



Association of Academic Health Centers

*Leading institutions that serve society*

# Dialogues

## 2006 Spring Meeting Highlights

March 27 & 28  
Washington, DC

**Strengthen. Advocate. Lead.**

## DIALOGUE ON RENEWING AMERICA'S SCIENTIFIC ENTERPRISE

### John Marburger III, PhD

Director, Office of Science and Technology Policy, Executive Office of the President

### Addressing Public Concern While Maintaining Science Investment

- Policy must address both the hierarchy of science and the hierarchy of public need; the uncharted territory between science and politics is problematic.
- Although health care financing threatens academic health centers, **public respect for the National Institutes of Health (NIH) will continue investment** in these institutions.
- General public concern for the NIH budget signals the importance of research.

### The Current Administration and Science and Research

- Administration is sympathetic toward tax policy that encourages research.
- The pie is limited and competition for resources between the physical and life sciences is real; because the domestic discretionary budget grows only linearly over time, line items cannot grow exponentially with the rate of the gross domestic product.
- Current under-investment in scientific instrumentation hurts all sciences.
- Serious problems exist in the physical sciences; **recruitment and retention of young people in science and medical careers are of great concern**, but federal government has a difficult time getting involved in K-12 education, which is largely controlled by the states.
- The recent report *Gathering Storm* exaggerates the case for investing in science with a misleading sense of panic; "Tiger" economies based on exports cannot last forever.
- U.S. should focus on what it does well and allow the rest of the world to develop; the U.S. will remain a leader.
- Structure of NIH could benefit from a radical restructuring.

### Lessons for Academic Health Centers

- With globalization of research and reliance on foreign staff, academic health centers face increased security concerns and should establish an initiative to educate Congress on the importance of international exchange in research and education.
- Tremendous pressure to **target research programs at the intersection of disciplines** makes academic health centers logical places for those programs.
- Academic is a source of intellectual property, and IP issues are going to be on the front burner for a long time.

**"The diversity of academic health centers can be an advantage, but you need to develop a coherent, national agenda and programs as well."**

## **DIALOGUE ON BIOMEDICAL RESEARCH**

### **Elias A. Zerhouni, MD**

Director, National Institutes of Health, U.S. Department of Health and Human Services

### **Congress and the NIH**

- Congress believes in biomedical research but is faced with conflicting demands.
- Since Congress doubled the NIH budget, NIH has:
  - Developed new missions (e.g., biodefense)
  - Created new institutes (e.g., bioimaging, minority health)
  - Established new fields (e.g., computational biology)
  - Increased investment in the physical sciences

### **Statistical response to Congress's demands for NIH's return on investment**

#### **HIV / AIDS**

- In 1985, 50 percent of AIDS patients were terminal and experts predicted that AIDS patients would occupy 80 percent of all medical beds by 1995.
- Between 1985 and 1995, NIH investment in AIDS treatments was \$10 billion.
- That \$10 billion ultimately saved \$1.4 trillion in health care expenditures.
- Without the \$10 billion NIH investment, today there would be 200,000 terminal AIDS patients in the U.S.
- Investment in basic science in 1985 paid off at a rate of 140 to 1.

#### **Cancer**

- This year, for the first time in history, the number of absolute deaths from cancer in the U.S. decreased by 10,200 (according to the Centers for Disease Control and Prevention).
- This drop takes into account an increase in population since 1971, and the U.S. population is the first society to show a net drop – not relative drop, not percent drop – but a net drop in cancer deaths.
- Currently, NIH spends only \$16 per year per American for cancer research to fight a disease that 40-to-50 percent of the population will have to face.
- The total investment over the entire 34 years in cancer research per American is approximately \$260; during that period, survival rates for cancer patients increased from 6 months to 5 years.

#### **Heart Disease**

- Total investment in heart disease, lung disease, blood disease, and stroke over the 34 years is approximately \$110 per American.
- During those 34 years, there has been a 60-percent reduction in mortality.
- 815,000 fewer people are dying per year from coronary disease alone.
- Coronary disease is no longer the number one killer of people under 85.
- More than 200,000 people are saved each year from death due to stroke.

#### **NIH Overall**

- The average American has invested \$44 per year or \$1,300 per person over the past 30 years.

## NIH and Moving Forward

- There is currently an **exploding demand for clinical services, but we lack clinical science transformational strategy.**
- Clinical and Translational Science Awards (CTSAs):
  - CTSAs present a challenge to the scientific community to think outside of the 50-year-old model and create a new generation of clinician-scientists.

## Fundamental restructuring of NIH

- **NIH needs to move from a disease-focused to a community-based structure.**
- Rather than simply “moving the deck chairs,” we need to functionally integrate NIH centers and find ways to move funding between them. This will require a change in culture; we cannot tackle new areas of science if money is committed only in silos.
- We need to manage and invest in young investigators to ensure the future talent pool of researchers, because the existing scientific workforce is aging.
- Repositioning the NIH to give it the ability to manage a new generation of scientists.

## NIH in the “5 Ps” Era

- **Predictive:** Current understanding of the biological pathways of disease leads to development of fundamental technologies to predict health problems.
- **Personalized:** Increased investment in biomarker research identifies at-risk patients and should have the ability to prevent onset of disease.
- **Preemptive:** Preemptive medicine must be a top priority, along with prevention.
- **Participatory:** Patients must be more involved in decisions about their health care, and treatment must be in compliance with medical advice, especially for patients with chronic disease.
- **Payable:** Need for regulatory changes in reimbursement and transformation.

## NIH Roadmap and Common Funds

- Both large and small institutes gain opportunities and benefits from the Roadmap.
- In times of financial constraint, we should not give up the Common Fund idea.

## Lessons for Academic Health Centers

- Academic health centers have invested heavily in new research buildings, but this debt could create problems in the years to come; **academic health centers need to reanalyze research investment** in light of research funding plateau at NIH.
- You cannot be all things to all people. Academic health centers should focus on their strengths: if you cannot be in the top few, then let someone else do it.
- Create your own Roadmaps: find a way to scale internal competitiveness and put together proposals that truly break new ground.
- Create a **new generation of clinician scientists with a common ability to link across disciplines and interact with industry.**
- A science career today is not as valued as it was in the 1950s and 1960s; this is a problem that NIH and academic health centers cannot solve alone.

## DIALOGUE ON AMERICA'S PREMINENCE IN SCIENCE

The Honorable Jeff Bingaman

United States Senate (D-NM)

### "The 21<sup>st</sup> Century is going to be the Life Sciences Century"

- There will be global competition to retain science leadership in coming years.
- There is **public enthusiasm but no support for the physical sciences.**

**"We are at competition with the world to maintain our preeminence in science."**

### The Bush Administration and Health Care

- Health care is not at the top of the Bush Administration's agenda and Congress is ill-equipped to make any changes without Administration leadership.
- **Administration will not expand access or deal with health care costs.**
- Despite lack of overall health care agenda, Bush administration is focused on implementation of the Medicare prescription plan.
- Health savings accounts are going in the wrong direction. Instead of encouraging early intervention, they motivate people to wait for health care until they absolutely need it, which is ultimately more costly.

### Congress, the Budget, and Health Care Reform

**"Unless we change our fiscal situation, we will have great difficulty funding NIH."**

- Faced with large deficits and growing demands on defense and national security that are well-supported, Congress must look for areas to make cuts. **Although there is support for NIH, cuts will continue unless government revenue is increased.**
- Congress cares about health care, but budget proposals do not reflect this.
- Senate Bill 851 would establish ongoing Workforce Advisory Commission to review and issue annual reports on shortfalls in the health workforce.

### Lessons for Academic Health Centers

- Academic health centers need to **persuade Congress and the Administration to give science a higher priority** and to place health care on the agenda.
  - Lately, science has been neglected because the American public assumes that the U.S. will always be the leader.
  - Congress doesn't really believe we can fall behind and they are currently taking steps to actually facilitate our falling behind.

## DIALOGUE ON PUBLIC HEALTH AND EMERGENCY PREPAREDNESS

### Julie Gerberding, MD, MPH

Director, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services

### CDC and the Nation's Public Health Agenda

- The CDC must **balance mundane but urgent realities with urgent threats**.
- Difficult to make people see obesity as an urgent health care issue, although it is one of the top priorities for the CDC.
  - To address obesity, we need to follow the lessons learned from dealing with tobacco; we need a comprehensive, sustained commitment over time.
- We seem to be at a tipping point for public valuation of preventive care.
- Although it is unlikely in the current context, CDC would benefit from having a health protection research budget.
- Unlike the military, CDC is budget-limited, not mission-limited; we need to become mission-limited to obtain necessary funding.
  - Hope is not a strategy; leadership is most important.

### CDC and Emergency Response

- Lessons learned from Katrina:
  - **People prefer to obtain information from their community physician:** We need to empower providers with this information, and target different types of information to physicians and health directors.
  - Meta-leadership (leadership across agencies) is needed to ensure institutional memory.
  - Scientific agencies need to be able to communicate information more quickly and effectively in emergencies.
  - An effective emergency response must be prepared to handle chronic illness and mental health issues.
- **Communities must plan to deal with a flu epidemic on their own for approximately 6 months, until vaccines become available.**
- CDC has checklists for colleges and universities and health care facilities.

**“Academic health centers need to provide the science base that CDC needs so that CDC can provide the health protection our country needs.”**

### Lessons for Academic Health Centers

- Academic health centers provide the science base for successful approaches to obesity and also deal with the health care consequences.
- In emergencies, academic health centers provide the following:
  - **Credibility:** They send an assurance of excellence and standards.
  - **Depth:** They have a lot of capacity for workforce needs.
  - **Information:** They gather important information, in real time, on the effectiveness of medical interventions during emergencies.
- To better integrate public health with the rest of the academic health center, we should develop “Schools of Health,” of which all professions are a part.

## DIALOGUE ON HOMELAND SECURITY

### The Honorable Mark Pryor

United States Senate (D-AR)

#### Homeland Security and Bureaucratic Structure

- **The Federal Emergency Management Agency (FEMA) should be an independent, cabinet-level agency.**
- In the Department of Homeland Security, the left hand doesn't know what the right hand is doing; this leads to inefficient delivery of services and slow response time.
  - Department of **Homeland Security is not living up to its responsibility and funding levels.**
  - Tom Ridge and Michael Chertoff have not succeeded in exercising enough control within the department.
- If another disaster happened, FEMA would fail.

#### The Current Congress and the Upcoming Elections

**"Everything Congress tries to do has to be evaluated in light of dire budget constraints that leave little or no space to focus on the programs most important for the health of our country."**

- Congress is currently conducting every action under the condition of the budget, which serves as a major constraint.
- Congressional priorities on homeland security and defense include increasing funding, border security, and information technology.
- Upcoming elections look promising for Democrats.
- There are approximately 40 to 50 seats available.
  - In many Congressional races, the incumbent Republican is behind the Democratic challenger.
  - Expects to see increased numbers of Democrats in the Senate, House, and state governorships in 2006 and 2008.

#### Lessons for Academic Health Centers

- Bush Administration is not taking care of the needs of academic health centers and the academic community in general.
- **Our country has serious problems in the health arena; since government is not taking care of them, academic health centers should take the lead.**

## DIALOGUE ON THE GOVERNORS' ISSUES: THE AGENDA FOR THE STATES

**Raymond C. Scheppach, PhD**

Executive Director, National Governors Association

### Top Policy Issues for the Governors

- **Health care**
  - Health care is breaking state budgets.
  - Has not reached the federal agenda; this is a big issue for the states.
  - **Top priorities include coverage for the uninsured and the cost and quality of health care.**
  - Medicaid has grown at a rate of 11 percent per year over the last few decades, and it now accounts for approximately 30 percent of state budgets (exceeding K-12 education).
  - States are holding summits to look at confidentiality and privacy issues of electronic medical records.
  - States are pushing electronic health records and increasing and defining quality and transparency standards because health care consumers need information on quality and cost for a market system to work.
  - Does not expect to see a move toward single-payer system.
  - **Since the federal government is not moving on health care, a state or region is going to have to take the lead.**
  - Health workforce issues are on the radar screen, but have not reached a priority position on the NGA's or states' agendas.
- **Education**
  - Increased investment in science and education.
  - **States will likely cut higher education funding to pay for Medicaid.**
  - Education is currently approximately 21 percent of state budgets (higher education is an additional 8 percent).
- **Economic development and job creation**
  - Greater investment in research and development and/or education.

**"Health care is not a true market because there is no competition for the uninsured. However, we are so far from a true market, we can't even tell if a market would work."**

### Gubernatorial Elections in 2006

- 36 seats (9 open) in the next gubernatorial elections.

### Lessons for Academic Health Centers

- **Burden on the safety net will continue to get worse** as businesses push employees out of employer-sponsored health insurance.
- To advocate, get to the right staff members, get on their agenda, and present a specific proposal for reform.

## DIALOGUE ON REFORM: REDESIGNING THE HEALTH CARE SYSTEM

**Len M. Nichols, PhD**

Director, Health Policy Program, New America Foundation

### Toward Health Care Reform in 2008

- Health care will be the predominant domestic issue in 2008, and the **nation may be ready for actual health system reform in 2008**. Health care costs are increasing, and insurance markets are not competitive enough.
- Medicare could become a smarter buyer, which could be a catalytic relationship with the private sector.
- The Bush Administration's current push toward extreme individualism with health savings accounts will not address cost and will benefit only the healthy and wealthy.

**"Health care has become like food, an indispensable commodity."**

### The Moral Case for Health Care

- A "culture of value" is needed in health care delivery:
  - An information systems backbone permits real-time information exchange on best practices.
  - Evidence-based medicine provides safe harbors from malpractice.
  - Better incentives (e.g., performance-based) are needed.
  - Comparative technology assessments are needed.
- Employers are trying to move from a defined health benefit toward a defined contribution health insurance system (like the defined contribution pension system).
- **Health community must be able to defend and articulate the moral case behind access to health care.**
- Trust and community are needed in order to ration health care.

### Lessons for Academic Health Centers

- Must determine which treatments and technologies work.
- Must learn to **articulate and disseminate the moral case for health care.**
- High level of community involvement and trust within community can open the door for discussions about rationing of care.

## **ACADEMIC HEALTH CENTERS RESPOND TO EMERGENCIES**

### **John D. Stobo, MD**

President, The University of Texas Medical Branch

### **John F. Williams, MD, EdD, MPH**

Provost and Vice President for Health Affairs, The George Washington University

### **Daniel W. Jones, MD**

Vice Chancellor for Health Affairs, University of Mississippi Medical Center

Echoing earlier comments by both Dr. Elias Zerhouni, director of NIH, and Dr. Julie Gerberding, director of CDC, AAHC members emphasized that **academic health centers cannot rely on outside assistance and must be prepared to handle emergencies on their own.**

*Look for a special brief on disaster response and Hurricanes Katrina and Rita to be issued shortly.*