At the National Health Policy Conference (NHPC), AcademyHealth and *Health Affairs* bring together federal and state policymakers, researchers, industry executives, and clinical decision makers for a comprehensive analysis of the year ahead in health policy. With 750 participants, the 2005 NHPC captured the perspectives of Bush administration officials, members of Congress, state legislators, and business leaders in the wake of the 2004 presidential election.

One panel featured this year took a much broader look at the health policy horizon. Titled “The Future of Entitlements: When Push Comes to Shove,” and moderated by Jack Meyer, Ph.D., of the Economic and Social Research Institute, the session was designed to get policy experts and researchers thinking about the future of Medicare and Medicaid, particularly the way they are financed. Although many Americans take such programs for granted, expected future trends in federal and state expenditures for these programs over the next three decades may require restructuring them substantially.

**Economic Realities Fuel Reform**

A critical part of the safety net for the elderly and disabled, Medicare has grown to provide health care to nearly every American over age 65 and more than six million who are living with permanent disabilities. However, the Medicare program’s financing was not designed to support the number of beneficiaries that will be enrolled over the next 20 years as the Baby Boom generation ages. And, as people live longer, the need for chronic and long-term care services, as well as prescription drugs, are prompting a re-examination of the benefit package that Medicare provides. As Medicare rolls expand from the current 41 million to approximately 76 million by 2030, and with the addition of prescription drug coverage for the elderly, pressures to restrain increases in Medicare spending are mounting.

Vulnerable to the political ups and downs of state budget crises, Medicaid is experiencing its own challenges. States are under constant pressure to balance their budgets. In tough economic times, the reliance on Medicaid is at its highest. Kansas Governor Kathleen Sebelius (D) described Medicaid as a double-edged sword. “It helps the states provide health insurance to 50 million people,” she said, “but it continues to frustrate us with seemingly

Continued on page 3
letter from leadership

At AcademyHealth’s December Board meeting David Blumenthal completed his term as chair of the Board and mine began. I am very pleased to have the opportunity to serve as AcademyHealth’s Board chair during this fifth anniversary year.

The Board will focus on several critical activities in 2005. Paramount to AcademyHealth are activities that advance the health services research base and facilitate the use of research findings in policy and practice. Our 2004 experiment with topic-specific Interest Groups has proved to be remarkably successful, and we will continue their development this year.

We also will continue to actively disseminate the new Ethical Guidelines for Managing Conflicts of Interest in Health Services Research. Furthermore, with the establishment of comparative effectiveness research under the Medicare Modernization Act and the reauthorization of AHRQ scheduled for later this year, the Board is reviewing options and recommendations developed by a special, joint AcademyHealth-Coalition for Health Services Research Committee on the placement, coordination, and funding of health services research within the federal government.

AcademyHealth also will launch a Council of Sponsors of Health Services Research in 2005, which will comprise governmental agency and foundation leaders who support the field of health services research. The purpose of the Council is to advise us on the development of a strategic plan for the field, much like the “roadmap” for medical research completed by NIH in 2003.

AcademyHealth and Health Affairs just hosted the fifth National Health Policy Conference in February, attended by approximately 750 health policy professionals and researchers. This conference complements the Annual Research Meeting, and we are very pleased that so many participants look forward to this event as a way to learn about the critical health issues facing the nation in the year ahead. For the second year in a row, we also offered participants two minicourses titled “Health Policy Tools & Techniques,” which focused this year on risk adjustment and on understanding federal cost estimates. And for the first time, we launched a one-day conference on health and foreign policy. With more than 180 registrants this first year, we expect the Health in Foreign Policy Forum to grow over time and to substantially expand the topics of meetings offered to our members.

With a successful National Health Policy Conference behind us, we are looking ahead to the Annual Research Meeting (ARM) in Boston, June 26–28. This is only the second time that Boston has hosted the ARM, and judging from the number of abstracts we have received (1,400...the largest ever), we expect an excellent turnout.

We appreciate your support, and I look forward to a productive year as your Board chair.

Sara Rosenbaum, J.D.
George Washington University

What do you read?

We want your feedback on AcademyHealth Reports. Do you read it from cover to cover? Do you glance at selected articles? Do you always check the Moving On and Moving Up column? So that we can continue to meet your changing needs, we invite you to participate in a short reader’s survey. Please go to www.academyhealth.org/2005readersurvey to participate. The online survey should take less than 10 minutes to complete.
unstoppable cost increases.” Indeed, in 2004, Medicaid surpassed elementary and secondary education as the largest component of total state spending (21.9 percent). With Medicaid such a critical component of the safety net, states and other proponents of the program have expressed concern over proposals to cap federal expenditures or transform it from an entitlement into a block grant program for states.

Former CBO Directors Outline Changes Needed to Maintain Programs
In setting the context for the future of Medicare and Medicaid, Dr. Meyer noted that “entitlements were well-intentioned and well-designed for the era they grew up in,” but their architects couldn’t foresee the substantial increase in life expectancy, nor the advances in technology that will accompany the mapping of the human genome, stem cell and organ transplants, and the fruits of pharmaceutical and biotechnology research. “With the current trends in health expenditures for the elderly, there is no way the system as we know it can be sustained for the next 30 years,” said Meyer.

Asked to give the “big picture” about the federal budget within which the entitlement programs operate, Alice M. Rivlin, Ph.D., founding director of the Congressional Budget Office (CBO), said that “unless current policies change, deficits will continue to grow over the next decade, and the only options available are to spend less or tax more.” In the near term, “this dismal outlook isn’t due to high federal spending...rather, it’s the result of falling revenues that have dropped below historic averages and are likely to stay there.”

Dr. Rivlin added that 10-year budget predictions “give a deceptively positive view” because the budget outlook will worsen dramatically as the Baby Boomers begin to retire, longevity increases further, and medical costs continue to rise rapidly. Three programs focused on the elderly (Social Security, Medicare, and Medicaid) are projected to increase from approximately 9 percent of gross domestic product (GDP) in 2010, to 14 percent in 2020, and to 17.7 percent in 2030. Dr. Rivlin added that these predictions are based on an optimistic view of future medical cost increases. “We should take these figures seriously,” she concluded, “as the demographics are compelling.”

“With the current trends in health expenditures for the elderly, there is no way the system as we know it can be sustained for the next 30 years.”

— Jack Meyer, Economic and Social Research Institute

Rudolph Penner, Ph.D., who followed Rivlin as director of CBO, said that it is important to remember that we have not financed the entitlement programs by raising taxes, since “taxes as a share of our economy have remained remarkably constant in the past 50 years.” Rather, Dr. Penner continued, “The most important source of financing of entitlements has come from the secular decline in defense spending, which was 10 percent of GDP just after the Korean War compared with only 4 percent of GDP now, even with the war in Iraq.”

However, Dr. Penner noted that we’re coming to the end of using defense savings to support the entitlements and, going forward, we could be looking at tax increases in the neighborhood of 33–50 percent to support the entitlements at the current level of benefits. This situation has been exacerbated, Penner noted, with passage of the Medicare prescription drug benefit.

In facing this crisis, Dr. Penner said that we are now “veering back and forth between denial and hysteria.” There are many other countries facing the same problems, but what makes the United States unique is its “especially high income level.” The panel members emphasized the need to make difficult choices about how to shore up the entitlements programs and modernize them to fit a new demographic era. Currently there are three taxpayers for each beneficiary; in 2030, this ratio will drop to two taxpayers to each beneficiary.

Among the options available to policymakers for keeping the entitlement programs solvent with current benefits are to:

◆ Encourage Americans to work longer.
(In 1950, the average age for applying for Social Security benefits was 68; today it’s 63.)

◆ Increase the age for eligibility and/or slow the growth in benefits.

◆ Raise taxes.

◆ Reduce dependence on “pay as you go financing” and move to a funded system.

◆ Downsize government dramatically to underwrite the entitlements.

Both Drs. Rivlin and Penner noted that Social Security is a relatively easy problem to fix compared with expected increases in the costs of Medicare and Medicaid. However, Dr. Penner concluded that the entitlements and their impact on the federal budget “will be easier to fix the earlier we act, and there’s a compelling argument to be made for acting as quickly as possible.”

A webcast of this session is available through kaisernet.org at www.kaisernet.org. For more information about the 2005 National Health Policy Conference, including speaker presentations, go to www.academyhealth.org/nhpc.
Released in February, the President’s budget proposal met the expectation that funding for all public health agencies—including those that support health services research—would either remain at the previous year’s level or be reduced for FY 2006.

Agency for Healthcare Research and Quality (AHRQ)
The budget provides level funding for AHRQ at $319 million. Of the $84 million the Agency will be required to spend on patient safety and health information technology, it must transfer $14 million to the Office of the National Coordinator for Health Information Technology.

The Coalition recommends that AHRQ’s FY 2006 budget be increased to $440 million to allow for more comparative effectiveness and patient safety research, and provide support for translation and health information technology. Increasing spending also enables AHRQ to fund more grants in their priority portfolios and possibly eliminate the current cap on grants (see Q&A with AHRQ Director Carolyn Clancy, page 5.)

Centers for Medicare and Medicaid Services (CMS)
The CMS budget for the Office of Research, Demonstrations and Evaluations continues to see its funding limited, allowing it to meet only its statutory requirements. The Coalition recommends that CMS receive an additional $60 million over the proposed $45 million, providing the agency with the capacity to fund research on important topics such as improving quality for those with chronic illnesses and assessing the impact of technological changes on Medicare and Medicaid.

National Center for Health Statistics (NCHS)
The FY 2006 budget request for the Centers for Disease Control and Prevention’s NCHS followed the FY 2005 request of $109 million. Understanding the importance of NCHS data to the research community, the Coalition recommends that funding be increased to $180 million to allow NCHS to increase its surveys and the questions it asks within those surveys, as well as enhance its technological capacity.

National Institutes of Health (NIH)
The Bush budget provides for NIH to receive a small increase of .5 percent from $28.6 billion to $28.8 billion.

Substance Abuse and Mental Health Services Administration (SAMHSA)
The Substance Abuse and Mental Health Services Administration would receive $3.2 billion, a cut of $54 million under the President’s plan.

Veterans Administration (VA)
After years of constant growth, research funding at the VA was cut last year; the 2006 budget proposes additional cuts. The Coalition will work with the Friends of the VA to increase research funding for the agency during this time when more veterans are entering the system and their injuries are more severe.

For more information, visit www.chsr.org.

AcademyHealth to Honor Influential Research with New “Impact” Award

The AcademyHealth Board of Directors has created a new Health Services Research “Impact” award to recognize research that has had a significant impact on health and health care. Through an open call for nominations from its membership, AcademyHealth is challenging the field to identify examples of outstanding research that have been successfully translated into health policy, management, or clinical practice. Through this award, AcademyHealth will be enlisting researchers to increase public and private decision makers’ awareness of the importance of their work.

A distinguished advisory committee comprising leaders in the health policy and health services research fields will select one to two research examples each year from among the nominations, announcing the winner at the National Health Policy Conference held each winter in Washington, D.C. The award-winning Impact will form part of a series of two-page narratives describing how health services research influences health policy, management, and clinical decision-making processes. The series will be disseminated on an ongoing basis to public and private sector decision makers, as well as to health services researchers and the media. The Health Services Research Impact series will be prominently featured on the AcademyHealth Web site.

AcademyHealth members will receive additional information, including a call for nominations, later this spring. For more information about the AcademyHealth awards or the Health Services Research Impacts series, contact Jennifer Muldoon at 202.292.6735 or jennifer.muldoon@academyhealth.org. ▲
AHRQ Director Carolyn Clancy, M.D., Addresses the Challenges Facing Health Services Research

AcademyHealth: What is your vision for moving the Agency forward?
Dr. Clancy: My vision is captured in the mission statement that we adopted last year: “to improve the quality, safety, efficiency, and effectiveness of health care for all Americans.” While AHRQ has always supported the best and brightest in health services research, we have realized that, as an Agency, we needed to do more than just conducting, supporting, and disseminating research. As AHRQ, our role had expanded to helping the health care system translate research into improved practice and policy. Although AHRQ is first and foremost a research funding agency, we recognized that research is not an end in itself, but rather, a vehicle to improve health care and health. To that end, we are working with our public- and private-sector partners to translate the research we support and conduct into knowledge and information that can be used immediately to improve health care for all Americans. We also are funding research that leads to implementation more quickly or that supports the implementation and evaluation of a technology, strategy, or research findings, and we work to disseminate the results broadly to the health care system.

AcademyHealth: Congress provided $15 million in new funding for AHRQ to conduct comparative effectiveness research for the current fiscal year. Why is comparative effectiveness research a priority for AHRQ? How do you envision these funds being programmed?
Dr. Clancy: AHRQ has been a leader in synthesizing clinical evidence on a wide range of health care issues that have addressed a critical need for knowledge. Providing evidence-based information for clinical and policy decisions has always been a priority for AHRQ and this new initiative is an extension of that priority. I am very pleased that the Medicare Modernization Act provides us with an incredible opportunity to do more of this exciting work. Under Section 1013 of MMA, AHRQ will conduct research on effectiveness and comparative effectiveness of health care interventions and services of importance to Medicare, Medicaid, and SCHIP. However, the information that will be generated by this effort will be vital to the health care community as a whole.

AHRQ will support systematic reviews on key questions for 10 priority conditions determined by Secretary Thompson. A list of the conditions is available on our Web site at www.ahrq.gov/news/press/pr2004/mmapr.htm. These reviews will be kept current, and they will be disseminated to a variety of audiences in formats that can be used whenever and wherever they are needed. These reviews also will highlight gaps in knowledge, and this information will fuel future research efforts.

Because of the tight timeframes in the MMA, we anticipate that we will use existing AHRQ research programs, including our Evidence-based Practice Centers, Integrated Delivery System Research Networks, and Centers for Education and Research on Therapeutics, for this first phase of systematic reviews. We may explore additional options for research in future phases of this initiative.

AcademyHealth: Since 1999 the AHRQ budget has increased from $205 million to $319 million. Congress and the Administration have allocated $15 million for comparative effectiveness, $84 million for patient safety, $50 million for health information technology, and $55 million for the Medical Expenditure Panel Survey, leaving a balance of $115 million. How are these remaining funds used to support the AHRQ mission?
Dr. Clancy: The remaining $115 million in AHRQ’s budget supports the continuation of multi-year research projects as well as a number of very important initiatives, including the U.S. Preventive Services Task Force, Evidence-based Practice Centers, Centers for Education and Research in Therapeutics, the Healthcare Cost and Utilization Project, primary care practice-based research networks, and Translating Research into Practice. AHRQ also supports a series of health services research training programs, dissertation grants, and projects to build the capacity for health services research around the country.

AcademyHealth: The field of health services research is concerned about the recent stipulation AHRQ placed on grant awards, which places a maximum of $100,000 (direct and indirect) a year on new grant awards. Why was this ceiling placed on applications and how long do you think this limitation will be needed?
Dr. Clancy: This decision reflects the reality that we have extremely limited resources for new research applications that address topics outside

Continued on page 6

AHRQ’s Research Portfolios

<table>
<thead>
<tr>
<th>Portfolio</th>
<th>Percentage of AHRQ budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality/Safety of Patient Care</td>
<td>10.5</td>
</tr>
<tr>
<td>Informatics</td>
<td>21.0</td>
</tr>
<tr>
<td>Data Development</td>
<td>22.3</td>
</tr>
<tr>
<td>Chronic Care Management</td>
<td>9.7</td>
</tr>
<tr>
<td>Prevention</td>
<td>9.5</td>
</tr>
<tr>
<td>Bioterrorism</td>
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<tr>
<td>Socio-economics of Health Care</td>
<td>12.9</td>
</tr>
<tr>
<td>Pharmaceutical Outcomes</td>
<td>4.8</td>
</tr>
<tr>
<td>Training</td>
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</tr>
<tr>
<td>Long-term Care</td>
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<tr>
<td>Organizational Support</td>
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</tr>
<tr>
<td>Total</td>
<td>100.0</td>
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</tbody>
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1 There is a significant link between the Quality/Safety of Patient Care and the Informatics Portfolios. This budget is primarily the Patient Safety Earmark.
2 18.2 percent of the Data Development Portfolio is devoted to the Medical Expenditure Panel Surveys.
3 AHRQ receives $50m for bioterrorism research funded by the Office of Public Health Emergency Preparedness (OPHEP). This funding is reimbursable and is therefore not part of the Agency’s appropriated budget.
priority areas in our budget. Thus, we placed a temporary cap of $300,000 in total costs per year on new applications. This decision reflects a concern for new investigators and a strong interest in supporting promising applications at a time when multiple funding sources are constrained. After extensive debate, we concluded that supporting a larger number of focused projects (or components of larger projects supported by multiple funders) would provide support to a larger number of investigators and help to avoid the need for researchers and research teams to cease productive work. We will revisit this decision at least annually, more frequently should additional resources become available. We welcome feedback from AcademyHealth members regarding this decision.

AcademyHealth: Investigator-initiated awards are often the conduit to increased knowledge. Congress no longer appears willing to fund these investigator-initiated awards, preferring to fund more targeted solicitations for broad areas like patient safety. What advice do you have for how health services researchers obtain grant support for their work?

Dr. Clancy: The creative skills and contributions of the research community are essential to all AHRQ initiatives. Indeed, all new initiatives are preceded by extensive consultation with researchers and decision makers prior to being published to assure that priority areas reflect the most current research strategies and needs of stakeholders. At the same time, it’s important to recognize that Congress is emphasizing research focused on resolving the obstacles to implementation of effective health care services and system-design strategies. That’s in part because of concern about the very real challenges facing today’s health care system, and Congress’ belief that the lead time between when research is started and when Americans benefit from research findings is often too long. However, this emphasis provides a tremendous opportunity for the health services research community. Funding in the short-term will likely be greatest for projects linked to AHRQ’s 11 research portfolios—research that advances implementation and adoption of proven interventions, and clearly addresses the most pressing concerns identified by those who manage, deliver, or receive health care services. If we in the health services research community can rise to the challenge of showing the value of our work in these areas, we will ultimately ensure a broader base of support and funding for the entire spectrum of research in which we’re involved.

AcademyHealth: What is the proportion of research funded by AHRQ that is extramural compared to intramural? Do you see this proportion changing over the next four years?

Dr. Clancy: Approximately 85 percent of AHRQ’s budget goes to grants, cooperative agreements contracts, and other initiatives that take place outside of the Agency. Thus, an extremely large portion of the Agency’s resources goes to individuals and organizations, including states, that can use those resources for the critical task of improving the quality, safety, effectiveness, and efficiency of the nation’s health care system. We expect that the majority of AHRQ’s funding will continue to be directed outside of the Agency.

New Report Outlines Recommendations for Improving Federal Health Data Collection

Given concerns about the adequacy of federal health data to inform policy decisions at the national, state and local levels, AcademyHealth recently released Improving Federal Health Data for Coverage and Access Policy Development Needs. This report can be accessed at www.academyhealth.org/publications/federal-healthdata.pdf.

To provide information to address coverage and access issues at the national, state, and community levels, the report calls on the federal government to streamline the current federal surveys by eliminating the redundancies in the information collected, and use the savings from this reduction in duplication to increase sample size in order to produce sub-national or state estimates. It also recommends that foundations complement the federal government investment in national surveys with targeted research to provide a better balance between ongoing surveillance and research.

“While national surveys provide a long-standing and well-regarded way to assess overall needs, it will be important to complement these surveys with targeted research to help address specific health policy development needs,” says David Helms, president and CEO of AcademyHealth.

The report summarizes three papers commissioned on the issue of federal health data and findings from an expert meeting held in June 2004. It identifies the following four major themes:

◆ Scope and integration of current federal surveys;
◆ Specific improvements in current federal surveys;
◆ Increased investment in methodological research; and
◆ Increased integration and coordination among federal agencies.

“The recommendations highlight the need not only to continue documenting the characteristics of those who lack insurance coverage, but also the type of coverage that is being provided and how it translates into access to services—and ultimately to improving health outcomes,” continues Helms.

The commissioned papers are currently under review by Health Services Research and Health Affairs and should be available later this year. The project received funding from The Robert Wood Johnson Foundation and the Centers for Disease Control and Prevention’s National Center for Health Statistics.
Organizational affiliates provide institutional support to AcademyHealth’s many programs and member services. Our university-based and private organizations also support the critical work of the Coalition for Health Services Research as it advocates for funding for the health services research field. Our affiliates are essential partners in helping AcademyHealth fulfill its mission of facilitating the translation of research into policy and practice.

Organizational affiliates receive a variety of benefits, including:
- Exclusive space in AcademyHealth Partners for organizational announcements; organizational visibility through links on AcademyHealth’s Web site; annual listing in AcademyHealth Reports and the Annual Research Meeting (ARM) Agenda Book.
- Discounts on registration fees for our conferences and seminars; advertising in the online Career Center, exhibit booths, and agenda books; and subscriptions to more than 30 journals and newsletters.
- Complimentary uses of AcademyHealth’s membership list.
- A subscription to Health Affairs, HSR, and The Milbank Quarterly.
- Advocacy through the Coalition for Health Services Research.

If you would like to become an organizational affiliate of AcademyHealth, contact Kristine Metter, director of membership, at 202.292.6754 or kristine.metter@academyhealth.org.

We salute and thank our organizational affiliates.

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National Pharmaceutical Council
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New York Medical College, School of Public Health
Northwestern University, Institute for Health Services Research and Policy Studies
NRH Center for Health & Disability Research
The Nuffield Trust for Research and Policy Studies in Health Services
Office of the Assistant Secretary of Defense (Health Affairs)
The Ohio State University, Center for Health Outcomes, Policy and Evaluation Studies (HOPES)
Oklahoma University Health Sciences Center, College of Public Health, Department of Health Administration and Policy and Center for Health Policy
Park Nicollet Institute
Pennsylvania Department of Health
The Pennsylvania State University, Center for Health Care and Policy Research
RAND Health
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University of Minnesota, Carlson School of Management, Center for the Study of Healthcare Management
University of Minnesota, School of Public Health, Division of Health Services Research and Policy
University of Nebraska Medical Center, Section on Health Services Research and Rural Health Policy
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University of North Carolina, Chapel Hill, Program on Health Outcomes
University of North Carolina at Charlotte, College of Health and Human Services
University of North Texas Health Science Center
University of Pennsylvania, Leonard Davis Institute of Health Economics
University of Rochester, Department of Community and Preventive Medicine
University of South Carolina, Center for Health Services and Policy Research
University of South Florida, Louis de la Parte Florida Mental Health Institute
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West Virginia University, Institute for Health Policy Research
Yale University, Division of Health Policy and Administration

List current as of February 15, 2005.
members matter

Moving On and Moving Up
Keep in touch with friends and colleagues by sending your career news to membernews@academyhealth.org. Submissions of no more than 25 words will be printed on a first-come, first-served basis.

David M. Bott, Ph.D., has accepted a position as health insurance specialist in the CMS Office of Research Development and Information.

Bradford Gray, Ph.D., has moved to The Urban Institute as a principal research associate in the Health Policy Center. He continues as editor of The Milbank Quarterly.

Kristen Kjerulf, Ph.D., is now associate professor at the Penn State University College of Medicine.

Ann S. O’Malley, M.D., M.P.H., has joined the Center for Studying Health System Change as a senior health researcher.

Kevin Quinn, M.A., EMT-P, has been named director of payment method development for ACS State Healthcare LLC; he is based in Helena, Mont.

Helene Starks, Ph.D., M.P.H., has joined the University of Washington, Department of Medical History and Ethics as assistant professor.

Richard G. Stefanacci, D.O., M.G.H., M.B.A., has been named the founding executive director of the Health Policy Institute at the University of the Sciences in Philadelphia.

Interest Groups Provide Focus on a Variety of Topics

AcademyHealth’s Interest Groups, now in their second year, are moving forward with a variety of substantive activities and networking opportunities. Designed to complement AcademyHealth’s broad, multi-disciplinary work, the Interest Groups provide a forum for interaction around specific topics within health services research and health policy. In the past year, the Interest Groups have formed their volunteer leadership structures and are focusing on increasing the networking and presentation opportunities for individuals working in their specific areas.

In January, the Health Economics Interest Group hosted a Web discussion moderated by Roger Feldman, Ph.D. The two-week discussion focused on efficient Medicare pricing and featured comments and questions by individuals from all over the country. The discussion concluded that Medicare’s original prices were set too high, so ratcheting them down has increased welfare. But according to Feldman, the question is, “Where should Medicare stop?” If we have made any contribution toward that debate, it may be to point out that excess demand is a necessary but not sufficient sign that prices have been cut too far.” The full transcript can be found at www.academyhealth.org/membership/forum/.

The Long-Term Care Interest Group has established two workgroups that, through electronic discussions, will hone in on a few specific issues. The Quality Workgroup will be discussing quality measures in the homecare setting, workforce issues, and promoting culture change. The Dual Eligibles Workgroup will be discussing new models of long-term care and financing of long-term care.

All Interest Groups have planned a substantive meeting either before or after AcademyHealth’s Annual Research Meeting (ARM), which will feature interactive discussions and presentations on the current findings and issues, as well as updates from national leaders in the field. Each meeting has a different format, but many include panel presentations and posters. All will offer networking opportunities. For a complete schedule, see page 10, or visit www.academyhealth.org/arm/adjunct/interestgroups.htm.

In 2005, many of the Interest Groups are focusing on building the “next generation” of researchers and policy professionals through diverse activities such as gatherings at the ARM, mentoring through résumé and poster reviews, and online programs. Look for more information on Interest Groups in the coming months at www.academyhealth.org/membership/interestgroups.htm.

News from the Journals

Health Affairs
Health care disparities are the focus of the March/April issue of Health Affairs. Context-setting papers examine historical perspectives and the interaction of race and class. Other discussions address disparities as a dimension of quality; challenges for Medicare; the role of evidence in tackling disparities. Contributors include Senators Bill Frist and Edward Kennedy. Among other topics: access to psychiatric drugs in Medicaid; combating HIV in Botswana.

HSR
Health Services Research is going OnlineEarly in 2005! Beginning this fall, HSR will post complete, peer-reviewed, Web-functional articles online up to several months in advance of the printed issue. OnlineEarly speeds up the availability of forthcoming papers in HSR and shortens the acceptance-to-publication dates, a “reward” to authors for quick turnaround time and longer shelf life for their article. AcademyHealth members will be informed once OnlineEarly is fully functional and will receive periodic e-mail alerts announcing new postings with information on how to access articles online. For more information, contact Jennifer Shaw at jshaw@aha.org.

The Milbank Quarterly
The spring issue of The Milbank Quarterly includes an article showing how race has affected American health policy (broadly defined) and how health policy has contributed to racial differences in mortality in the United States, as well as differences in life expectancy between the United States and Canada. Also included are articles about welfare reform and substance abuse, the effects of block grant proposals in Medicaid, the potential effects of pharmaceutical utilization management under the Medicare Modernization Act, Canada’s reference-based pricing for pharmaceuticals, and experience in exporting the purchasing model of the Buyers Health Care Action Group from Minneapolis and St. Paul, Minn.
Boston to Host 2005 Annual Research Meeting, June 26–28

The AcademyHealth 2005 Annual Research Meeting (ARM) at the Hynes Convention Center in Boston will provide a forum for health services researchers to present cutting-edge research and engage top health policymakers and practitioners. An outstanding agenda for the 2005 ARM features 17 health services research and policy themes or areas of focus, technical sessions on research methods, and health policy roundtables to discuss timely health policy challenges.

More than 2,000 research and policy professionals are expected to attend more than 120 sessions addressing such topics as quality of care; the delivery, organization, and financing of health care; coverage and access; Medicare reform; and the effective translation of research into policy and practice. The exhibit program will feature leading public and private organizations in health services research and health policy. In his keynote address at the opening plenary session on Sunday, June 26, Atul Gawande, M.D., author of Complications: A Surgeon’s Notes on an Imperfect Science and finalist for the 2002 National Book Award, will discuss the nature and importance of fallibility in medicine, and the essential role of health services research in guiding the future capability of medical care.

Seminars in Health Services Research Methods
Full-day methods seminars are offered before and after the ARM.

Saturday, June 25 • 10:00 a.m. – 5:00 p.m.
◆ Advances in Methods for Monitoring Health Outcomes
◆ Introduction to Hierarchical Modeling for Health Services Research
◆ The Why & How of Risk Adjustment

Interest Groups Meeting Schedule—ARM 2005

| Saturday, June 25 | 8:30 a.m. – 4 p.m. | Long-Term Care Health Services Research
9 a.m. – 5:30 p.m. | Child Health Services Research
10 a.m. – 4 p.m. | Public Health Systems Research
10 a.m. – 4 p.m. | State Health Research and Policy
1 p.m. – 5 p.m. | Health Workforce
1 p.m. – 5:30 p.m. | Health Economics

| Monday, June 29 | 8:00 a.m. – 3:00 p.m. | Enhancing Your Methodological Toolbox: An Introduction to Qualitative Research
10 a.m. – 3:00 p.m. | The Healthcare Cost & Utilization Project (HCUP): Data & Tools for Health Services & Policy Analyses
1 p.m. – 3:00 p.m. | Behavioral Health Services Research
5 p.m. – 8 p.m. | Interdisciplinary Research Group on Nursing Issues

To learn more about the conference agenda, registration, and hotel information, visit www.academyhealth.org/arm.