The Role of Academic Health Centers in Health Care Reform
2006 Annual Meeting
San Antonio, Texas

Leading health experts and analysts, as well as academic health center leaders and key opinion-makers examined and debated the dimensions of academic health center leadership involvement in health care reform. Expectations for reform varied as did the visions for change and nation's options given economic and political realties. Everyone agreed that academic health centers must guide and influence the evolution of the nation's health system. These leaders recommended change at all levels of government and within all sectors of the economy that contribute to and impact health care delivery.

Summary

Reform is needed. The health system is broken because:

- The current system is fragmented and does not operate efficiently. There is increasing turbulence in the insurance market.
- The payment system is broken.
- There is a growing disconnect between hospitals and physicians.
- The health system needs greater transparency in terms of errors, efficiency, and pricing.
- People are overwhelmed by a sea of choices and need help navigating their way through the system.
- The American middle class is living with anxiety over the rising costs of health care services and insurance.
- There is also a lack of comprehensive, interoperable information technology.
- No one has enough information about what they are buying.
- Health promotion and disease prevention are not appropriately addressed. There is a need to change individual behaviors to combat unhealthy lifestyles.
- There is an insufficient response to chronic disease; systemization and coordination is required.

The nation will need to address the following to improve and reform the system:

- The uninsured
- The health workforce
- Taxes
- The baby-boomer generation

Academic health centers can improve and reform the health system by:

- Educating and advising policymakers about the uninsured.

- Developing new health care delivery and training models

- Addressing Research Issues
    - Address concerns that suggest academic health centers are compromising prestige and credibility by entering into joint ventures with the pharmaceutical industry.
    - Set clearly defined boundaries with industry and reassert control over research data and the research agenda. Perception exists that the nation's research agenda is driven by industry's willingness to invest in new projects rather than what the country needs.

- Acting as knowledge brokers

- Advising states and convening state leaders.

The AAHC was pleased to partner with the New America Foundation to examine and debate the dimensions of academic health center leadership and involvement in health care reform.

Highlights

Competing Visions and Common Elements

Len M. Nichols, PhD, Director, Health Policy Program, New America Foundation

Len Nichols, the John P. McGovern award recipient, shared his insights on where political parties and players stand on health reform and how and why they can find common ground. In the weeks before the Midterm elections, Mr. Nichols addressed the questions and controversies in health reform that he predicted would emerge regardless of the party in power.

Competing Visions and Common Elements of Health Reform

Political environment

- Progress on health reform is hampered by political gridlock and fear. Republicans don't want real reform discussions, because universal coverage threatens tax cuts and because serious cost-growth containment will require an enhanced government role.
- On the other side of the aisle, Democrats don't know what they want. Some see universal coverage as an advantageous political issue and want to capitalize on it, while others see it as a negative political issue and want to avoid it.

Competing visions of the health care system's problems

- Right: High costs are caused by too much insurance coverage (individuals are insulated from real prices and overuse health care as a result).
- Left: High costs are caused by excessive market power (adverse selection and the drive for high profits inflate costs).
- Center: All of these problems are linked, and must be addressed simultaneously, for both technical and political reasons.

"Progress on health reform is hampered by political gridlock and fear."

Competing visions of health reform

- Right: People are on their own — individual choice and market responses will drive efficiency.
- Left: Elite control and administrative streamlining will drive efficiency.
- Center: A credible policy must include individual and shared responsibility, encourage a culture of value, and preserve liberty and choice.
- **Common elements across visions**: (1) The system must become more efficient for all; (2) There will be an increase in the measurement and comparison of information, and in accountability; (3) Employers will play a less important role.

Opportunities for academic health centers to take the lead on health reform

- Demonstrate value to the local community
- Produce research to expand the evidence base for medicine
- Produce decision support tools for complex encounters
- Produce the right mix of health professionals
- **Create models of "Active Medical Homes", with providers acting as navigators to coordinate care and services for the individual patient.**

Roundtable: What's Broken in the System? What Needs to be Fixed?

James Guest, President, Consumers Union; Peter Wald, MD, PhD, Assistant Vice President for Wellness, USAA; Charles Kahn, MPH, President, Federation of American Hospitals; James Capretta, MA, Fellow, Ethics and Public Policy Center and Managing Director of Civic Enterprises, LLC

Health leaders representing consumer, corporate, provider, and government interests raised problems with the health care system from these particular perspectives and suggested ways to improve and reform healthcare quality.

"The public's trust and confidence in physicians and health care institutions is critical."

The public's trust and confidence in physicians and health care institutions is critical to the consumer/patient, according to Mr. Guest, who emphasized ways to maintain trust. People are overwhelmed by a sea of choices, and need help navigating their way through the health system. There is a need for information on the quality of hospitals and physicians to aid consumers in making decisions. Guest suggested a "Consumer Reports" for health.

From the perspective of businesses and employers, Wald noted the difficulty of decision-making in health care. Employees look to employers as proxies for decision-making. However, neither employers nor employees have enough information on what they are buying and its value. Wald emphasized that a major need from the health system is a way to change behavior and unhealthy lifestyles.

"The health system needs greater transparency."

The health care system has an insufficient response to chronic disease care. Coordination and systemization must exist in this area. There is also a lack of comprehensive, interoperable information technology. Kahn echoed the claim that the health system needs greater transparency—in errors, efficiency, and pricing, among other things. However, **efficiency is still not very well defined, and should not be viewed as a silver bullet for the problems facing health care.** Kahn voiced concern about a growing disconnect between physicians and hospitals. The specialty hospital movement is a symptom of this problem, and represents how economics have gone awry in the health care system.

Capretta raised a number of concerns about the U.S. health care system from the government's perspective. **Fragmentation is the most serious problem,** along with turbulence in the insurance market, the aging of the population, and a broken payment system, said Capretta. He suggested that the system might be improved by measuring the right things.

"Fragmentation is the most serious problem."

New Ideas and Political Realities?

Mark Schmitt, Senior Fellow, New America Foundation

Political analyst Mark Schmitt presented his vision of American politics in the near future, and provided an idea of how health reform might proceed in that context.

Schmitt anticipated a Democratic takeover of Congress, and speculated about what might happen after such an outcome. In any case, he argued, we will be seeing significant changes in the way Congress works.

A central issue for policymakers in the coming years will be growing economic anxiety among middle-class Americans. Health care and insurance are closely tied to this sense of anxiety, and these issues will become increasingly difficult to avoid. It will also become increasingly difficult to avoid the question of taxes—significant health care reform will require resources that our government does not currently have, and this will need to be addressed. Schmitt suggested that, depending on how bold the new leadership in Washington is, we might even see an effort to reform and restructure the entire tax system.

"The American middle class is living with anxiety over the rising costs of their health care and insurance."

Research: Leading or Coexisting in a New System?

Jennifer Washburn, Fellow, New America Foundation; Philip A. Pizzo, MD, dean, School of Medicine, Stanford University; Shannon Brownlee, Bernard L. Schwartz Senior Fellow, New America Foundation

To address how research should or could be incorporated into any health reform plan, speakers focused on institutional and public perceptions and issues that first need to be addressed.

Academic relationships with industry and their impact on public trust is the most pressing research problem, according to Washburn. Stricter regulations on industry's dealings with academic institutions are required to rebuild public trust, said Washburn, suggesting that academic health centers band together to take the lead.

"A growing reliance on industry funding sources and pervasive conflicts of interest has dangerously compromised the prestige and credibility of academic health centers."

A growing reliance on industry funding sources and pervasive conflicts of interest (which are not being adequately regulated) **has dangerously compromised the prestige and credibility of academic health centers**, according to Washburn. Universities are losing their autonomy and ceding too much power to pharmaceutical companies, especially when it comes to clinical drug research design and the reporting of research results. In effect, academic health centers have been trying to compete by behaving much like any other for-profit contract research organization. In the process, they are losing the very foundation of their public trust.

Academic health centers—and Stanford University in particular—**have been proactive in addressing conflicts of interest,** according to Pizzo, who pointed to public confusion and misperceptions about what is or is not a conflict. Stanford recently banned all gifts from industry to university faculty. Under current regulations, faculty members are banned from publishing ghostwritten materials.

Marketing representatives and salesmen are prohibited from entering the medical center without an appointment, and Stanford does not accept any gifts that support endowed activities.

"Academic health centers have been proactive in addressing conflicts of interest."

Stanford has long had a policy which requires all faculty to report any outside relationship that involves the exchange of money. Unquestionably partnerships with industry have led to scientific breakthroughs that are expected and needed by the public, said Pizzo. However, **the current financial and regulatory environments are straining the capabilities of academic health centers.** Pizzo also pointed out that academic health centers only accrue about 40% of the cost of education through tuition. Revenue derived from research helps to sustain education costs.

Academic health centers are constantly examining and remaking relationships with industry, said Pizzo. Stanford is currently redesigning how the university works with industry by examining conflict of interest and clinical disclosure polices.

University-industry relationships can compromise the university's reputation, said Brownlee, who believes the nation's research agenda is driven by industry's willingness to invest in new projects rather than what the country needs. Large research areas are being ignored, such as comparative drug research cost-effectiveness research and research on quality of care. Consulting contracts between academic health center physicians and pharmaceutical companies have had a negative effect on the integrity of research. Peer-reviewed medical literature has also been called into question because of false claims and scandals resulting from a lack of full disclosure and mischaracterization of research data.

Academic health centers should set clearly defined boundaries with industry, and reassert control over research data and the research agenda, said Brownlee.

"Academic health centers should set clearly defined boundaries with industry."

Education: Can We Get Buy-In Under Health Reform?

Dan W. Rahn, MD, President, Medical College of Georgia; Eugene S. Schneller, PhD, Professor, School of Health Management and Policy, Arizona State University

Speakers focused on questions related to how health reform might include education reform, and concluded that education must be part of any sustainable health reform initiative.

Dr. Rahn stated that **academic health centers are responsible for setting the national agenda for health professions education and health workforce issues.**

"Academic health centers are responsible for setting the national agenda for health professions education and health workforce issues."

The performance of health systems (e.g., outcomes, quality, and patient satisfaction) is deeply intertwined with health professions education and the health workforce.
This link must be made very clear. **The health sector is sustaining the U.S economy and the workforce is at the core of expansion, progress, and sustainability.**Any health system envisioned for the future will be populated by graduates of academic health centers.

"The health sector is sustaining the U.S economy and the workforce is at the core of expansion, progress, and sustainability."

Thus, academic health centers will need to ensure that the mix and skills of health professionals is appropriate to make such a system function properly. U.S. policy is deeply rooted in entrepreneurialism, autonomy, and competition, stated Rahn. The nation was built on these fundamentals with the first settlement being an exercise in profit gain. The U.S. is a very business-oriented culture with a strong faith in self-reliance rather than obligation to others, according to some analysts.

The nation's history reflects strong beliefs in the free market and decision making at the local level—all of which is reflected in the health care system today. Finally, the U.S. is anchored by a belief in equal opportunity, which also is highlighted in its approach to health care.

The U.S. system holds its strengths in:

- Entrepreneurialism
- Being a magnet for talent
- Innovation
- Productivity through competition
- Individual opportunity to succeed

Dr. Schneller discussed how academic health centers can take the lead on health reform and work to reform education at the same time. Successful changes in industry have come from careful scrutiny of the value and supply chains in which one is engaged, according to Schneller.

For reform to be successful, academic health centers must: better differentiate their services and how they can be brought to the patient; improve the market the value provided by their services; capture patient reserves to cross subsidize education; form alliances; continue to be knowledge brokers, not just disseminators of knowledge (charge for the intellectual property); get paid for performance; and become empowered and accountable.

Health Care Delivery: Incorporating Evidence-Based Care and the Uninsured in a New System

Bruce C. Vladeck, PhD, President, University of Medicine and Dentistry of New Jersey, George A. Chedraoui, Well-Being and Health Benefits Leader, IBM Global Well-Being Services

"Academic health centers must find a way to incorporate the uninsured into any health reform plan."

Major concerns about the uninsured, primary care, and evidence based care continue to generate debate when completing reform. Will such issues remain barriers to change?

Academic health centers must find a way to incorporate the uninsured into any health reform plan, says Vladeck. The uninsured receive about half as much care as the insured, and that care is less likely to be specialized or to involve elective procedures. **Academic health centers need to find new delivery and training models to enact change in the health system.**

"Academic health centers can improve and reform the health system by acting as knowledge brokers."

Contrary to what many believe, utilization does not drive the health system—price and supply and demand do. Fragmentation in the health system requires primary care physicians to act as navigators, and academic health centers need to focus on creating and training primary physicians. There needs to be a shift to primary care doctors receiving more reimbursement in the system.

IBM envisions a new system that balances quality and cost, according to Chedraoui.

The IBM strategy for driving value in healthcare: Create patient-centered care networks, encourage transparency, promote employee-centered change, focus on primary care, and engage in value purchasing.

IBM's recommendations for health system reform:

- Sub-specialties are important, but primary care (good primary care) matters more
- Information-rich, patient-centric healthcare isn't a marginal benefit, it is very good business – for all stakeholders
- Large employers can help drive reform

The States Grow Impatient: Leading Reform or a Crazy Quilt?

James J. Mongan, MD, President and Chief Executive Office Partners HealthCare Massachusetts; *David Carvalho, JD, Deputy Director for Policy, Illinois Department of Health; Frank B. Cerra, MD, Senior Vice President for Health Sciences, University of Minnesota; Douglas Barrett, MD, Senior Vice President for Health Affairs, University of Florida; Marcia J. Nielsen, PhD, MPH, Interim Executive Director, Kansas Health Policy Authority*

Should the federal government lead in health reform? If the federal government should not or cannot will states be able to create sustainable reform? Health reform plans from five states were examined. The plans in various stages of development highlight the need for academic health center leaders to engage state policymakers to take account of the risks and benefits of grass roots reform now.

Massachusetts

Massachusetts is uniquely positioned for health reform, according to Mongan. **The state has only 10% uninsured compared to 15% national average,** has broader employer coverage compared to the rest of the nation, and has a strong Medicaid program. Most importantly, Massachusetts has a pre-existing Uncompensated Care Pool that covers hospital costs for the uninsured.

The Uncompensated Care Pool will provide financing for the proposed reforms by:

- $160 million surcharge on insurance payments
- $160 million assessment on hospitals
- $220 million from general revenue

All players (Advocacy Groups/Business Groups/Insurers/ Providers) came to the table and agreed to work together on the new reform plan.

The most important elements of the plan: Coverage for 95% of uninsured through a number of elements:

- Individual mandate, requiring people to buy into the system with mounting enforcement
- Subsidies: for people with incomes at 300% of poverty [full subsidies for those with incomes under 100% of poverty]
- State Insurance Connector: will provide tax breaks/credits
- Medicaid expansion.

The Massachusetts plan will be expanded over the next 3 years depending on:

- The adequacy of subsidies to help with the purchase of insurance.
- The adequacy and availability of more affordable health insurance policies.
- The political viability of the individual mandate, which will be influenced by the two factors above.

For the plan to succeed, a balance between funding sources and cooperation between government, employers, and individuals will be needed.

Illinois

In 2004, the Illinois Health Care Justice Act created the Adequate Health Care Task Force, charged with developing a comprehensive health care access plan for the state. The Illinois Department of Public Health, the lead state agency, is working with representatives from the Departments of Aging, Medicaid, and Human Services.

The 29-member Task Force developed criteria for the reform plan, which include access to a full range of preventive, acute, and long-term health care services; improved quality of health care services; portability of coverage; core benefits for all Illinois residents; regional and local consumer participation; cost-containment measures; multiple approaches to preventive medicine based on new technologies; and affordable coverage options for the small business market.

The Task Force said that for a plan to be recommended for the state it must include:

1. an integrated system or systems of health care delivery;
2. incentives to be used to contain costs;
3. core benefits that would be provided under each type of plan;
4. reimbursement mechanisms for health care providers;
5. administrative efficiencies;
6. mechanisms for generating spending priorities based on multidisciplinary standards of care established by verifiable replicated research studies demonstrating quality and cost effectiveness of interventions, providers, and facilities;
7. methods for reducing the cost of prescription drugs both as part of, and as separate from, the health care access plan;
8. appropriate reallocation of existing health care resources;
9. equitable financing of each proposal; and

10. recommendations on long-term care services.

The Illinois Department of Public Health reviewed the plans submitted for consideration. The Consultant's Hybrid Plan was the most attractive because the plan incorporated an individual mandate, Medicaid expansion, state subsidies for residents under 400% of poverty, and insurance reform elements. The Illinois Department of Public Health will submit a final report for the consideration of the legislature to be approved at the January 9, 2007, task force meeting.

Minnesota

Minnesota has one of the most widely consolidated healthcare markets in the nation. **Only 5% of the state's population is uninsured—one of the lowest rates in the U.S.** Several years ago, Minnesota enacted a provider tax to be used to pay for care. This tax generates about $650 million annually; one third is deposited directly into a general fund. Out-of-pocket costs to consumers (between 25-30%) are one of the major driving forces for the state's reform initiative. Given the historical roots of Minnesota's population, many are looking to the Scandinavian model for ideas. The state has a government sponsored Health Reform Task Force. The University of Minnesota represents the educational sector on the Health Reform Task Force.

The Health Reform Task Force is currently reviewing a Physicians Plan for a Healthy Minnesota.

- There is near unanimous consensus on four key issue areas:
  1. Strong Public Health Element
  2. Quality Component
  3. Reform in the Healthcare Market
  4. Reform the in Insurance Market

The Physicians Plan for a Healthy Minnesota will be submitted to the state legislature in January 2007.

Florida

The Florida Legislature did not believe the state's Medicaid system was sustainable, and created a reform plan centered on cost containment. Currently, $2.2 million of the state budget is spent on Medicaid (24%). Budget analyses from the last few years have shown a consistent 8.8% growth in the number of Medicaid recipients. According to this model, Florida can expect Medicaid expenditures to be upwards of 30% of the state budget by 2010. Currently, **7% of Florida residents—about 1.2 million people—are uninsured.** Florida has a very strong anti-tax constituency, limiting the political options for policymakers. To control costs, the state is trying to manage the amount and scope of care that Medicaid recipients receive.

The state's plan is to take the financial burden from the state and move it to the private sector.

- Patient choice is the key
- People will receive a premium and then go buy a plan
- The state plans to create a number of different plans so people can choose which one works for them
- Patients will be rated (using their existing health conditions) and then assigned a number which translates into a dollar amount received by the participant who then buys a plan in the market.

- Medicaid eligibility standards will not be changed.

The state will have to determine ways to assess the adequacy of premiums and decide on appropriate profit margins for providers. It is not clear where all the money will come from.

Florida is currently implementing a 5-year pilot program in Jacksonville and Broward Counties involving 350,000 people (16% of Florida's Medicaid population). In this pilot, people have 30 days to choose a plan before one is assigned. Three university-based think tanks will be evaluating the plans and assessing the success of the pilot.

Kansas
The Kansas Health Policy Authority (KHPA) was created in 2005 by the state legislature based on Governor Sebelius' "Executive Reorganization Order." A nine-member board to govern health policy was established. The mission of the Kansas Health Policy Authority is to develop and maintain a coordinated health policy agenda that combines effective purchasing and administration of health care with health promotion-oriented public health strategies which are driven by health data.

In 2006, all Medicare/Medicaid and CHIP programs were transferred to the authority of KHPA. KHPA is trying to find a policy solution that:

1. Maintains current programs
2. Fit into larger Board vision
3. Is supported by data
4. Is developed with stakeholder input –
5. Focus on person/patient centered policies

To engage state leaders in reform initiatives academic health center leaders should:

- Educate state leaders in health reform issues from a broad perspective.
- Act as a convener of state stakeholders
- Assist in policy development
- Produce and analyze the data. (KHPA is looking at data sets in cost trends, cost effective policies and social determinants of health).