DISCUSSION

By: Sam Shapiro, H.I.P.*

As the discussant on this program, I am in a somewhat equivocal position, one might say a compromised position. For the past 4 - 5 years, I have been associated in one way or another with a number of the research projects carried out by HIF-NORC and as Walt Simmons has mentioned, for the past year or two, we at H.I.P., have been under contract with the NHSP to conduct one of their important methodological studies - the cross-checking of medical record information regarding medically attended illness against household survey reports of these illnesses.

However, I am not particularly concerned about these associations unduly coloring my views since I am also in the position of a consumer of the data being produced by the two organizations. Actually, their records of accomplishment are already so clear that I would be remiss if I were to ignore them. There is no serious discussion today of medical care financing or health insurance that does not utilize the results of H.I.F's research and the prospect is that H.I.F. will continue to play a critical role in finding solutions to the problems that plague the health insurance and medical care fields.

In the case of the NHSP, we have already seen the unusual happen - the release of a multiplicity of survey results within a few months of the completion of the field work. This undoubtedly is one of the values of the continuous sample design described by Walt Simmons. Also, major strides have been made in generating methodological studies in the brief period of NHSP's existence.

Having H.I.F. and NHSP on the same program inevitably leads to a joint consideration of their research activities. Both have a continuing concern with health and medical care - they are to be in business, hopefully, for a long time. Both have been dependent on the household survey as the primary source of information. And both have been producing base line data with an eye principally to national consumption.

There are some obvious differences of a substantive and methodological nature between the 2 organizations. H.I.F. has concerned itself with economic issues and with attitudinal and perceptional influences on health and medical care behavior. The NHSP, on the other hand, is currently concerned with measurement of morbidity, impairment, disability, volumes of medical care, types of care and the like. To be sure there is some overlap, but I think there is little danger of the 2 organizations getting in each other's way.

There are research issues that present special problems for governmental agencies to explore, which a non-governmental group can investigate <u>almost</u> without inhibition. Jack Feldman's paper is a case in point. It is focused on the probing of attitudes and the searching of socio-psychological correlates of behavior in the medical care field. These are research prongs that will continue to fall, I believe, in the province of "private enterprise."

The preview of the type of data Sheatsley and Feldman are incorporating in their book, strongly suggests that they will have a wide audience. Despite some overtones of pessimism about what the health educators are likely to get out of the material - especially since it seems to fly in the face of dogma - I think the findings are of great interest and use. The fact that a sizable minority in the population have negative attitudes on the components of doctor-patient relationship covered in the survey is important to people involved in dispensing medical care on an organized basis. It gives them a perspective on the problems they face and a framework for investigating their own situations.

I do not want to engage in a critical review of the specific points made in Feldman's paper but I do wonder whether the tentative conclusion of no association between attitudes towards doctors and receipt of medical care can be accepted without further analysis. There may be some question about the measure that was used to assess the influence of attitudes on behavior. Frequency of doctor visit is a very crude measure which may well conceal responsiveness to a set of symptoms. I think Feldman put his finger on the issue when he said "it seems that if a person recognizes that he is ill, he will generally consult a doctor no matter what he thinks of the profession as a whole." But, the point is when does a person recognize that he is ill? Do his attitudes towards the medical profession influence this recognition?

To return to my main theme, the comparison of the H.I.F. and NHSP programs, interspersed with a few critical comments, there are some interesting differences between the 2 in methodology and coverage. H.I.F. has used national probability samples for most of its major inquiries but has not hesitated to use local settings when these could help illuminate particular problems that would be difficult to investigate nationally. All of the studies are of an ad hoc nature - one-shot enterprises, with an emphasis on issues that are immediate. There is a tendency, therefore, to speed up the whole process of methodological development with calculated risks taken. There is also a tendency not to make its experiences and knowledge gained generally available. For example, in the national cost study, information reported on interview regarding hospitalization and costs was checked against hospital records. The findings of this reliability check would be of interest to other groups using the household interview as the source of data on hospitalization. But the details of this study have not been published.

One other study currently underway has the potential for providing unique data on the reliability of medical care information obtained via the household interview. In this investigation, 2 sources of information were used, with considerable overlap. The sources were the household interview and the records of physicians' services and hospital care in the health insurance plans where the families were enrolled. H.I.F. can perform an extremely useful service for the field as a whole by providing the opportunities to study

these materials in detail. Any future efforts elsewhere to exploit health insurance plan records as a source of data would profit from this experience.

NHSP is apparently even more heavily committed at this point than H.I.F. to the production of national data, with the household survey the primary mechanism. Regional data, although relegated to a secondary position, are not to be ignored, and it is to NHSP rather than H.I.F. or any other non-governmental group that we will be looking for regional information. The resources required to produce such data quickly outstrip the capacity of other groups - as witness the difference in sample size between H.I.F. studies and NHSP - about 3,000 households in H.I.F. and 35,000 households in NHSP.

Even with the production of regional data there will always be a gap in what NHSP can provide for the consumer at the local level. I do not know who should be concerned with the question of how to go from the national product to the local situation, but it does need attention and in time NHSP should be interested in advancing ideas on ways to resolve the problem.

Simmons has also mentioned that the development of trend data is an integral part of the program. This gives the organization an aura of permanence but 'permanence' cannot be bought with trend data. The longevity of NHSP will be directly related to its ability to contribute a quantitative basis for dealing with specific national problems of an immediate and long term nature. This, of course, will require a flexible program utilizing a variety of approaches, possibly including longitudinal type studies and follow-back studies aimed at amplifying a host of issues including social and economic consequences of illness, who takes advantage of rehabilitation programs, knowledge regarding these programs, etc.

Many of these issues do not lend themselves to a simple expansion of the regular interview but require special questionnaires quite different from the usual census type. Walt Simmons and Forrest Linder have put the matter succinctly in this way- "The Survey is a program of surveys, which use different approaches and have different end objectives as both the techniques and the needs for data evolve." What is left unsaid is that the NHSP has to take an aggressive role in clarifying these needs and that the development of special studies has to proceed expeditiously.

A distinguishing feature of the NHSP is the special position given methodological research. A primary objective is to find ways of improving the quality of the data. But this raises the question of how reliable the data have to be and how much of the resources should be devoted to the improvement of data. For example, if it is found that a measure of prevalence of diabetes is off by 20% are we to conclude that the figure is grossly deficient, moderately deficient, or satisfactory. Obviously there is no answer unless we know how the figure is to be used and the consequences of a specified error. This comes back to the point made previously - definition of the uses of the statistics is of critical importance.

There is one final comparison that I want to make between the 2 organizations. This has to do with background and modus operandi. The development of H.I.F.'s research program is really the product of 2 men - George Bugbee and Odin Anderson with a frequent strong assist from NORC. Whatever philosophy of action or framework or grand design for research that has emerged, is their handiwork. There are no advisory committees, no policy restrictions of serious consequences, no axes to grind. In short, the millennium! But, since part of my function is to needle, I wonder whether an occasional meeting with a group of experts in the field might not be advantageous as a way of supplementing the points of view Anderson now obtains informally. I am not suggesting a permanent advisory committee but a sounding board that has no "official" status.

NHSP came into existence with a blueprint which contributed greatly to its birth. I am referring to the document prepared in 1952 by the Subcommittee on National Morbidity Survey and called, "Recommendations for the Collection of Data on the Distribution and Effects of Illness, Injuries, and Impairments in the U.S." On rereading this report the other day, I was struck by the fidelity of the product to the model. There are to be sure, many areas which NHSP has not yet become involved in and many techniques mentioned that have not been developed or applied. The document encompasses activities that would take many years to carry out. The major problem is to determine priorities and the changes that experience dictates. It would be interesting to see the document rewritten 5 years after the NHSP started operating.

In conclusion, I believe that the consumers of morbidity and medical care data in this country have much to look forward to in the products of NHSP and H.I.F. We can only hope that a satisfactory division of labor continues and that the field will profit not only from the substantive material that is produced but from the methodological advances that will be made.

* Health Insurance Plan of Greater New York