

# Health Policy and the Politics of Research in the United States

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**Abstract.** During the past decade research has been more important to the health policy-making process in the United States than at any time in the past. This article describes and assesses three competing normative models for research on health affairs: economizing, social conflict, and collective welfare. The three models provide a context for the history of research bearing on health policy in the past half century, with particular pertinence to the years since 1980. The article concludes with a discussion of some of the consequences of the new legitimacy of research.

During the past decade research has been, rather unexpectedly to many people, more important to the health policy-making process in the United States than at any time in the past. From the 1930s to the 1980s, most of the people who did research pertinent to health policy frequently complained that their work was irrelevant or marginal to major policy decisions. Their contemporary counterparts have a different problem: addressing the consequences of increasing prominence in public decision-making. In particular, they must worry about the adequacy of a normative model of the purposes and methods of research that assumes that regulating expenditures for health services and assessing their results are more important than achieving collective welfare or resolving conflicts among social classes, racial and ethnic groups, or generations.

My overall theme is that the purposes and methods of any research that influences health policy must be consistent with the values (or more broadly the ideas, as I will define them below) held by the most influential people in American politics at any time.<sup>1</sup> This consistency is not the only condition that research must satisfy

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1. This article is grounded in my experience as a researcher, research manager, editor, consultant,

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to be relevant to policymakers, but it is a fundamental one. During the twentieth century, objectivity, value neutrality, and thoroughgoing relativism have proven to be elusive goals for social scientists who aspire to influence policy.<sup>2</sup> They are valuable goals because they remind us and our sponsors of the highest aspirations of science. Nevertheless, they do not yield practical answers to the question most often asked of experts by legislators and appointed public officials: "So what?"<sup>3</sup> In exchange for influence on policy, for answering "So what?" many social scientists have chosen to advocate or at least acquiesce in particular values and their consequences for policy. Our choices have not always been conscious. Most of the social scientists who study health affairs have not, or have not systematically, asked themselves what values they want to support or to promote, what they believe about disputed issues of social choice, or even what incentives would lead them to embrace or dismiss particular goals for social policy.

My purpose in this article is to promote discussion among the participants in what we often call the research community (another normative concept that is usually used without reflection).<sup>4</sup> I would like us to discuss more forthrightly the consequences of the values that guide the questions we ask in our research and that influence the methods and data we choose to answer them. I am particularly concerned about the values that guide our answers to such questions as these: What do we believe to be right and desirable goals for health policy? What compromises with those beliefs do we consider acceptable?<sup>5</sup>

In the analysis that follows, I describe three competing normative models for research on health affairs and assess their recent history and contemporary status. These models are economizing, social conflict, and collective welfare. I caricature each of these models because I intend, as a strategy of argument, for readers to see themselves oversimplified and their antagonists skewered in my descriptions.

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professor, university administrator, and public official. As a result, some of my observations are the result of formal inquiry, while others derive from my being a privileged witness to events or from conversations. Few of the people I quote or whose behavior I describe agreed to be my research subjects. As a consequence, I cannot ethically identify most of the quotations or behaviors I describe here. I have, moreover, chosen not to clutter the text with citations to articles in journals that exemplify my generalizations about models of research or to well-known secondary sources that describe the history of health affairs and policy during the past half century. I have reached the generalizations in this article by being a participant in the events I describe.

2. A recent assessment of these issues as they apply to historians, but with important implications for other social scientists, is Novick (1988).

3. I am grateful to Senator Charles Bruner (Iowa State Senate) and Representative David C. Hollister (Michigan House of Representatives) for persuading me, over several years, that "So what?" is the most important question elected officials ask about research.

4. Peter Buck of Harvard University first called my attention to the normative use of the phrase *research community*, which often does not quite describe how the people who do research in any field actually behave toward each other.

5. I do not preach and am demonstrably not righteous. In my own career in social science research, I have often been insensitive to and just as often disingenuous about the normative implications of my work. I have described aspects of this disingenuousness (or disingenuity, since it was a cover for my identification with the "irrelevant" discipline of history) in a previous paper (Fox 1985).

(I also intend a modest satirical comment on the limits of modeling; that is, of oversimplification as a means of improved understanding.) The purpose of my caricatures is to make more vivid the normative bases of our work. I have, of course, employed all three models during my own career and have shamelessly, but only occasionally cynically, baited adherents of the ones I was not using.

I should explain the inescapably vague concept of values or, as I prefer, ideas, in both politics and research. The politics that gives us our health policy is driven by three factors: ideas, interests, and illness (Fox 1989). By *ideas* I mean what are usually called values, that is, strongly held opinions about the purposes of human beings and societies; ideologies, or perhaps more accurately political principles, that are derived from values; and what I call operating assumptions, untestable opinions, grounded in values and ideologies, about how the world works, such as the significance of science and technology or of such socioeconomic arrangements as classes, races, ethnic groups, markets, corporations, and nonprofit associations. By *interests* I mean what individuals, usually acting through or allowing themselves to be spoken for by organized groups, believe to be good for themselves. By *illness* I mean the events, some well understood, others not, that lead to particular patterns of morbidity and mortality in the populations that compromise a society. My concern in this article is with the ideas, as I have just defined the word, that drive health politics and policy-making and with the normative models of research chosen by social scientists who want to influence policy.

The ideas that have mattered the most in health politics in the United States in the last half century, according to a vast literature, include the following: the rights, liberties, and welfare of individuals matter more than any concept of the collective (or public) interest; private-sector or public-private solutions to social problems are almost always superior to public remedies; as a test of the effectiveness of policies and the institutions that implement them, efficiency is more important than benefit to a community; and wealth and poverty are mainly economic conditions rather than statuses acquired or ascribed as a result of class, racial, ethnic, gender, or geographical characteristics. In addition, for most of the twentieth century the ideas governing health politics have included the belief that medical science is inherently progressive and that, as a consequence, the established methods of producing it offer an organizing principle for health services.<sup>6</sup>

The story I tell here is about how these ideas have influenced research on health services and policies. I do not tell that story chronologically, which would improve the paper as historical science but make it less accessible to colleagues whose methodological loyalties are to political science, economics, sociology, or medicine. Instead, I begin with the recent past in order to describe the substantial influence of research on health policy in the 1980s. Next, I characterize the three

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6. I have written elsewhere about this idea and the recent loss of confidence in it (Fox 1986, 1988, 1989).

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normative models for research on health policy that social and medical scientists in the United States have employed during the past half century. I then describe how one of these models, economizing, became ascendant beginning in the late 1960s. By *ascendant* I mean dominant rather than determining; that is, this model was available to influence policy when events made research based on it useful to the makers of political decisions. Finally, I speculate briefly about the implications of my analysis for research in the future.

#### *Research and health policy in the 1980s*

Research had considerable importance to people who made health policy in the United States in the 1980s. The creation of the Medicare Prospective Payment System was the most prominent application of research to policy in the decade. The basis of this system, which substitutes administratively calculated prices for cost-based reimbursement, are diagnosis-related groups (DRGs). DRGs are a method devised in the mid-1970s by Yale researchers of relating inputs and outputs in hospital care. A number of states have extended the DRG-based payment system to other payers.<sup>7</sup>

Research on physicians' fees influenced policy in 1988 and 1989. As a result of congressional action on a recommendation by the Physician Payment Review Commission (PPRC), the Health Care Financing Administration (HCFA) is implementing what, in jargon, is called a resource-based relative value scale in order to pay physicians in different specialties who treat patients under Medicare.

Research on the results (conventionally called outcomes) of medical intervention has begun to affect policy. The findings of several studies of outcomes (mortality studies, randomized controlled trials, and small-area analyses) have been reported in leading newspapers and newsmagazines, have been cited in testimony on pending legislation, and, in some states, have been the basis of decisions about whether to certify hospitals to perform particular procedures. Data on comparative rates of mortality in different DRGs among hospitals, issued annually by HCFA since 1987, have become headline news in the print and electronic media, to the embarrassment of institutions reported as having an "excess" of deaths among their patients. In 1989, the Bush administration proposed and Congress authorized significant expenditures for research on the outcomes of medical interventions. Most of this research is being conducted by the new Agency for Health Care Policy and Research, formerly the less prominent National Center for Health Services Research and Health Care Technology Assessment (NCHSR/HCTA).

This recent recognition of the importance of research to health policy is influencing senior appointments in federal agencies. In May 1989, for example, the secretary of Health and Human Services designated Drew Altman to head HCFA.

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7. DRGs are one of the few subjects in recent health policy on which there has begun to be a historical literature (see Menges 1986, for example).

Altman, who holds a doctorate in political science, has been identified with the practical application of research as a foundation executive and a state official. After Altman withdrew his name from consideration, the secretary nominated Gail Wilensky for the position. Wilensky, an economist, has been an influential researcher in academe, government, and the consulting industry.

The organizational map of the health services and health policy research community has changed in the past decade. The most visible innovations have been in the upgraded NCHSR/HCTA and the organizations that serve Congress, but there have also been changes in the executive branch, in the voluntary and private sectors, in state government, and in universities. Two long-established congressional agencies, the General Accounting Office (GAO) and the Congressional Research Service, have become more aggressive and sophisticated evaluators of health policies and programs. Two congressional agencies established in the mid-1970s, the Office of Technology Assessment (OTA) and the Congressional Budget Office (CBO), routinely produce studies that influence legislative decisions. Two commissions established by Congress, the Prospective Payment Assessment Commission and the PPRC, have major roles in commissioning and synthesizing research applied to policy.

Expenditures by the executive branch of the federal government for research bearing on policy grew during the 1980s. The budget of NCHSR, which had declined in the 1970s, increased as the organization acquired new tasks. The National Center for Health Care Technology, which had been abolished in the first year of the Reagan administration as a result of combined opposition from manufacturers of medical equipment and the American Medical Association (AMA), was reborn in 1985 as part of NCHSR/HCTA. Manufacturers and organized medicine now actively support independent assessment of new health care technology. Beginning in 1986, NCHSR/HCTA and the National Institute of Drug Abuse have received additional funds for research bearing on policy for HIV infection and related diseases.

Important changes have occurred in the array of institutions that employ the researchers who compete for grants and contracts bearing on health policy and who serve as consultants to public agencies and foundations. Less research pertinent to policy is produced in universities now than twenty or even ten years ago.<sup>8</sup> Moreover, the most successful university-based health policy research centers (at the University of California, San Francisco, the University of North Carolina at Chapel Hill, and the Johns Hopkins, George Washington, and Georgetown Universities, for example) are managed like the most effective private and independent

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8. This is, of course, an impressionistic statement based on my assessment of the relative prominence of researchers employed by independent research organizations, consulting firms, and trade associations. I do not intend to be dismissive of research conducted by academics; indeed, most of the innovations in the theory or methodology of research applied to health policy continue to occur in universities.

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nonprofit research organizations rather than like traditional academic centers linked to disciplinary departments. Within universities, more researchers, including social scientists, whose work bears on health policy are based in business, law, medical, or public policy schools than in social science departments. Studies of high quality and considerable influence on policy have been conducted by such private sector groups as Lewin/ICF and by such nonprofit organizations as Battelle Memorial Institute and the Center for Health Affairs of Project Hope, the RAND Corporation, and the Urban Institute.

Two significant changes have occurred in the research commissioned or performed by interest groups. The first is a change in the groups that seek to be represented by research, as well as by the more traditional methods of lobbying, in debates about health policy. In the 1970s, hospitals and the Blue Cross Association were the most visible trade groups that conducted or commissioned reasonably objective research. These organizations have now been joined by groups representing private industry (e.g., the Washington Group on Business and Health and the Employee Benefits Research Institute), the elderly (American Association of Retired Persons), children (Children's Defense Fund), and private insurance companies (Health Insurance Association of America [HIAA]). Organized labor, which supported research pertinent to health policy from the 1930s to the 1970s, has, with limited exceptions, ceased to do so.

The second change is that many of the trade associations and advocacy groups employ researchers who have substantial credentials, including regular publication in refereed journals. Moreover, people with backgrounds in research bearing on health policy can now become senior executives in these groups. A notable example is Carl Schramm, president of HIAA and former director of the health policy research center at Johns Hopkins University.

Although the increased importance of research for health policy has been most noticeable at the national level, there is also more activity in the states. Several states commission faculty members from their public, and occasionally from their private, universities to do studies that bear on policy (e.g., California, New York, North Carolina, and Utah). Several states have established commissions empowered to do research pertinent to policy bearing on health care costs. Some states (e.g., Michigan and New York) mandate that such studies be done by executive branch agencies.

Most of the studies commissioned by federal and state officials are rigorously empirical and highly quantitative. The core disciplines of research pertinent to health policy, to judge from published studies and reports, are now epidemiology (both general and clinical), economics, biostatistics, operations research, and the branch of sociology that studies organizational behavior. Research that employs the qualitative or historiographic methods of sociology, anthropology, or political science rarely has any influence on contemporary policy-making.

Investigators are more modest about their goals, and many more of them are less willing to be drawn into polemics, than ever before. Although many re-

searchers will, when asked, offer opinions about the costs and burdens of alternative proposals for policy, they often hesitate to do so in public. More important, many researchers insist that their recommendations for policy have no basis in values or principles. As a senior researcher for one of the congressional commissions recently wrote to me, "We're more comfortable with discussions of technical matters and analysis than with discussions of justice and fairness."<sup>9</sup> Moreover, the authors of research studies often choose to present their findings as if they had emerged magically from data rather than from systematic inquiry using the paradigms of particular disciplines. During a lecture at a medical school, for example, a leading expert on physicians' practice behavior once said, with a barely perceptible wink that went unobserved by most of his appreciative listeners, "I'm an epidemiologist, I don't have hypotheses."<sup>10</sup>

An important reason for the recent ascendancy of research in health policy is that investigators and their sponsors have similar values. Historically, Americans have distrusted intellectuals, not knowledge. Many are hostile, not to research—witness, for instance, the enormous prestige in this century of scientists and engineers—but rather to those who proclaim that the life of the mind (and by implication the people who live it) is superior to that of the marketplace. Many who consider themselves intellectuals have either claimed such superiority or had it attributed to them. The number of intellectuals, by this definition, who do research on health policy has declined markedly in the past quarter century. In the 1980s, few researchers who worked on issues affecting health policy claimed that elected and appointed officials got things wrong because they were insufficiently analytical or had the wrong values. Researchers in this field share the values and goals of those who pay them, just as most other consulting professionals (physicians, lawyers, and accountants, for instance) have done for centuries.

In sum, in the 1980s the people who did research on health policy and those who made it had a great deal in common. Events in that decade, as Lawrence D. Brown (1990) has recently described, precipitated shared ideas into such new policies as the Medicare Prospective Payment System and the recent changes in how Medicare will pay physicians. My concern in what follows is with ideas: with the alternative models available in recent decades for research on health policy; with the process by which one of those models became ascendant, while the others

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9. The researcher is David Colby (letter of April 1989). I cite him because he is the only person I quote in this paper whose remark followed a formal inquiry.

10. The researcher was John Wennberg, the medical school the State University of New York at Stony Brook. I cite him by name because the remark was made at a public lecture. The foregoing generalizations about the character of contemporary research bearing on health policy are not intended as criticisms of either researchers or their sponsors. Readers who are familiar with my work know that I have collaborated in studies of the kind I have just characterized and that I have frequently defended their integrity and importance (see Fox and Thomas 1989). That I have also contributed discipline-based, hypothesis-driven research only helps me to appreciate that mind workers can employ different conventions for different audiences.

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receded in importance; and, finally, with whether, because history is cyclical or because men and women behave in ways that sometimes make it seem so, that ascendancy is in jeopardy.

***Alternative models for research on health policy***

I want to characterize more precisely the assumptions shared by researchers and those who pay them before suggesting an explanation for the ascendancy of research in health policy. I classify these assumptions into three normative models of research: economizing (not, as I will describe shortly, to be confused with economics), social conflict, and collective welfare.

Before explaining these models, I issue two warnings. The first is that, viewed internationally, each model has been the basis of a wide range of political behavior along the conventional left-center-right spectrum. For example, most economizers in the United States are centrist or right of center in their professed politics. But their counterparts in Canada and Western Europe often use the methods and concepts of the economizing model for ends that they describe as left of center. As one Canadian economist said in response to an earlier version of this article, "I think it is important to emphasize consumer sovereignty as well as commodities." Similarly, I have recently learned from doing research in Hungary that the economizing model is entirely compatible with the entire spectrum of political beliefs about the most desirable immediate future for what used to be the Communist party (Hungarian policymakers have, for example, defined DRGs as technical devices independent of values or ideology).

The second warning is that within the United States, the models I sketch are oversimple descriptions (like all models, of course) of human behavior. Many researchers in this country have behaved as economizers because they view that model as leading most effectively to grants, contracts, publications, jobs, tenure, and influence on policy. A number of researchers who have spent their careers working within that model have recently tried to reason their way to a national health insurance program that includes universal coverage without changing their fundamental assumptions about the priorities of research or appropriate methods of analysis.<sup>11</sup> Throughout the ascendancy of the economizing model, proponents of alternatives to it have found it in their interests to caricature the views of its adherents. During a meeting of the American Sociological Association in the late 1970s, a distinguished investigator privately accused me of being a political conservative because I was employed by NCHSR. He explained that anyone who could work for an agency that had shifted its research priorities from issues involving

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11. A notable example are the important contributions of Alain Enthoven. I must emphasize again that I intend no criticism of Enthoven or anyone else by describing them as working within a normative model.

access to matters of cost, quality, and manpower did not have a strong commitment to the welfare of the poor.

**Economizing.** Many, perhaps most, of the people who call themselves health services or health policy researchers and their sponsors in the United States describe the health polity as a sector of the economy. The institutions of this polity, in their formulation, produce commodities or what can, with caveats, usually be regarded for analytical purposes as commodities, for consumption by individuals. They also produce externalities (nonmarket effects) that have a generally benign influence on society. As a sector of the economy, the polity can therefore usually be understood best through the principles of economic science. Changes in health policy occur most efficiently by way of economic incentives and disincentives, notably those provided through regulation (which includes rules to stimulate competition).

The health sector cannot, however, be comprehended by economics alone. Understanding the behavior of its institutions also requires study of how people behave in complex organizations dominated by professionals. Moreover, the commodities produced by the industry should be evaluated by other criteria than whether consumers continue to purchase them. In part this is so because the health sector is structured so that third parties (public and private insurers and welfare programs), rather than individual consumers, exercise most of the effective demand. More important, it is a result of the complicated effects of health services on consumers. Health care, unlike most other commodities, either leaves consumers unaffected or makes them sicker, better, or dead. Thus the logic of other disciplines, notably epidemiology and biostatistics, must be employed to evaluate the effects of health services on particular populations. For simplicity, I call these assumptions about the health polity and studies based on them the economizing model in order to suggest that the research, though based on economic reasoning, embraces some other considerations.

While I was preparing this article, I participated in a meeting at which two economists, one from Thailand, the other an American employed by the World Bank, offered a vivid illustration of the economizing model. The Thai insisted that a "certain amount of equity should be allowed for as a constraint in the development of efficiency." The American replied that "in most countries today there is no trade-off between equity and efficiency."

**Social conflict.** Adherents of this model assume, in contrast to economizers, that health care is a set of necessary services that people who are better off usually want to withhold from, or provide sparingly to, people who are less well off. This selfishness often includes provision of inferior services to members of different ethnic or racial groups, residents of particular geographical areas, or even other generations. Adherents of a social conflict model insist that decent health care for everyone, like decent wages, can be obtained only as a result of struggle between

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the owners and the producers of wealth (or between the dominant and subordinate classes, races, regions, or generations).

In this model, the primary goals of research bearing on health policy are documenting the consequences of inequality of access and entitlement to services for morbidity and mortality; describing for enlightened business and political leaders the benefits of a healthier work force; and assessing the size and strength of the interest groups that seek either to change or to maintain existing policies. This model has been unfashionable in the United States since the 1960s. Echoes, and often more than echoes, have been heard in the past decade in the claims of some researchers associated with the disability rights/independent living movement and from advocates of Jesse Jackson's Rainbow Coalition.

*Collective welfare.* Adherents of this model assume that health care, unlike other commodities, is a set of unique services that societies owe to each of their citizens in order to promote the well-being of all of them. They generally believe that the logic of collective interest in well-being, rather than conflict or competition, is (or should be) the engine of innovation in health policy. Health, they claim, like defense (and, in many formulations of the argument, housing and education), is only to a limited extent an appropriate subject for economic analysis. Researchers should study the consequences of different levels of expenditure for services in order to maximize health (defined broadly as well-being or narrowly as less morbidity and lower mortality rates). Health is not primarily a market phenomenon; it is a social utility which should be the subject of research, in a variety of disciplines, designed to provide more of it to more people within the budget that society has allocated.<sup>12</sup>

The salience of the collective welfare model has recently been remarked on in unusual forums. For example, the *Economist* (1989), the London-based news-magazine, in summarizing research findings about the health services industry in the United States, reflected that "healing the sick has for centuries been an act of charity. Why should a few MBAs think they could change it into a money-making proposition in just a few years?"

Although contemporary researchers on health policy in the United States occasionally make use of the conflict and collective welfare models (and a few use each of them exclusively), most of us are more comfortable as economizers. Moreover, most of the officials who make policy and the organizations that sponsor health services research prefer an economizing model. Adherents of social conflict or collective welfare models would not accord priority to studying the outcomes of a list of medical interventions, manipulating mechanisms to pay physicians and

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12. Notable examples are the essays by deJong et al., Scotch, and Zola in Fox and Willis (1989). The same collection also includes papers that use economizing (e.g., Robinson) and social conflict (e.g., Markowitz and Rosner) models.

hospitals, or figuring out how to offer the most insurance for catastrophic illness and long-term care at the lowest cost. They would want to reorganize the priorities of research to emphasize the consequences of our existing policies for health. In particular, they would emphasize what an earlier generation of researcher/reformers in the United States called misery and its causes, and would recommend who should be made to do what by what political means to reduce misery.

For most of the history of research on health policy in the United States—that is, from the 1890s to the 1960s—the social conflict and collective welfare models dominated research bearing on health policy. The few investigators who used earlier versions of an economizing model usually worked for organizations committed to preserving the status quo in health affairs. Two such organizations were the AMA and the Prudential Life Insurance Company, both of which employed researchers of considerable technical skill whose guiding model often offended many of their colleagues in universities and research organizations.

### ***Before the 1980s: Mobilizing health services research***

Researchers who preferred either a social conflict or a collective welfare model of the health polity had their greatest success from the late 1920s to the early 1950s. A collective welfare model was the basis of the numerous monographs on the cost and utilization of health services that were commissioned by the Committee on the Costs of Medical Care, a policy inquiry financed by ten foundations between 1927 and 1933. In the mid-1930s, the foundations most active in research bearing on health policy, the Commonwealth Fund, the Milbank Memorial Fund, and the Julius Rosenwald Fund, conducted studies based on both class (or interest group) conflict and collective welfare models. Until the late 1940s, researchers who used these models held influential posts in the federal Social Security Board (later Administration) and in the Division of Public Health Methods of the United States Public Health Service. Others worked for industrial unions (notably coal, steel, and automobiles), for the few craft unions with ambitious social agendas and leaders who had socialist sympathies (for instance, the men's clothing and ladies' garment workers), or for the national labor federations.<sup>13</sup>

In the late 1930s, a group of researchers associated with the collective welfare and social conflict models devised proposals for national health insurance. Senator Robert Wagner and (the first) Congressman John Dingell introduced legislation based on their proposals in Congress, though without White House support. For a few years, from 1948 until 1951, national health insurance was part of the program of President Truman. Many of the researchers were optimistic.

But when national health insurance was defeated, as a result of congressional elections in 1950 and the Eisenhower landslide two years later, the leadership of

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13. I have elsewhere described the primary sources of some of the history in this section (Fox 1979, 1986).

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research on health services also began to change. Most of the research on health services in the 1950s was sponsored by health planning agencies, hospital associations, the pharmaceutical industry, large prepaid group practices, and city and state health departments. The names of many of the people who did this research are familiar to anyone who followed the journals in the field between the 1950s and the early 1970s: for example, Odin Anderson, Lester Breslow, George Bugbee, Paul Denson, Eli Ginzberg, Herbert Klarman, C. Rufus Rorem, and Sam Shapiro.

These investigators disagreed with each other about many significant matters of methodology and policy. I emphasize here their agreement that research on health services that could influence the policies of public and private organizations needed to focus on discrete questions, to strive for objectivity, and to be carefully grounded in the theories and methods, especially the quantitative methods, of the social sciences and epidemiology. Moreover, they chose issues for research that could lead to policy decisions within the authority of acquaintances in power in public, voluntary, and private organizations. They were pragmatists at a time of lowered expectations for American social policy and for research to improve it, and at a time when pluralism (the theory that mutual accommodation among interest groups led to a generally decent society) was the dominant ideology in American politics as well as in academic sociology and political science. Their studies of the utilization and cost of services, of the behavior of professionals, and of the design of facilities and the organization of work within them set the agenda for research pertinent to health policy for the next two decades.

The researchers who had used social conflict and collective welfare models as the basis for both analysis and advocacy and, in their view, had been close to success in the late 1940s were out of power and, with a few exceptions, would remain outsiders. A number of them accommodated themselves to the new pragmatic research agenda, occasionally with considerable bitterness. A few others remained vigorous advocates of conflict and collective welfare models as staff members of labor organizations or, occasionally, large prepaid group practices. When people who used these models retired from university positions, they were usually replaced by pragmatists, often by pragmatists who worked within an economizing model. The adherents of class conflict and collective welfare inspired some younger men and women who were primed by the New Left radicalism of the 1960s. But most of these disciples either joined the mainstream of research or remained at the margins of the growing field of health services research.

A series of related events in the 1960s stimulated additional institutional support for investigators who approached research on health services with an economizing model. The study of the economics of health care achieved higher status as a result of the involvement in it of major figures in economic science, notably Kenneth Arrow and John Dunlop. Many of the younger health economists combined mathematical theory and labor economics in the contemporary variant of the institutional tradition, which gave their work considerable prestige among other econ-

omists and increased its immediate pertinence to health policy, particularly for assessing the initial impact of Medicare and Medicaid. By the late 1960s, the reputation of these health economists was also rising among a few prominent medical school deans (notably Robert H. Ebert, then dean of the Harvard Medical School) and in the legislative branches of the federal government and some of the states.

In the late 1960s, moreover, hospital administrators redefined academic preparation for their profession to require significant exposure to pragmatic health services research based on the economizing model. This research applied the new health economics and organizational sociology to hospital operations and finance. The graduate programs in hospital administration at business schools, especially those of the University of Chicago and Northwestern University, were widely emulated. Hospital administration programs soon employed a significant number of health services researchers.

The late 1960s were an opportune time to conduct research bearing on health policy. The health program of the Johnson administration included funding to study the impact and operating problems of Medicare and Medicaid, neighborhood health centers, subsidies for medical education, comprehensive health planning, the dissemination of biomedical technology, and community-based programs in mental health and mental retardation. Innovation was, temporarily, routine; so was research to evaluate it. Thus, in 1966 Assistant Secretary for Health Philip R. Lee, the most powerful health official in the nation's history to that time, established a National Center for Health Services Research and Development to sponsor studies bearing on health policy.

The increased availability of funds for health services research as a result of Great Society programs temporarily stimulated a few studies derived from the social conflict and collective welfare models. Most of the researchers who used these models were sociologists, psychologists, or physicians who worked in schools of medicine or public health and were personally and ideologically involved in such reformist initiatives as neighborhood health centers. These researchers were soon without funds or significant influence on policy.

The institutions of the burgeoning field of health services research were increasingly dominated by the people I have loosely defined as pragmatists committed to an economizing model. These pragmatists were a coalition of people in a variety of disciplines who defined objectivity as highly quantitative empiricism. Most of them used or appreciated the techniques of economics, biostatistics, and epidemiology. Some members of the coalition who had been trained in sociology even began to call themselves social epidemiologists (often for intellectual reasons, sometimes because it led to higher pay in medical faculties); political scientists began to prefer being identified as policy analysts.

By the early 1970s, adherents of the economizing model controlled some of the major institutions in the field. Gerald Rosenthal, a former student and colleague of John Dunlop, became the director of NCHSR in 1974. NCHSR's leaders were pleased when Public Health Service officials removed the center's mandate to dem-

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onstrate alternative approaches to organize and “deliver” health care. They were pleased to give priority to studies of the cost and quality of health care (Fox 1976). In the next few years the principal achievements of NCHSR were recruiting talented economists to its newly established intramural research program (including Gail Wilensky, who in 1990 became administrator of HCFA) and conducting a generously funded national household survey of medical care utilization and costs. The HCFA research program, which had been established to sponsor research on the costs and benefits (or effectiveness) of the Medicare and Medicaid programs, grew faster than that of NCHSR. The third major source of funds for research on health policy, the Robert Wood Johnson Foundation, invested mainly in studies of the cost effectiveness of its demonstration programs in health care financing and organization.

The editors of the leading journals in the field gave increasing space to articles whose authors employed the methods of economics and epidemiology or at least assumed that health care was, for most analytical purposes, a commodity. By the late 1970s, most researchers and a number of policymakers regarded the *Milbank Quarterly* (under a somewhat different name), which had helped to define the new field of health services research in a 1967 supplement, as the most prestigious outlet for rigorously objective papers that had a strong bearing on policy. The new *Journal of Health Politics, Policy and Law* set out to serve researchers, primarily from political science, hospital administration, and law, who wanted to apply the techniques of policy analysis to health policy. Articles in *Health Services Research* and *Inquiry*, as well as in other journals, were increasingly quantitative and focused on questions which assumed that the institutions of the health polity should be analyzed primarily as economic organizations.

The priorities of research sponsors and journal editors influenced the market, especially its academic sector, for researchers interested in health policy. Jobs in professional schools and social science departments were offered most frequently to people who used the methods of economics, policy analysis, epidemiology, and biostatistics. Responsible teachers reinforced the implications of these events, advising graduate students who could not accept the dominant model of research to try another field.

By the late 1970s, then, the institutions of health services research had been reorganized to apply the economizing model to policy. Meanwhile, three events in the political life of the United States were supplying a new constituency for health services research: skepticism about technology, the economic shock precipitated by the oil crisis of 1974, and institutional changes in the legislative branch of the federal government.

By the early 1970s, influential political leaders in Congress and the executive branch had concluded that technology too often yielded burdens as well as benefits. This conclusion, initially in the areas of defense, the environment, and highway safety, led to the invention of technology assessment as a new area of multidisciplinary applied research. Public officials now demanded studies of the effects

and effectiveness of new and even established technologies. In health affairs, funds for technology assessment became available as a result of controversies about kidney dialysis and transplant, of the incidents that led Congress to expand the authority of the Food and Drug Administration to regulate medical devices, and of pressure from manufacturers and physicians to cover particular new drugs and devices under Medicare and Medicaid. Many of the questions asked by researchers in the 1980s about the outcomes of health care and the methods they use to answer them have antecedents in studies of the use, quality, and effectiveness of health services that were conducted in the 1970s.

The economic crisis that began in 1974 made cost containment the major priority of health policy. An unprecedented combination of inflation and recession in the general economy caused employers to complain about the rising cost of health benefits for their employees, a cost that in times of prosperity they had passed on to consumers. Declining state and federal tax revenues created pressure to reduce or at least restrain growth in the costs of Medicare and Medicaid. Many leaders of business and government found persuasive arguments by economists, notably Martin Feldstein, that public and private health insurance programs created perverse incentives to overutilize medical and especially hospital services and therefore led to higher costs. Many business leaders were also sympathetic to arguments by lawyers (Clark Havighurst, for example) and economists that much of the inflation in medical care costs was the result of policy made by woolly-minded liberals who believed that health care was special, a collective good, not a commodity. National health insurance, which had been proclaimed imminent for several decades, ceased to be on the national agenda after about 1977 (except for some weak, at times pro forma, efforts by the Carter administration and a few members of Congress). Organized labor, which had been the strongest interest group supporting national health insurance, effectively ceased to be an influential force in national health affairs, although it remained powerful in collective bargaining for benefits in particular industries. As the 1980s began, studies that proposed or evaluated methods to control costs had a large and growing audience and receptive sponsors.

Institutional change in the House of Representatives created a new and effective constituency for incremental innovations in health policy and for research to assess their potential effects. This constituency consisted of congressmen and their staffs, who were more specialized and more insulated from the power of national lobbying groups than ever before (Brown forthcoming). A successful revolt in 1975 against the seniority system in the House led to the proliferation of subcommittees in increasingly specialized areas. Staff members and often the chairs of these subcommittees became more knowledgeable consumers of research knowledge. At the same time, the budget reconciliation process, adopted in response to the impoundment practices of the Nixon administration, made it more difficult for lobbyists to insert and remove (and often to know in advance about) seemingly minor points of legislation which could have an enormous impact on policy. Congressmen

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and their staffs used the results of health services research to influence financing policies in the annual budget reconciliation acts. Simultaneously, changes in campaign financing laws protected incumbency, further insulating congressmen from interest groups. The new congressional agencies (CBO and OTA) and the reoriented GAO also responded to increasing congressional demand for research bearing on health policy.

As the 1980s began, then, the people who produced and consumed research on health policy in the United States had stronger mutual interests than ever before. Most researchers worked within the economizing model (note, for example, the preceding sentence). They had outlived, outtheorized, and outmaneuvered colleagues who believed that research pertinent to health policy should be guided by assumptions about social conflict or collective welfare. They plausibly claimed objectivity (not neutrality, since they would offer opinions on policy if asked) and usually did not care to discuss the evidence that their definition of objectivity offered more moral comfort to politicians of the right and right of center than to those of the left and left of center.

Most of the policy professionals who used the results of research on health services did so because they recognized the convergence between the ideas that energized the economizing model and their own views. They used the research not because it was there or because researchers were eager to help them, but because they decided that the results of research helped them to promote priorities and agendas that had other sources in the political process.<sup>14</sup> These research results provided policymakers and their staffs with information that could be used to advance the major items on their agendas, notably containing growth in the cost of health care, making providers and their patients more responsive to economic incentives, and increasing the financial responsibility of state and local government for means-tested programs for the poor and the medically indigent.

Recent research on health services provided useful information to policymakers without creating any politically hazardous ambiguity about whether they agreed with, or even knew, the investigators' political preferences. For the first time in the century during which Americans have done research bearing on health policy, investigators, their sponsors, and most of the potential users of research results shared fundamental ideas. Moreover, the institutions of the research and the general political communities had been structured to respond to this convergence. Good science was now good politics for people who cared about health policy, as it had been for a generation for those involved with biomedical research.<sup>15</sup>

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14. I am indebted to Lawrence D. Brown for this generalization.

15. Ironically, in 1990 some well-connected observers of the politics of biomedical research were worrying that the recent appropriations for studies of medical effectiveness signaled that the conventional wisdom that laboratory science leads to better health status was losing its power to leverage money from Congress and the executive branch.

***The new legitimacy of research***

Researchers who lament their marginality in policy and policymakers who complain about the inconclusiveness or the obscurity of research results usually forget to ask a question that has an empirical answer: compared to what? Research is more important in health policy-making in the United States today than it has ever been. The price that researchers have paid for their relative importance in policy-making is the dominance of the economizing model. In another time or country, with another set of political ideas and interests or another perceived pattern of illness, research derived from other models (of which social conflict and collective welfare are examples) might appeal to public officials and powerful leaders of private organizations. In the United States today, such research does not appeal to more than a handful of the people who study health services and health policy, and it has no constituency among policymakers.

The economizing model is ascendant, I have argued, because, as one reader of an earlier version of this article wrote, it acquired power from "social and political imperatives." These imperatives are the dominant ideas that I earlier described as driving American politics in the consideration of health policy: ideas about individuals and social classes, the public and private sectors, efficiency, and the promise of medical science. We have the health policy that we deserve, that is, the health policy that comes from the interplay of ideas, interests, and illness in the American polity.

Some colleagues who heard or read earlier versions of this article have argued that the economizing model will be less serviceable in the near future because the dominant ideas that drive the politics of health policy are changing. Perhaps. Recent complaints by large industrial employers about the cost and inadequacy of health insurance and the proliferation of state initiatives to address the uninsured may be signs of fundamental change. But it is also useful to remember that in 1989 Congress voted overwhelmingly to repeal catastrophic insurance under Medicare, and that in 1990 almost everyone in public life, including its most powerful members, dismissed the recommendations of the Pepper commission as financially unfeasible.

I am therefore equivocal about the consequences of the history I have presented. Perhaps it is better for policymakers to be able to choose information produced by systematic analysis that uses whatever model is in fashion over knowledge based on uninformed opinion and anecdote. But perhaps not, if you believe that policymakers armed with information based on this research will ration health services to the detriment of people in the lower socioeconomic classes, or that they will deliberately create more fragmentation in health affairs in the name of competition. Perhaps knowledge based on the economizing model can be a powerful tool for policy-making, despite the well-known methodological problems of cost-benefit and cost-effectiveness analysis. But perhaps not, if normal science (in the Kuhnian sense) too often becomes a subnormal science in which investigators convince

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themselves that hypotheses are simply convenient ways to array data and that their work is innocent of ideas as I have defined them.

Where particular readers will stand on what, if anything, to think or do as a result of my analysis necessarily depends on where they sit, in Rufus Miles's classic law of political behavior. That is, the implications of my analysis for the behavior of people who study health policy will be a result of their ideas, their interests, and their perceptions of illness, the current and future epidemiological situation.<sup>16</sup>

Knowledge that bears on policy, like knowledge about anything else, is made and remade by people in particular political situations; it is, in sociologists' useful metaphor, socially constructed. Unlike people who work in some other areas of inquiry, however, those of us whose research bears on policy cannot, even temporarily, separate ourselves from the political culture (or, if you prefer a different metaphor, the policy system) in which we live. We must endure the irony of studying ourselves at the same time that we solemnly apply our methods to studying what other people have done.

### References

- Brown, Lawrence D. 1990. The New Activism: Federal Health Politics Revisited. *Bulletin of the New York Academy of Medicine* 66: 293–318.
- . Forthcoming. Knowledge and Power: Health Services Research as a Political Resource. In *Health Services Research: Key to Health Policy*, ed. Eli Ginzberg. Cambridge, MA: Harvard University Press.
- Economist*. 1989. Pay Now, Pay Later. 14 June, pp. 67–68.
- Fox, Daniel M. 1976. The Development of Priorities for Health Services Research. *Milbank Memorial Fund Quarterly* 54: 237–48.
- . 1979. From Reform to Relativism: An Intellectual History of Economists and Health Care. *Milbank Memorial Fund Quarterly* 57: 297–336.
- . 1985. History and Health Policy: An Autobiographical Note on the Decline of Historicism. *Journal of Social History* 18: 349–64.
- . 1986. *Health Policies, Health Politics: The Experience of Britain and America, 1911–1965*. Princeton, NJ: Princeton University Press.
- . 1988. The New Discontinuity in Health Policy. In *America in Theory*, ed. D. Donoghue, L. Berlowitz, and L. Menand. New York: Oxford University Press.
- . 1989. Policy and Epidemiology: Financing Health Services for the Chronically Ill and Disabled, 1930–1990. *Milbank Quarterly* 67, suppl. 2, pt. 2: 257–87.
- Fox, Daniel M., and E. H. Thomas. 1989. *Financing Care for Persons with AIDS: The First Studies, 1985–88*. Frederick, MD: University Publishing Group.

16. It will also be a result of health policy researchers' preferences among competing contemporary versions of the philosophy of science. This point, in contrast to the rest of this article, is intended as a criticism of research on health policy. I believe that our discourse about research bearing on policy would be more cogent if we took more seriously contemporary discussions about the philosophy of science, especially those bearing on epistemology and recent work in the sociology of knowledge.

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- Fox, Daniel M., and David P. Willis. 1989. Disability Policy: Restoring Socioeconomic Independence. *Milbank Quarterly* 67, suppl. 2, pts. 1–2.
- Menges, Joel. 1986. From Health Services Research to Federal Law: The Case of DRGs. In *From Research into Policy: Improving the Link for Health Services*, ed. M. E. Lewin. Washington, DC: American Enterprise Institute for Public Policy Research.
- Novick, Peter. 1988. *That Noble Dream: The "Objectivity" Question and the American Historical Profession*. New York: Cambridge University Press.