus no dialysis in seriously ill hospitalized patients with renal failure, statin in men ages 45-74 with no prior history, and screening and treatment for HIV in low-risk populations.



“It is also important,” Neumann stresses, “to know whether we are studying the right interventions, focusing on the right diseases, and asking the right questions.”

To shed light on this issue researchers broke down the CUA database by primary disease category and compared it with diseases with the highest burden in the U.S. (measured in disability-adjusted life years, DALYs, according to the 2002 World Health Report and the leading causes of death). The discrepancies in rankings among the lists are notable.

Carrying the highest burden are depression and bipolar disorder, injuries, substance abuse disorders, and Alzheimer’s disease. In the CUA registry, these conditions collectively make up only six percent of the CUAs. Conversely, some conditions—such as cerebrovascular disease, diabetes, and breast cancer—carry mid to low burden but make up a disproportionately high percentage of CUAs.

Looking at the leading causes of death shows similar trends. Heart disease, the leading cause of death (measured by the 2002 World Health Report) makes up 6.2 percent of the CUA registry. Bigger gaps occur with the third to sixth leading causes of death—lung cancer, injuries, chronic obstructive pulmonary disease, and Alzheimer’s disease—which collectively make up less than five percent of CUAs.

Ranking CUAs by type of intervention shows that pharmaceuticals make up 40 percent of the registry, surgicals 16 percent, and screening 12

percent. At the other end of the spectrum, health education makes up 7 percent and immunizations 4 percent. “Medicine may outrank public health in CUAs because cost-effectiveness analyses are often reimbursement driven,” says Neumann. “If you want your drug to be reimbursed you must fund a study on it.”

“Our findings suggest that we’re not studying the right things,” he explains. “Our findings also suggest that we could be getting a lot more health for the money we’re spending. So why aren’t we using cost-effectiveness analysis?”

**“The future success of cost-effective analysis hinges not only on researchers but on policy makers.”**

Neumann says decision makers overlook CUAs not just because researchers aren’t studying the right things but because they resist the information. He cites mistrust of methods and motives as two reasons: “CUA methodologies have improved but they still vary and as we’ve seen, the studies aren’t always relevant.” In addition studies funded by drug companies aren’t always regarded as credible.

What’s at the heart of CUA resistance, Neumann says, however, is not a technical failure but a political failure: the fear of explicit rationing. “When discussing CUAs, how you say it matters,” he explains. “Policy makers must try to communicate the message that

these analyses are not equated with rationing but with getting good value for money. In addition, CUAs must not be used too rigidly, and they cannot be effective until system incentives are successfully implemented.”

He suggests that policy makers must understand some key realities. CUAs, when used correctly, do not save money. Correct implementation of these studies often shows underuse, which results in corrective, higher health care spending. If CUAs are to succeed, he says, “they cannot be sold to politicians as a cost saver.”

“These analyses, at best, have had a troubled history,” says Neumann. “The future success of cost-effective analysis hinges not only on researchers but on policy makers and how well they apply these studies in the political arena.”

*More information about this research, including the CUA database, can be found at <http://www.hsph.harvard.edu/cearegistry>. Funding for this research was provided by the Agency for Healthcare Research and Quality. ■*

**HEALTH SERVICES RESEARCH SEMINAR SERIES**

**Rural Hospital Linkages to Long-term Care and Rehospitalization Rates**  
Friday, April 11, 1:00-2:30pm  
Moos Tower, room 2-520

**Mary L. Fennell, Ph.D.**, professor of sociology and community health and dean of faculty, Brown University

*Seminars are co-sponsored with the Center for the Study of Healthcare Management, Carlson School of Management, University of Minnesota.*

*See page 12 for more upcoming events.*



## Faculty and Staff

■ **Timothy Beebe**, SHADAC senior research associate, in January presented on the Alabama Health Care Insurance and Access Survey in Alabama. The University of Minnesota is conducting the survey under the Alabama State Planning Grant, funded by the U.S. Health Resources and Service Administration. In February he and **Michael Davern**, SHADAC research associate, presented “Evaluating Methods of Standard Error Estimation for Use with the Current Population Survey’s Public Use Data” at the Hawaii Coverage For All technical workshop in Hawaii.

■ **Lynn Blewett**, assistant professor, in March discussed Gov. Pawlenty’s proposed cuts to MinnesotaCare and other state-funded insurance programs for an article that appeared in the Star Tribune. In March she presented “An Overview of the U.S. Health Care System” for public health professionals visiting from Belarus. The visit is part of a business internship program sponsored by CON-NECT/U.S.-Russia.

■ **Michael Davern**, SHADAC research associate, in February presented “An Overview of Small Area Estimation at the CDC’s Public Health Assessment: Current Issues and Future Directions” at a conference sponsored by the Centers for Disease Control and Prevention. In March he chaired the 4th Upper Midwest Conference on Demographics for Policy Analysts in Minneapolis.

■ **Roger Feldman**, professor, in January presented “A Family Decision-Making Model of Health Insurance Choices” at the American Economic Association annual meeting in Washington, D.C. He also chaired a session, “The Balanced Budget Act of 1997 and Medicare Health Plans.”

■ **Susan Bartlett Foote**, associate professor and division head, in January presented on medical technology innovation at the conference, Accelerating Quality Improvement in Health Care: Strategies to Speed Diffusion of Evidence-based Innovations, sponsored by the National Institute for Health Care Management Foundation. In March she appeared as a guest on Minnesota Public Radio’s Midday show to discuss the President’s Medicare reform and prescription drug proposal.

■ **Ira Moscovice**, professor, was recently appointed to be a member of the Health Services Research Study Section for the Agency for Healthcare Research and Quality.

■ The **State Health Access Data Assistance Center (SHADAC)** in March hosted a conference call with 66 participants from 24 states, along with officials from Families USA, the Lewin Group, and the Robert Wood Johnson Foundation. The conference call allowed state analysts to ask questions of Families USA and the Lewin Group about “Going Without Health Insurance: Nearly One in Three Non-Elderly Americans,” a study they published for Cover the Uninsured Week. In March SHADAC sponsored “Current Population Survey Workshop on Small Area Estimates of Health Insurance.” The workshop, held in Washington, D.C., drew 56 participants from 17 states and 11 federal agencies and national organizations.

■ **Robert Town**, assistant professor, in January was a discussant in a panel on modeling health plan choice at the American Economic Association annual meeting in Washington, D.C.

## Students

■ **Veena Choudary**, M.S. student, in March was one of six out of 100 nominations to receive the 2003 President’s Student Leadership and Service Award from the University of Minnesota.

■ **Rada Dagher**, **Hassan Ghomrawri**, **Kyoungeae Jung**, and **Lixin Zhang**, Ph.D. students, participated in HSRP’s annual program in Washington, D.C. Students in the program (facilitated in conjunction with the National Institute of Health Policy at the University of St. Thomas) met with members of Congress, agency heads, lobbyists, and journalists. **Susan Bartlett Foote** served as faculty leader.

■ **Rachel Halpern**, Ph.D. student, presented “Product Differentiation in the Medicare+Choice Program: Beneficiary Choice at the Product Level, 1999-2000” at the American Economic Association annual meeting in Washington, D.C.

■ **Sheila Moroney**, M.P.H. student, in January appeared as a guest on Minnesota Public Radio’s Midday show to discuss the impact of rising health care costs.

■ **Lisa Griffin Vincent**, Ph.D. student, in January defended her dissertation, “A Study of Adherence to HIV Antiretroviral Therapies and the Economic Impact in a Managed Care Organization.”

■ **Trisha Wood** and **Stephanie Hauge**, M.P.H. students, have been recently accepted to participate in the Medical Education Cooperation with Cuba (MEDICC) public health program. The program, which will take place in Cuba from June 15 to July 27, will educate participants about Cuban health care and public health systems.

For more notable activities, see [Division Highlights on pages 4-5](#).

## HSRP at the Seventh Annual Minnesota Health Services Research Conference • March 4, 2003

- **Timothy Beebe** (staff) presented “Measuring the Adequacy of Insurance Coverage.”
- **Lynn Blewett** (faculty) convened the symposium “Latino Health Care” and presented “Use of Limited English Proficiency on Access and Health Status Indicators.”
- **Susan Bartlett Foote** (faculty) convened the symposium “Evaluation of Medicare’s Local Medical Review Policies (LMRP): Process and Outcomes” and presented “History and Current Policy Debates.”

- **Suying Li** (student) presented “Mortality and Cost Association with Cardiovascular Disease in the Minnesota Elderly Medicare Population.”
- **Todd Rockwood** (faculty) convened the symposium “Designing and Fielding Research to Understand Health Disparities in a Community: The SHAPE II Study” and presented “Issues Associated with Fielding a Large Complex Survey.”

- **Sitinee Sheffert and Rachel Halpern** (students) presented “Carrier and Fiscal Intermediary Medical Directory Survey.”
- **Beth Virnig** (faculty) presented “Use of Surname Matching to Identify Elderly Hispanic Males in Combined Medicare/VA Files” and “Do Rural Beneficiaries Have Limited Access to the Medicare Hospice Benefit?”
- **Douglas Wholey** (faculty) presented “LMRP Database and Analysis.”

## Publications

Andes, S., L.M. Metzger, **J. Kralewski**, & D. Gans. (2002). **Measuring Efficiency of Physician Practices Using Data Envelopment Analysis**. *Managed Care*, pp. 48-56.

**Blewett, L.A.**, S.A. Smaida, C. Fuentes, & E. Ulrich Zuehlke. (2003). **Health Care Needs of the Growing Latino Population in Rural America: Focus Group Findings in One Midwestern State**. *The Journal of Rural Health* 19(1):33-41.

Christianson, J., & **R. Feldman**. (2002). **Evolution in the Buyers Health Care Action Group Purchasing Initiative**. *Health Affairs* 21(1):76-88.

Christianson, J.B., **D.R. Wholey**, L. Warrick, & P. Henning. (2003). **How Are Health Plans Supporting Physician Practice? The Physician Perspective**. *Health Affairs* 22(1):181-189.

Flynn, K.E., M.A. Smith,\* & M.K. Davis.\*\* (2002). **From Physician to Consumer: The Effectiveness of Strategies to Control Health Care Utilization**. *Medical Care Research and Review* 59:455-481.

Harrison, P.A., **Beebe, T.J.**, Park, E., & Rancone, J. (2003). **The Adolescent Health Review: A Test of a Brief Computerized Screening Instrument in School-Based Clinics**. *Journal of School Health* 73:15-20.

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## Grants

PI: Timothy Beebe  
**Montana HRSA State Planning Grant**  
Montana Department of Public Health and Human Services  
7/1/02 - 6/30/03

PI: Kathleen Thiede Call  
**Disparities in Minnesota’s Health Care Programs**  
Stratis Health (Prime: Minnesota Department of Human Services.)  
1/6/03 - 10/1/03

PI: Michael E. Davern  
**Consultation of Sampling for the Minnesota Adult Tobacco Survey**  
Blue Cross and Blue Shield of Minnesota  
1/1/03 - 12/31/03

PI: Principal Investigator

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## Mission Statement

The mission of the University of Minnesota's Division of Health Services Research and Policy is to stimulate, coordinate, and conduct high-quality research focused on the organization, financing, and effectiveness of health services, and to provide a broad range of training programs for those interested in these issues.

Our purpose is to provide research-based information and educational programs that will enhance the provision of cost-effective health services to improve the quality of life.

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Upcoming  
Events

## HEALTH SERVICES RESEARCH SEMINAR SERIES

### Rural Hospital Linkages to Long-term Care and Rehospitalization Rates

Friday, April 11, 1:00-2:30pm • Moos Tower, room 2-520, University of Minnesota

Mary L. Fennell, Ph.D., professor of sociology and community health and dean of faculty, Brown University

*Free and open to the public. For more information, contact Kris Stouffer at 612-624-4460 or stouffer@umn.edu.*

## RESDAC MEDICARE AND MEDICAID WORKSHOPS

The Research Data Assistance Center (ResDAC) will present workshops on Medicare and Medicaid data to help researchers become aware of the strengths and limitations of CMS databases and how claims-based studies might explore important health care issues.

### CMS 101, Introduction to the Use of Medicare Data • May 14-16

University of Minnesota  
Taught by Marshall McBean, M.D., M.Sc., and Beth Virnig, Ph.D., M.P.H.

### CMS 102: Conducting Research with Medicaid Claims Data • June 2-4

University of Minnesota  
Taught by George Rust, M.D., M.P.H., and Patrick Minor, M.S.P.H., National Center for Primary Care, Morehouse School of Medicine.

*For more information or to register, contact ResDAC at 1-888-9RESDAC (1-888-973-7322) or resdac@umn.edu.*

## CENTER ON AGING SUMMER INSTITUTE

### Caring for Chronic Illness: Can It Be Done?

Thursday, June 5, 7:45am-4:30pm • Earle Brown Heritage Center, Brooklyn Center, MN

**Keynote Speaker:** Edward H. Wagner, M.D., M.P.H., senior investigator and director, MacColl Institute for Healthcare Innovation, Center for Health Studies, Group Health Cooperative of Puget Sound.

*For more information or to register, contact the Center on Aging at 612-624-3904 or coa@umn.edu.*

## CLINICAL OUTCOMES RESEARCH CENTER SUMMER INSTITUTE

### Conducting Health Outcomes Research

August 2-9 • Radisson Hotel Metrodome, Minneapolis

*For more information or to register, contact the Clinical Outcomes Research Center at 612-624-1185 or corc@umn.edu.*

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