When 2 leaders in the healthcare field, coming from entirely different perspectives, arrive at the same conclusion, it’s time to pay attention. Please allow me to explain. Lawrence P. Casalino, MD, PhD, is the Livingston Farrand Associate Professor of Public Health and Chief of the Division of Outcomes and Effectiveness Research at the Weill Cornell Medical College in New York City. Dr Casalino has been a prolific contributor to the literature in health services research and our paths have crossed several times, most recently when we cohosted a Commonwealth Fund’s Harkness Fellow from the United Kingdom.

Jeffrey Brenner, MD, has risen to national prominence as a recent MacArthur Fellow Genius Grant awardee, as well as the Executive Director and Founder of the Camden Coalition of Healthcare Providers, a nonprofit organization committed to delivering better care at lower costs in Camden, NJ, one of America’s poorest cities.

In their separate, recent publications, they came to the identical conclusion. Dr Casalino’s article was published by the Agency for Healthcare Research and Quality (AHRQ) in February 2014, and was based on a February 2011 presentation at an AHRQ conference entitled, “The Challenge and Promise of Delivery System Research.”1 Dr Brenner’s conclusion was written in his GrantWatch blog dated February 18, 2014—within days of the publication of Dr Casalino’s article.

Despite spending hundreds of billions of dollars in biomedical research, which is largely funded through the National Institutes of Health (NIH), and spending nearly 18% of the US gross domestic product (the world’s largest economic engine) on healthcare, we still have “little understanding of how to deliver better care at lower cost to every American…and we do not understand the fundamental drivers of healthcare utilization; the basic rules for designing and implementing effective interventions; the best ways to use data to plan, implement, manage, and evaluate interventions; nor how to train staff to run and lead these interventions.”2

In his AHRQ synthesis article, Dr Casalino expresses pretty much the same idea, but he obviously has to cast it in a different light, because of the support from the AHRQ. In his article, he concludes that, “the discoveries of basic scientific and clinical research have no impact on patients’ health unless they are used effectively by the healthcare delivery system.”3 To improve quality and to contain costs, Dr Casalino recommends that “research should focus on (1) identifying the types of organizations that are high performing; (2) identifying the types of incentives that induce these organizations to continually improve care; and (3) identifying the types of incentives likely to lead to the creation of more high-performing organizations and to physicians and other providers becoming members of high-performing organizations.”1

I think Dr Brenner and Dr Casalino would agree that it is the culture that makes the difference, and a core component of the culture is the leadership that motivates these organizations. In other words, although the awesome biomedical research engine represented by the NIH and the health services research engine represented by the AHRQ are certainly the envy of the world, what value do we have to show for this investment? When the United States ranks number 17 in the world (behind Slovenia) with regard to the quality of life of our citizenry, I would argue that we have not achieved a great return on this sizable investment.3

We need a new type of research framework. The questions become what should be the components of this research framework, and who ought to drive it?

Dr Casalino eloquently describes what the components of the new research framework should be. He has gone so far as to establish the criteria for selecting the priority areas for delivery system research, and these are detailed in his article.1 It should come as no surprise to our readers that Dr Casalino considers the critical framework to involve an evaluation of accountable care organizations, patient-centered medical homes, and other components of the Affordable Care Act. I have discussed many aspects of this exact challenge in this column previously. Dr Casalino goes on to ask probing framework-like questions regarding “what effects, if any, does the structure, process, or incentive have on areas for care not directly related to it? For example, do large organizations score better on typical measures of quality but not on areas of quality that are not typically measured (eg, timely diagnosis)?”
I concur with most of the framework discussion articulated by Dr Casalino. So where should this new work occur, and who should support it? Dr Brenner is seeking a “scientific revolution of better care at lower cost,” and he declares that the revolution will not be led by academic health centers alone, because they are at risk of losing too much.\(^2\) He believes that “the underpinnings of their financial model would collapse if their unneeded bed capacity went occupied.” Finally, Dr Brenner proposes that the creation and support of industrial population health research laboratories in disparate locations across the country be funded by private foundations. This industrial population health resource, as he describes it, would be led by community-wide, nonprofit organizations with broad stakeholder and community support. Local hospitals may be participants in this process.\(^2\)

I have tremendous respect for both Dr Casalino and Dr Brenner. I believe that they have come, largely, to the same conclusion—it is the system. We desperately need more insight as to what will deliver the greatest care at the highest level of value to the largest number of patients. However, I do not agree with Dr Brenner that a local coalition of not-for-profit organizations is going to make it work. Nor do I agree with Dr Casalino that more AHRQ funding is the answer to gaining a better understanding of the culture and leadership. I think they are both off the mark in this regard.

My own view is to “let 1000 flowers bloom.” Let the private sector, driven by powerful and inexorable market forces, recreate the healthcare system. Let private organizations build the platforms to create population health registries, create the companies that will deliver economic incentives for patients to change their behavior, and ultimately, and perhaps in a messy way, we will get to a population health agenda that our nation so desperately deserves.

As always, I am interested in your views, and you can reach me via e-mail at david.nash@jefferson.edu.

References