Editorial

A Half-Century of Change

Marking 50 years of publication excellence from *Health Services Research* is an opportunity to step back and reflect on how the field of health services research (HSR) has evolved over the past half-century. In response to the evolving needs of policy makers and practitioners in the public and private sectors as well as fluctuations in funding available to support HSR, we are a very different field today. Changes span across three key components of the field: *who* does HSR, *what* questions we address, and *how* we do our work.

Through all these changes, *Health Services Research* has been a valued avenue to showcase some of the most critical findings in the field. Over the years, dozens of the AcademyHealth Annual Research Meeting's Article of the Year Winners have been published here—from assessing the health of the homeless to the dynamics of health status and health plans to HIV cost and utilization (AcademyHealth 2017).

THE PEOPLE AND ORGANIZATIONS WHO DO HSR ARE GROWING AND CHANGING

The first Annual Research Meeting of the HSR field was held in 1983 and had just over 200 attendees. The 2016 meeting in Boston had 2,910 attendees, a testament to the growth of our community. Further evidence of this growth was documented first by McGinnis and Moore (2009) and more recently by Bianca Frogner (manuscript under review at *HSR*).

Within this overall growth, there has also been growth in the background of members of the community. HSR has always been a multidisciplinary field, drawing members from diverse educational, regional, and employment backgrounds. As the health care system and its workforce have evolved, HSR has grown to attract additional disciplines such as engineering, human factors, systems scientists, demographers, and others to tackle

challenges as diverse as patient safety and social determinants of health. We have also seen that HSR is now being carried out in many more employment settings than traditional academia. Over the last decade, the AcademyHealth HSR Learning Consortium brought together training program directors and employers to understand these trends as delivery systems, hospitals, health plans, life sciences companies, and the emerging sector of data analytics companies all began to recruit well-qualified health services researchers.

As the leading professional organization representing the health services and policy research fields, AcademyHealth engages in regular surveys of its membership. Respondents from the most recent survey data available (2013) worked in the academic and private sector in equal proportions. This represents a steady shift since the 2002 survey reflecting an increase in the proportion in the private sector, while the proportion in government has remained constant (AcademyHealth 2013).

- Among those holding a master's degree (regardless of whether it was their most advanced degree), the most common field was public health (27 percent), followed by public policy (10 percent), and economics (9 percent).
- Among those holding a nonclinical doctorate, the most common disciplines were health services research (24 percent) and economics (15 percent).

That same 2013 survey found that, compared to the 2010 U.S. population, respondents were less likely to be black (4 percent), Hispanic/Latino (2 percent), and multiracial (3 percent) and were more likely to be white (82 percent) or Asian (9 percent). This is consistent with previous AcademyHealth surveys and a pattern shared by the rest of the U.S. scientific workforce (Tabak and Collins 2011). Recognizing the critical need to diversify the HSR workforce, AcademyHealth established the Center for Diversity, Inclusion and Minority Engagement in 2013. The center released a report in 2015 highlighting recommendations from an expert panel that encouraged AcademyHealth to provide national leadership to promote workforce diversity and inclusion in the field of HSR (Edmunds et al. 2015).

THE QUESTIONS HSR ANSWERS ARE CHANGING

Public policy, market forces, and consumer demand are changing how health care is organized, delivered, and paid for, and HSR is both helping to inform

these changes and evaluate their impact. In 2009, the American Recovery and Reinvestment Act (ARRA) infused \$1.1 billion into the HSR funding pipeline to spur the conduct of comparative effectiveness research (Simpson 2014). ARRA was followed by the passage of the Affordable Care Act in 2010, which also increased HSR investments with the creation of the Patient-Centered Outcomes Research (PCOR) Trust Fund and the establishment of the PCOR Institute. Together these investments have increased attention to comparative studies and methods, raised the bar on doing research on questions that matter to stakeholders (including patients), and helped to create an enhanced research infrastructure to leverage the vast new types of data available for research stemming from electronic health records and other technology platforms.

Historically, our research community had relied heavily on nationally representative datasets produced by federal agencies (e.g., Agency for Healthcare Research and Quality and National Center for Health Statistics) and on transactional data such as claims data. Today, researchers are learning entirely new ways to turn messy electronic health record data, or m-Health-generated data, into research quality datasets that are increasingly linked to other types and sources of data. This has required application of both traditional methods and emerging analytics to answer previously unanswerable questions.

The field is also moving beyond documenting and explaining health services phenomena—certainly an enduring and critical focus of HSR—to developing and testing interventions at the policy, system, community, and individual levels, as well as studies to understand how to more effectively move evidence into practice. For example, as detailed in a recent report (Alberti et al. 2014), there has been an increasing emphasis on solutions-focused health equity research (HER) and a decrease in the proportion of studies that aim solely to detect health inequities. In another example, the number of scientific abstracts and attendees at the Conference on the Science of Dissemination and Implementation in Health (which is cohosted by AcademyHealth and the National Institutes of Health) has grown steadily.

HOW HSR GETS DONE IS CHANGING

Just as the breadth of questions the field confronts is increasing, so too has the pace of innovation and health system transformation, creating new demands on all of us to produce results faster and more efficiently. In response, some in the field are turning toward the principles of team science and open science to

facilitate greater access to data and the information produced by the processes of scientific inquiry. Lessons learned about collaborative research through the Electronic Data Methods Forum (EDM Forum) and PCORNet have helped to accelerate the application of new findings to practice. The growing instances of research programs linked to delivery systems' operational priorities (e.g., through the Delivery System Science Fellowship or the VA-QUERI programs) are also changing how researchers work with leaders in health care settings. Concepts such as the learning health system are growing in prominence as the benefits of working more transparently and collaboratively are revealed in areas like cancer research and precision medicine (Chambers, Feero, and Khoury 2016).

Beyond collaborating with each other, the field has also increased its focus on engaging patients and their caregivers in both identifying research needs as well as throughout the research itself (Selby, Beal, and Frank 2012). These engagement efforts extend well beyond the individual patient or clinician and build on the field of community-based participatory research that has been refining methods for engaging community representatives in research design and execution (NIH 2011).

CONCLUSION

While the changes over the last half-century have been significant, what endures is our field's thirst for relevant knowledge that will improve health and the performance of the health system. What is even more prominent today, however, is the imperative to translate our research into policy and practice impact for our field to continue to be supported by taxpayer investments. There are many examples of where we have had impact, but not nearly enough to loudly and clearly demonstrate the value of HSR in the corridors of power. This may be our challenge for the next 50 years. I am ready! Are you?

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