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Moving From Health Care Research to Action

Claudia R. Baquet, MD, MPH,* Katherine Marconi, PhD,† and George Alexander, MD‡

Although the United States spends more on health care than any country in the world, access to that care is becoming increasingly difficult. The National Cancer Institute and other federal agencies are sponsoring innovative research for delivering effective medical services, particularly to underserved populations. Models of successful collaboration between private and public sectors concerned with health care can be adapted and implemented at the national, state, and local levels. However, other measures are needed to ensure access to adequate health care for all Americans. Minimal but effective regulations are needed to ensure quality control, reduce duplication of services, and minimize cost increases. Public and private sectors also need to consider ways to extend adequate health insurance coverage to all Americans and to provide compensation for preventive services. (Henry Ford Hosp Med J 1992;40:66-70)

Although the United States spends more on health care than any other country in the world, adequate medical services are becoming increasingly difficult for Americans to obtain. The rapidly rising cost of health care has prompted many providers of medical insurance to initiate utilization controls and to increase the consumer's share of the burden for paying these costs. Thus, many Americans who have health insurance are paying more money for less coverage. At the same time, the changing structure of the American economy has led to a greater portion of the population being employed by smaller companies and service industries which are less likely to provide health insurance benefits (1,2). Consequently, the number of Americans without health insurance has increased dramatically. Moreover, the nation's poor tend to be more vulnerable to injury and disease and also more likely to be without public or private health insurance.

The National Cancer Institute (NCI) and other federal agencies are sponsoring innovative research to develop models for delivering planned, effective preventive and medical services, particularly to underserved populations. These models include cancer control interventions to encourage the use of cancer screening and other medical services among native Hawaiian women, to expand cancer screening services for low-income blacks who use hospital emergency rooms as a source of primary care, and to overcome cultural barriers to the use of cancer screening services among Mexican-American women.

Nevertheless, other measures are needed to ensure access to adequate health care by all Americans. Public and private groups at the national, state, and local levels must work together to define problems and policies, enact legislation, and secure funding for these services. Minimal but effective regulations are needed to ensure quality control, reduce duplication of services, and minimize cost increases. Finally, health insurance coverage needs to be extended to all Americans, regardless of socioeco-

nomic status, and coverage must include compensation for preventive services.

Gaps in the Delivery of Health Care

Public and private spending on health care—particularly for personal health services—has increased dramatically since the 1960s. In 1960, 5% of our country's gross national product was devoted to health care costs; in 1990, it was expected to reach 12% (3). The price of this care includes the highest rate of inflation for consumer goods and services purchased in this country during the past year. Between April 1990 and April 1991, costs of medical care rose 9.1% compared to 4.7% for food and beverages and 4.5% for housing. According to the Bureau of Labor Statistics, the consumer price index rose only 4.9% during this period (4). These escalating costs are attributed in part to the adoption of new medical technology and the overuse of existing technology as well as to competition among hospital systems which leads to the duplication of expensive services and equipment (5).

Despite increased spending, there are indications that the nation's health care system is faltering in its ability to provide adequate services to all Americans. For example, every year thousands of people in the United States die from illnesses that could have been prevented or easily controlled if they had had access

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to prompt and routine basic medical care. Between 1980 and 1986, an average of 17,366 deaths occurred and 286,813 years of potential life before age 65 were lost to 12 sentinel conditions, which include tuberculosis, influenza, asthma, hypertensive heart disease, and cervical cancer. Moreover, the rate for needless deaths from these treatable diseases was 4.5 times higher among blacks than among whites (6).

Infant mortality rates are an indicator of the effectiveness of a health care system to the extent that lack of prenatal care is a major factor in poor obstetrical outcome (3). Although sophisticated medical interventions to prevent infant mortality are available in this country, the United States continues to have a higher rate of infant mortality than most developed and some less developed nations. In 1987, nearly 40,000 infants died in their first year of life, and black infants died at twice the rate of white infants (7). Similarly, cervical cancer usually can be cured with early detection and treatment. Nevertheless, 4,423 women died from cervical cancer in 1987, and black women were 2.7 times more likely to die of the disease than white women (8).

These indicators suggest that access to regular medical care is an important factor in preventing unnecessary morbidity and mortality among certain populations in the United States. In addition, several studies have indicated that socioeconomic factors are key contributors to disease incidence rates. For example, the NCI used data from its Surveillance, Epidemiology, and End Results program to correlate cancer incidence rates among blacks and whites in three metropolitan areas with U.S. census-tract data on socioeconomic status. Before correlation with census-tract data, age-adjusted incidence data indicated that blacks had a significantly elevated risk for cancer at all sites combined and at four of seven separate sites. After incidence data were correlated with socioeconomic status, blacks maintained their elevated risk at three cancer sites and whites showed an elevated risk at all cancer sites combined and at three separate sites. These findings suggest that much of the excess burden of cancer among blacks may be due to the overrepresentation of this group in lower socioeconomic levels (9).

One of the most notable ways in which lower socioeconomic status affects health status is by increasing the likelihood that individuals will be uninsured for medical costs and therefore less able to access regular health care. Of the nearly 48 million Americans who lacked insurance coverage for all or part of 1987, people who were members of families with incomes below or near the poverty line were most likely to be uninsured. Blacks and Hispanics also were overrepresented in this group (10). Medically indigent Americans, who are unable to pay for health care when they need it, include about 37 million people who are uninsured and an additional 17 million who are underinsured. According to a survey by the Robert Wood Johnson Foundation, at least 15 million Americans every year are without needed health care because they cannot afford to pay for it (11). Moreover, many other individuals who have no regular source of medical care tend to postpone seeking treatment until the need becomes urgent. Consequently, they do not avail themselves of primary or secondary prevention measures that could prevent excess incidence, morbidity, and mortality for conditions such as cancer and hypertensive heart disease.

Studies have shown that even when the uninsured gain access to the health care system through public clinics and hospitals, the care they receive is not as good as that received by patients who are insured. For example, recent studies reported that uninsured patients admitted to hospitals had more serious or urgent conditions, underwent fewer procedures, had shorter hospital stays, and had a higher relative risk of in-hospital death compared with privately insured patients (12,13). These findings suggest that hospitals may be conserving their use of resources for at least elective or more highly discretionary services when caring for the uninsured, with possible deleterious effects on uninsured patient outcome.

Collaborative Efforts to Provide Health Care

Although protecting the health of Americans is a government function, the provision of health care services is a responsibility shared by both the public and private sectors. The Institute of Medicine's report on the future of public health emphasizes the need for cooperative efforts among federal, state, and local public health agencies and private organizations such as professional membership groups, nonprofit associations, foundations, citizen groups, media, and health care providers (14). Government agencies need to assess and monitor health problems, establish policies and objectives, assure a statutory base for activities, and guarantee a minimum set of essential services. Private groups can play important roles in exchanging information, focusing attention on health issues, assisting policy development, supporting research, lobbying for changes in programs and policies, and providing services. For example, the American Medical Association has played a prominent role in supporting research related to the health effects of smoking and in promoting antismoking campaigns. Similarly, many state and local business coalitions sponsor health promotion programs at the worksite. Ultimately, these public and private activities seek to help individuals and families protect their health by adopting risk-reducing behaviors and by using preventive and medical care services.

There are many other models of successful collaborations between private and public sectors concerned with health care. For example, the Michigan Department of Public Health's Center for Health Promotion has developed a program that involves health care providers, mammography facilities, and patients in an effort to prevent mortality from breast cancer through early detection (15). Legislation enacted in 1989 created a Breast Cancer Mortality Program within the state health department, increased regulatory control of mammography equipment and personnel, encouraged third-party coverage for breast cancer services including mammography, and reaffirmed the responsibility of physicians to discuss options with women prior to treatment.

This legislation provided the statutory base for creating a system of care designed to reduce breast cancer mortality. A document created by the Michigan Cancer Consortium recommended schedules for breast cancer screening and defined the roles and responsibilities of key providers in the system. For example, primary care physicians should perform clinical breast

examinations within one month of screening mammograms; mammography facilities accepting self-referred women must have procedures for notification and follow-up; and women should assume responsibility for following recommendations for screening, referral, and follow-up.

The state of New York also has enacted legislation facilitating cooperative efforts to encourage the early detection of breast cancer. In 1990, the state established grants for organizations that provide breast cancer education and detection programs specifically targeting unserved or underserved populations and mandated that every insurance policy providing coverage for medical care also must cover regular mammography screening.

In the same year, a group of 19 public and private sector organizations involved in breast cancer education and screening collaborated to sponsor the Breast Cancer Awareness Partnership Breakfast. Participants included nationally based agencies such as the American Cancer Society, NCI's Cancer Information Service, and the National Alliance of Breast Cancer Organizations; local medical and political leaders; and representatives from more than 70 businesses, unions, service groups, and women's health organizations. After an educational program, guests were asked to pledge their involvement in individual ongoing activities ranging from planning breast health education activities for employees to cosponsoring a local breast health program. Pledgers were teamed with organizations that could provide resources needed to fulfill these commitments. The success of this initial collaborative event prompted planners and participants to establish a permanent coalition called the Metropolitan Area Breast Cancer Awareness Partnership. This group is organizing new cooperative initiatives aimed at reducing morbidity and mortality from breast cancer by increasing local public demand for affordable, comprehensive, and accessible breast cancer screening.

The National Black Leadership Initiative on Cancer (NBLIC) was established in 1987 as a national structure for mobilizing black leaders to organize, implement, and support cancer prevention programs at the national level and in their communities. NCI provides funding and technical oversight to the NBLIC, including the transfer of scientific information and research results to NBLIC and thereby to the black community. NBLIC, in turn, has developed strong relationships with national, state, local, and special interest organizations and has established a network of more than 50 coalitions that conduct community cancer control activities throughout the country. Through these contacts and activities, NBLIC has directly or indirectly delivered cancer prevention and control messages to 15 million to 20 million black Americans, or 50% to 66% of the U.S. black population.

Individual NBLIC coalitions have focused on efforts to increase awareness about cancer prevention and control in the black community, to increase participation in screening and early detection programs, and to organize support groups for cancer survivors. In addition, coalitions have mounted local media campaigns against tobacco advertisements that target black communities. For example, the Philadelphia NBLIC successfully collaborated with the Department of Health and Human Services to deter the test-marketing of a new brand of cigarettes

to blacks living in that city. The coalition was able to organize this large cooperative effort because it already had established a broad membership of local groups and voluntary organizations committed to improving and protecting the health of the black community.

Another potentially valuable collaboration between public and private sectors is the creation of a centralized system for tracking women who receive screening tests for breast and cervical cancers. These two diseases often can be cured with early detection and treatment, yet thousands of American women die every year because their malignancies are detected too late or because they did not receive proper follow-up care for positive or questionable screening results. A centralized registry would allow women to be reminded when they need to be screened and to be notified when their test results require further follow-up. The system would be particularly valuable for tracking women who do not have a regular source of medical care. This proposed registry would require the combined efforts of screening facilities, primary care physicians, and local health care agencies in much the same way that public and private medical care systems have collaborated to provide organ transplant registries.

Models for the Effective Delivery of Health Care Services

To plan and implement more effective systems for delivering health care services, public health officials and community leaders need working models based on the results of documented research. The federal government is sponsoring numerous intervention studies aimed at determining optimal ways of increasing access to care among specific underserved populations. This research focuses on establishing collaborations between the public and private sectors and on developing intervention strategies based on input from members of the community and target populations.

For example, NCI is funding a project to test the effectiveness of an integrated, community-based cancer control intervention targeting native Hawaiian women. The project was prompted by the observed underutilization of cancer screening and other medical services by these women, often due to the cultural inappropriateness of the existing health care system. After obtaining input on the study design from community representatives, researchers were able to identify native Hawaiian social and family networks that are strong potential resources for allowing health workers to reach community members who are not themselves users of medical services. The intervention also takes advantage of "Kokua," a Hawaiian social concept that encourages mutual support among community members. Kokua groups will be formed to provide linkage between health workers and native Hawaiian women and to encourage support for addressing cancer issues and promoting health-seeking behaviors among community members. The effectiveness of the intervention will be measured by changes in mammography and Papanicolaou (Pap) screening rates as well as changes in knowledge, attitudes, and practices among Kokua group members.

NCI also is sponsoring a collaborative effort by Harlem Hospital Center and Memorial Sloan-Kettering Cancer Center to

implement and evaluate a cancer control intervention targeting low-income blacks who use hospital emergency rooms as a source of primary care. The Harlem Hospital Emergency Room Cancer Screening Program is designed to expand the availability and use of cancer screening services by these individuals and to increase their early cancer detection behavior. It will provide an opportunity for low-income blacks to be screened for cancers of the breast, cervix, colon, rectum, and prostate in a setting that usually does not provide prevention services. Many members of the target population have never sought or been given the opportunity to receive cancer screening. The intervention emphasizes cooperative efforts between institutions and programs with cancer control expertise and the established local programs sharing a concern for the welfare of the community. It will evaluate program utilization, barriers to use, clinical outcomes, and cost. If the program proves successful, it may be incorporated throughout the New York City Health and Hospitals Corporation system of 11 hospitals to help increase cancer screening among blacks.

NCI's Public Health Approaches to Breast and Cervical Cancer Screening initiative provides funding for the development of culturally sensitive intervention models designed to increase the number of women screened for these diseases. For example, researchers in Rhode Island are testing an intervention model that encourages poor and minority women ages 40 years and over to seek screening mammograms and Pap smears. The project will study the effectiveness of a cultural peer outreach intervention in predominantly black neighborhoods using volunteers from the Rhode Island Ministers Alliance. It also will test a health center intervention in low-income clinics using trained health educators. The outreach initiative will be managed by the American Cancer Society, Rhode Island Division, and the health center intervention will be coordinated by the Rhode Island Health Department. Additional collaborative arrangements have been made to eliminate financial barriers to screening for breast and cervical cancers. The American Cancer Society, Rhode Island Division, and local health care providers such as radiologists and surgeons, as well as local health centers, clinics, and hospitals have agreed to provide no-cost screenings, diagnostic services, and treatment for women who are uninsured or unable to pay for this care.

NCI-supported investigators at San Diego State University and the University of California-San Diego are collaborating on *Por La Vida*, a project that develops innovative approaches to health promotion among Mexican-American women. Researchers are expanding the *Por La Vida* model originally developed for reducing cardiovascular risk factors in Hispanic women to include preventive cancer interventions focusing on the increased use of cancer screening measures, including mammography, Pap smears, clinical breast examinations and breast self-examination, and changes in dietary habits. The first phase of the project will attempt to identify barriers to the use of screening services by conducting a series of focus group meetings with women who have participated in earlier *Por La Vida* activities. A similar set of focus groups will be conducted with health care providers and representatives of voluntary organizations and public health agencies. The intervention phase will address im-

portant cultural barriers to screenings by using naturally occurring social networks of Mexican-American women as well as trained group leaders (*consejeras*) who are recruited from the community. In addition, one component of the program will include training on how to legally use existing services available to low-income residents. Measures of the effectiveness of the program will include records of clinical mammography and Pap smears, dietary recalls, and changes in knowledge, behaviors, and attitudes among participants.

Alternative Measures for Improving Access to Health Care

These and other research projects will provide valuable information on the efficacy of collaborative interventions designed to encourage access to health care services by populations currently underutilizing the system. In addition to funding this research, the federal government plays a vital role in disseminating information about successful intervention models to the state and local levels. However, the broad implementation and continued provision of medical services based on effective models requires other measures to ensure sustained support.

The market forces of supply and demand have affected expenditures for health care differently than for other private goods. For example, when Medicare and Medicaid were instituted in 1965, they increased the demand for health care services by extending access to the aged and poor. However, when the supply of medical services increased to meet this demand, costs rose rather than decreased as would occur in a normal competitive market. When this demand began to decline in the 1980s, health care facilities were faced with declining occupancy ratios. Many hospitals competed for physicians and their patients by introducing high-technology equipment and services (1). Unfortunately, this form of competition has led to the duplication of expensive equipment and services, which has further inflated health care costs. Moreover, many hospitals in urban and rural communities cannot afford to adopt increasingly sophisticated technology and risk losing their patients to more affluent suburban facilities.

Federal and state legislation has attempted to control inflated health care costs by instituting mechanisms for reducing the capital expansion that leads to the duplication of services and equipment. For example, in 1974, the National Health Planning and Resources Development Act introduced the certificate-of-need (CON) program to aid the review of expansion by hospitals and other health care providers in areas such as the construction of new facilities; the renovation or modernization of existing facilities, beds, or services; and the purchase of major types of medical equipment. However, several states left the CON program when subsequent legislation weakened its regulatory power by prohibiting the imposition of penalties for noncompliance.

Nevertheless, states can use other mechanisms to regulate capital expenditures and to control health care costs, including the imposition of moratoriums on new construction of hospital or nursing home beds, restrictions on the market share of corporate ownership of health care facilities, and conditions linking

compliance with cost containment goals to licensure and certification. Because a competitive market has not controlled the cost of health care, mechanisms may be needed to monitor and prevent the duplication of costly equipment and services, to curb overutilization and perhaps unnecessary utilization, to control costs, and to ensure the equal distribution of equipment and services. With or without the structure of regulatory mechanisms, public and private health care systems need to share responsibility for finding ways to ensure that the interests of both groups are served and that the needs of all patients are met.

Even if costs are controlled and services become more available in areas of need, millions of Americans—many of them children—will continue to lack access to adequate health care because they have no insurance. Millions more will lack adequate coverage for all but minimal care or will not be able to afford important preventive services that are not covered under their insurance policies. Numerous approaches to providing greater access to care for the uninsured have been proposed and analyzed. They range from modifying the current system of health care insurance to replacing the system with a universal health care plan.

For example, the proposed Kennedy-Waxman Basic Health Benefits for All Americans Act would include a mandate that all businesses offer health insurance to full-time employees and that this coverage include compensation for specific services. Another option for providing health care coverage to the uninsured is to expand eligibility for the Medicaid program to all individuals at or below the poverty line. Other proposals call for allowing the near poor to purchase Medicaid coverage with premiums set according to income. The American Academy of Family Physicians recently called for Congress to enact legislation that would expand insurance coverage through a plan that incorporates elements of each of these options (16).

Other alternatives include establishing direct subsidies or statewide uncompensated care pools for funding hospitals that treat uninsured patients. Proponents of a national health program usually cite the Canadian health plan as a model. The Canadian system includes such features as public financing through a single source of payment and private provision of care. Variants on this model include a proposal to create a single, tax-funded comprehensive insurer in each state (17).

Regardless of how costs are distributed among public and private sectors, the ultimate goal of any system of health care insurance should be to extend adequate coverage to the entire population and to provide compensation for preventive services such as routine physical examinations, immunization, screening tests, and counseling for risk reduction. To fulfill its mission of protecting the public health, the health care system cannot continue to allow socioeconomic status, membership in minority or ethnic groups, residence in particular geographic areas, or any other demographic factor to determine the level of preventive and medical care that is received. When the biotechnology revolution provides new procedures and therapies, such as methods of genetically detecting and treating disease, the system must find ways to extend the benefits of these advances to all Americans.

The challenges to public health are considerable, but the opportunities for meeting these challenges are numerous and varied. As researchers develop new technologies and strategies for addressing health care problems, public and private institutions and individuals must contribute their professional skills, political support, and commitment to transform this knowledge into practical solutions. Only by mobilizing these combined energies can the nation gather sufficient resources to achieve and maintain standards of good health for the entire populace, including the large numbers of underserved and unserved populations currently lacking access to care. To preserve the health of the nation's poor and disadvantaged as well as the viability of its medical institutions, governments and private citizens must work together to improve the conditions that have led to the high costs and the unequal distribution of preventive and medical care. Models for cooperation and effective service delivery already exist. Now they must be translated into collaborative action that commits the resources needed to implement and sustain improved health care for all Americans.

References

1. Lerner M. Access to the American health care system: Consequences for cancer control. *CA* 1989;39:289-95.
2. Nexon D. Senator Kennedy's proposal to guarantee basic health benefits for all Americans. *Henry Ford Hosp Med J* 1990;38:110-3.
3. Healthy people 2000: National health promotion and disease prevention objectives. Washington, DC: U.S. Government Printing Office, 1991.
4. Health care costs escalating. *USA Today*, May 31, 1991:1B.
5. Committee for Evaluating Medical Technologies in Clinical Use, Institute of Medicine. Assessing medical technologies. Washington, DC: National Academy Press, 1985.
6. Schwartz E, Kofie VY, Rivo M, Tuckson RV. Black/white comparisons of deaths preventable by medical intervention: United States and the District of Columbia 1980-1986. *Int J Epidemiol* 1990;19:591-8.
7. National Center for Health Statistics. Health United States, 1989, and prevention profile. Hyattsville: U.S. Department of Health and Human Services, 1990.
8. National Cancer Institute. Cancer statistics review: 1973-1987. Bethesda, MD: Department of Health and Human Services, Public Health Service, National Institutes of Health, 1990.
9. Baquet CR, Horm JW, Gibbs T, Greenwald P. Socioeconomic factors and cancer incidence among blacks and whites. *JNCI* 1991;83:551-6.
10. Short P. Estimates of the uninsured population, calendar year 1987. National Medical Expenditure Survey Data Summary 2. Rockville, MD: Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research, 1990.
11. Americans report on their health care. Robert Wood Johnson Foundation Survey, 1986.
12. Weissman J, Epstein AM. Case mix and resource utilization by uninsured hospital patients in the Boston metropolitan area. *JAMA* 1989;261:3572-6.
13. Hadley J, Steinberg EP, Feder J. Comparison of uninsured and privately insured hospital patients: Condition on admission, resource use, and outcome. *JAMA* 1991;265:374-9.
14. Committee for the Study of the Future Public Health. The future of public health. Washington, DC: National Academy Press, 1988.
15. Breast cancer screening and detection in Michigan: Recommendations to reduce mortality. Lansing: Center for Health Promotion, Michigan Department of Public Health, 1990.
16. Aukerman GF. Access to health care for the uninsured: The perspective of the American Academy of Family Physicians. *JAMA* 1991;265:2856-8.
17. Woolhandler S, Himmelstein DU. A national health program: Northern light at the end of the tunnel. *JAMA* 1989;262:2136-7.