The 3rd Annual

World Health Care Congress

A Dynamic Curriculum of Vision, Strategy and Execution Road Maps to Improve Health Care Quality, Cost and Access

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The Global Perspective

Overview

Access to health care is inadequate in both developing and industrialized countries. While the specific solutions vary, common elements include strong leadership and the political will to drive necessary changes. Developing countries require more investment in health care infrastructure and better availability of critical drugs. Addressing lack of access and other systemic problems in industrialized nations requires some form of national catastrophic insurance, breaking down silos and viewing health care more holistically, and continuing to pursue innovation.

Context

GlaxoSmithKline CEO, J.P. Garnier, shared his thoughts about the challenges and potential solutions to inadequate access to health care in both developing and industrialized countries.

Key Conclusions

- **Access to adequate health care is a major problem in many corners of the world. Addressing it takes leadership and political will.**

  Lack of access is an enormous problem for millions around the globe. Mr. Garnier described access problems affecting children in South Africa, a woman with breast cancer in the UK, and a man employed by a small company in the United States.

  Addressing access problems in third-world countries will take the political will of leaders in those countries. In Botswana, political will has been shown and progress has been made addressing HIV/AIDS. In contrast, some countries are not truly focused on helping their own citizens, demonstrated by the Health Minister of South Africa spreading inaccurate and misleading information that hurts the citizens of the country. NGOs need to play a role in making governments accountable.

  The obstacles are different but equally great in the developed countries, including the United States. Political courage to make hard choices is in short supply. Visionary and courageous leadership will be required to navigate these forces.

  > *"It's not going to be pleasant to reform health care…but conquering access in America will have a profound effect on cohesion in American society."*
  > — J.P. Garnier, PhD

- **The developing countries require infrastructure and drugs.**

  While the challenges in the developing world are complex, the starting point is investing to create the necessary health care infrastructure. There are positive examples. For example, The Global Fund to Fight HIV/AIDS, Malaria and Tuberculosis established by the Bush administration in 2001 is beginning to make a mark, with establishment of small hospitals and dispensaries to reach populations in need. However, to date, the developed countries have not lived up to their commitments to provide the funds to assist impoverished countries. Those funds are desperately needed.

  In addition, the world's drug companies must develop and make drugs available at low cost to help the populations in these countries. Again, there are examples where this is occurring. GlaxoSmithKline is a partner with the World Health Organization in the Global Alliance to Eliminate Lymphatic Filariasis (also known as Elephantiasis). GSK has committed $1 billion over 20 years to eradicate LF in affected countries.

  > *"We need to develop and make drugs available to poor countries at really, really low prices."*
  > — J.P. Garnier, PhD

- **Addressing access and other systemic problems in the U.S. requires a set of specific government actions.**

  Mr. Garnier outlined several steps that he sees as necessary to address the health care problems in the United States:

  - *National health insurance*: Some form of catastrophic national health insurance is necessary, with the cost being subsidized for the poor.
  - *Complete privatization*: The health care system should be completely privatized. The government's role should be to regulate and referee, but when the government is directly involved, micromanagement occurs.

    > *"The role of government should be to regulate, to serve as a referee, and to act as a budget holder, but not to micromanage patient care."*
    > — J.P. Garnier, PhD

  - *Focus on the major risks*: Just as government efforts to curb smoking have been successful, so too must the government take on obesity.
  - *Create standards*: There is a lack of standards and best practices. The NIH should take the lead in developing evidence-based best practices.
  - Malpractice reform: There needs to be reform to eliminate excessive lawsuits. These have caused the practice of defensive medicine, resulting in unnecessary evaluations, tests, and procedures.
  - *Encourage innovation*: Innovation must be squarely on the agenda. Those who aim to reduce drug costs are missing the point. Health care and addressing diseases need to be thought of holistically, which requires drugs and innovation. Continued investment in research is critical as several conditions, such as Alzheimer's, are on the verge of major increases due to demographic changes. A medication developed through innovation might make it possible for such patients to live without requiring institutionalized long-term care. Thus, the goal is not to reduce drug costs, but to think of the overall costs and implications of disease.

Other Important Points

- **International learning.** The U.S. was the last industrialized country to offer a drug benefit. Much could have been learned by looking at other countries in developing the Medicare drug benefit, but it does not appear this was done.

Pandemics and Preparedness

Overview

While 50% of WHCC attendees believe a pandemic is likely in the next five years, most U.S. health care organizations are not yet prepared. Such a pandemic could have enormous human and economic consequences. Speed is the key to responding to a pandemic, which requires coordination and connectivity internationally, at the community level, across all sectors of health care, and throughout the private sector.

Context

These experts on disaster preparedness discussed the status of avian flu and what is being done and needs to be done to increase preparedness.

Key Conclusions

- **H5N1 is an epizootic (an epidemic among animals) with the potential of becoming a pandemic.**

  Due to wild bird migration and trade this epizootic is moving rapidly, with 20 countries reporting H5N1 in the past six weeks. This has the potential to have a big impact on the worldwide poultry industry, which affects poor people across the globe.

  Even more importantly, H5N1 has the potential to become the next human pandemic. The prerequisites for a pandemic are a virus or organism: 1) to which the general population lacks immunity; 2) that can replicate and cause disease in humans; and 3) that can be efficiently transmitted from person to person. H5N1 meets the first two criteria, but not yet the third.

- **The consequences of a pandemic could be enormous.**

  The largest previous pandemic—the Spanish Flu of 1918—is estimated to have killed perhaps 50 million people worldwide. SARS—which was controlled quickly and had a relatively low human toll—still had an economic impact of $50 billion. Because the world today is so interconnected, a global pandemic could have enormous human, political, and economic consequences, resulting in millions of deaths, affecting governments and the rule of law, and having an economic impact in the trillions of dollars.

  Because of the vast impacts of a pandemic, and the speed with which a pandemic could spread, is it not just a health care issue but an issue that affects all segments of business and society. These potentially severe consequences make it imperative to be prepared.

  > *"We need to be prepared. Once the problem arises, it's too late to get prepared."*
  > — David Nabarro

- **Much can be learned from the preparation and response to previous disasters.**

  Since Dr. Gerberding has been at the CDC there have been 25 urgent threats, including 9/11 and Katrina. The key lessons learned through these experiences include the challenges of:

  - *Imagination*: Many of the disasters that have occurred were scenarios almost beyond imagination. Failing to imagine a possible scenario is a barrier to preparation.
  - *Complacency*: The main challenge has often been one of complacency in failing to believe action was necessary.
  - *Scale*: There are many examples of outstanding responses to urgent situations. What made Katrina different was the scale of the crisis. A worst-case pandemic scenario could also create challenges of scale. The two elements that Dr. Gerberding is most concerned about are the capacity of the health care system and the vaccine capacity.
  - *Connectivity*: When responses were inadequate it was because there was not adequate connectivity. In preparing for a possible pandemic, a "seamless network of connectivity" is essential. The vision is that all countries, communities, and sectors are connected so any pandemic can be detected, diagnosed, and dealt with immediately.

- **Dealing with a pandemic requires speed, which in turn requires preparedness.**

  The strategy being pursued for preventing and/or dealing with a potential pandemic involves: 1) working to stamp out influenza in animals; 2) preventing the emergence of influenza in humans; and 3) in the event that influenza does emerge in humans, quickly containing it to mitigate its impact. The critical elements in this strategy are speed of response in containing the disease, providing services for those affected, and providing services to those not affected so that societies can have continuity and can recover quickly.

  The key to effectively executing on this strategy is preparedness. Preparedness must be driven by the leadership of high-level government officials. It involves coordination with local governments, and the full engagement of community groups across all sectors. Local medical personnel must be trained and information must flow quickly. Both the media and the private sector must be engaged. Drs. Nabarro and Gerberding both commented that coordination preparedness is among their highest priorities.

  > *"Level of preparedness is related to level of successful outcomes and response."*
  > — Jack McGuire

Other Important Points

- **Urgent realities.** Dr. Gerberding noted that while pandemic preparedness is a high priority, a pandemic is simply an urgent threat. However, there already exist "urgent realities," such as obesity, which must not be forgotten. A balance must be struck between the urgent threats and urgent realities.
- **U.S. leadership.** Dr. Nabarro commended the U.S. for the strong leadership being shown in preparing for a pandemic.
- **International variance.** Dr. Nabarro noted that some countries such as Thailand and Vietnam are far along in pandemic preparedness, while other countries such as Egypt need to do a great deal more.

Microfinance: Improving Economic and Health Status in Developing Countries

Overview

As seen by Grameen Bank in Bangladesh, microfinance has the potential to initiate a cycle that eradicates poverty. Through small loans that provide poor individuals with the opportunity to start businesses and unleash their potential, the poor are able to lift themselves out of poverty. They are able to achieve better health for themselves and their families and assure that their children receive an education. This can transform society.

Also transforming society are social business enterprises. These ventures are focused not on profit, but on doing good. Examples include Grameen Cell Phone and Grameen joint ventures with Dannon Whole Foods.

Context

Muhammad Yunus described the history and expansion of Grameen Bank and microfinance in Bangladesh, and the important role of social business enterprises.

Key Conclusions

- **Grameen Bank is rapidly expanding the provision of microcredit in Bangladesh and beyond.**

  Professor Yunus initiated microcredit in Bangladesh in 1976 with $27 which he used to make loans to 42 poor people in one village. In 1983 he founded Grameen Bank, which is owned by and lends to the poor. Last year, Grameen's staff of 16,000 made six million collateral-free loans averaging about $120; 96% of these loans are to women who use them to start small businesses. In 2005, 380 new branches were opened; in 2006 there will be 500 new branches. Each new branch achieves break-even status in roughly one year.

  About two and a half years ago Grameen began a new program of targeting and loaning to beggars, beginning in amounts of about $10. Loans have been made to about 70,000 beggars. These loans aim to help beggars stop begging: as beggars go door-to-door begging, they are encouraged to carry and sell merchandise. Grameen is also exporting microfinance to other poor countries around the globe.

  > *"All human beings have the capacity to take care of themselves. They just need the opportunity."*
  > — Muhammad Yunus

- **Grameen Bank is doing more than just lending money; it is transforming society.**

  Professor Yunus' goal is to eradicate poverty. He is guided by a philosophy that people have enormous capacity and the power to achieve. Microfinance can unleash that capacity and give people the means to lift themselves out of poverty. Grameen's microcredit loans have broad reach: because the average household in Bangladesh has five people, Grameen's six million loans touch 30 million people.

  But beyond the loans, Grameen is changing people's lives. Borrowers hold weekly village meetings in groups of 50-60. (Bill Gates, upon attending one such meeting last year, described it as "a religious experience.") Also, those receiving the loans are encouraged to consider "16 decisions." These include decisions such as whether or not to send their children to school. The result is that borrowers are sending their children to school, these children are staying in school, and many are going on to colleges and universities. Grameen is now providing more than 10,000 student loans to support these individuals. These children, born to illiterate parents, are now becoming doctors and engineers. The act of microcredit has helped people lift themselves out of poverty and focus their children on education, and is transforming society.

- **Poverty and health are linked.**

  Lack of health limits a person's ability to lift herself out of poverty; experience has shown that about 50% of the time when one of Grameen's borrowers doesn't repay a loan, it is due to a health-related issue. Having health gives a person the opportunity to escape poverty. At that same time, as people earn money, their health will improve.

  > *"Income is the best medicine for the poor."*
  > — Muhammad Yunus

  As microfinance has touched millions of people in Bangladesh, the health of the Bangladeshi population has improved. Despite India's outstanding doctors and hospitals, infant mortality in Bangladesh is lower than in India. In addition, in the United Nations Development Program's Human Development Index, Bangladesh ranks third in the world. Bangladesh also has one of the highest rates in the world for employment of women.

- **Corporations can assist the poor and help eliminate poverty through social business enterprises.**

  A social business enterprise is a business focused not on profit, but on doing good. An example is that Grameen and Dannon—one of the world's largest food companies—have recently formed a 50/50 joint venture to create fortified, nutritious foods to help malnutrition in Bangladesh. (Such an enterprise should not lose money, but Dannon may take its initial investment back and 1% of the profits.) Grameen is also working with Whole Foods on a social business program for Costa Rica and Guatemala.

  In addition, Professor Yunus is helping start a chain of cataract hospitals in Bangladesh, and Grameen Phone Company, the largest cell phone company in Bangladesh with 6.5 million subscribers, is selling cellular phones and service to rural areas through 200,000 "phone ladies" who act as retailers. In the future, these phone ladies will also become food and nutrition retailers as they sell the Dannon fortified products to individuals such as pregnant women. In this way, social business enterprises are creating jobs and income, while providing products and services that improve people's lives.

Perspectives from Leading Purchasers

Overview

Rising health costs are adversely affecting American productivity and profitability, but healthy employees are business's most important asset. So employers, health plans, employees, and providers must learn to spend health dollars more effectively. A greater emphasis on patient-centered care, including a greater degree of employee accountability in how health dollars are spent, can help rein in costs. Investment in technology, prevention-focused wellness programs, and compliant use of drugs for those with chronic conditions would be money well spent.

Context

The CEOs of Verizon, Pitney Bowes, and CIGNA and the executive director of The Permanente Federation discussed what is needed to reduce escalating health costs.

Key Conclusions

- **Rising health costs threaten to wipe out profits and hurt competitiveness, requiring employers to respond.**

  About 60% of Americans receive their health coverage through an employer, placing a huge financial burden on business. The cost of providing that coverage has risen on average from $700 per employee per year in 1989 to more than $8,000 today. The rate of increase is viewed by business as unsustainable. That burden damages productivity and profitability. Without gaining control over rising health care costs, American industry cannot compete. Employers must examine the causes of the spiraling cost increases (such as chronic disease treatment) and find ways to improve and manage the health of their employees.

- **Employers have a significant stake in maintaining a healthy and productive workforce.**

  Productivity is dependent on a healthy workforce. Pitney Bowes has modeled what drives costs, and is focused on keeping employees healthy, catching illness early, and preventing illness from progressing. Their philosophy is, "It is more effective to maintain health than restore it." To do so, they are investing in worksite clinics and education and wellness programs aimed at keeping employees from developing costly chronic conditions. They have also lowered employee co-pays for critical medications. These efforts are saving $5 for every $1 spent.

  > *"Managing costs instead of health creates both poorer health and higher costs. Our focus is maximizing health."*
  > — Michael Critelli

  Verizon is taking a different approach. To lower its health care costs for its 250,000 people (which last year were $3.4 billion), its executives believe that involving employees more in their care—with increased financial/payment responsibility—will encourage and empower employees to make better health decisions. Verizon's approach includes a move toward consumer driven health care with higher co-pays and deductibles. Ultimately—though not likely in the near future—Verizon would like to extricate itself from decisions related to health plans or care for its employees, viewing such decisions as outside the company's competencies. Verizon's CEO commented, "We would love to use our scale to help in purchasing, but we want to get out of wholesale subsidies."

  > *"It is not the cost I want to shift to employees; it is the responsibility."*
  > — Ivan Seidenberg

  Dr. Crosson cautioned that current "consumer directed" plans are primitive and could provide an incentive for people to avoid care. He believes that just the opposite is required to improve health and decrease costs: positive incentives to seek care.

- **Regardless of approach, employers want employees to take greater control of their health.**

  To take greater control of their health, employees need more flexible benefit design, which includes benefit portability, greater personalization of care, and information to make more informed decisions. The patient must be at the center of the health care system if the system is going to provide quality care and control costs.

  > *"Patient-centered care is a practical matter. Fully implemented, it will transform the way health care is delivered in this county."*
  > — H. Edward Hanway

- **Employers see the need for an increased IT investment by plans and providers.**

  Transparency is the key to improved quality. Achieving transparency requires the implementation of an interconnected industry-wide system of electronic health records. This will allow for accountability, portability, and improved management of chronic conditions, and will eventually lower costs through improved quality of care. Mr. Seidenberg said that the technology is mature and available. The key barrier is the cost, which is billions of dollars for a truly effective industry-wide system. Policy reforms are necessary, as is collaboration by employers, plans, and providers in sharing these costs.

- **Outreach is the biggest challenge facing employers and plans, but it is the only way to improve delivery.**

  Health plans and employers should reach out to employees and their families—especially individuals in segments such as obesity—to encourage behavior change, participation in wellness programs, and better management of chronic diseases. Consumer driven health care will result in a greater degree of employee accountability, but will not be effective in controlling health costs unless health plans and employers are proactive in improving health education and literacy for employees.

Other Important Points

- **The Massachusetts plan.** Legislation in Massachusetts is encouraging in that it encourages individual responsibility, but some questions are unanswered such as will there be insurance to buy, where will the funding come from, and will Massachusetts taxpayers subsidize care?

Wiring the Nation

Overview

Building an integrated health information technology (HIT) infrastructure requires public education about what is needed and why, and collaboration between the private and public sectors. The Bush administration's approach is that the optimal solution in creating this infrastructure is through a "guided market" where the government smoothes the ability for the market to function. The role the government is taking includes facilitating the creation of standards, certifying vendors, helping initiate demonstration projects, and coordinating government policy making.

In the private sector, moving to a more integrated IT infrastructure is not just about adopting new technologies, but requires a shift in attitude and culture, and new business processes. Also needed are more aligned financial incentives to reimburse providers for overall care and not units of work.

Context

Dr. Brailer, DHHS's Coordinator for National Health Information Technology, and two leading health care executives discussed the evolving progress and challenges involved in building a technology infrastructure for the American health care industry.

Key Conclusions

- **To create the health IT infrastructure, DHHS is focused on getting the public to understand *what* is needed, *why* it is needed, and *who* should do it.**

  In the two years since the Presidential Directive surrounding the electronic health record (EHR), Dr. Brailer, the first-ever Coordinator for National Health Information Technology, and DHHS have focused on creating the IT foundation for the U.S. health care industry. Priorities at this stage include:

  - *What*: Educating the public about what health-related IT is needed, including the function and use of the EHR.
  - *Why*: Educating the public around why HIT is so desperately needed. This includes enhancing understanding of how health care data can be used to reduce errors and improve care, and how health care data can unleash consumerism.
  - *Who*: Some people believe there should be a government agency devoted to implementing an HIT infrastructure; others advocate a "laissez faire" approach with no government role whatsoever. But, market failure is clear, leading to the conclusion that laissez faire is not an adequate solution.

  > *"It is clear that there is market failure. We are seeking a 'guided market' that smoothes the ability for the market to function."*
  > — David J. Brailer

  The decision DHHS has made and is pursuing is that government should "guide the market." This includes creating standards, certifying products to create trust, creating guidelines for data privacy, coordinating interagency policy making, and creating demonstration projects. While this guided solution is progressing, it still needs momentum. Building momentum requires:

  - *Certification*: A certification process is required for EHR vendors. Trust is an essential condition for buyers; certification helps create trust.
  - *Revisions to the anti-kickback laws*: This is required so health systems can help provide technology to physicians without being in violation of the Stark laws.
  - *Work group recommendations*: Multiple work groups have made progress and are close to issuing recommendations in areas including the ambulatory EHR, secure messaging, portable lab information, and information sharing in public health. These groups make important contributions by figuring out what is/isn't working, and fixing the problems.
  - *Transparency*: HIT can provide valuable information to consumers. Efforts are underway to make this a reality in several markets across the country.

- **Changing health care is not just about technology, but about changing processes, cultures, and incentives.**

  While the EHR and an improved IT infrastructure are important, they are only the beginning. The value of technology is in taking a system that is fragmented and episodic and linking it together to deliver care, especially for the chronically ill, that is continuous. This requires fundamental process redesign.

  > *"Process redesign is the key."*
  > — Robert Pearl, MD

  Dr. Steele commented that for HIT to be successful requires a culture focused on a common goal and paying providers differently. Financial incentives must be changed to reimburse providers for overall care and not units of work. He also said that a "force function" is needed to drive IT adoption.

Case Study

The experience at Geisinger Health System illustrates the value added in implementing an EHR. Geisinger serves 2.5 million in western Pennsylvania through tertiary care centers, specialty hospitals, community practice sites, and hundreds of physicians.

Since 1995, Geisinger has invested more than $70 million in hardware, software, manpower, training, and operational costs to integrate the EHR across the system. This EHR holds millions of records and provides access to hundreds of users from multiple locations. The IT system offers the capability to track clinical metrics by department and physician, provides clinical decision support, allows for web-based image distribution, and includes a quality control system linked to dashboards and tied to incentives.

Lessons learned include the importance of institutional commitment and strong physician leadership; the opportunities provided by the system for workflow assessment and redesign; and the realistic assessment that achieving an ROI took five to seven years, though that should be faster today.

Innovation vs. Access

Overview

There seems to be a tradeoff between innovation and access. Innovation yields new treatments which can improve health, but which often increase costs and limit access. And, the true benefits of these often expensive new treatments are often not clear.

Improving access and reforming the health care system require an emphasis on value. This requires changing the payment system and provider incentives through efforts such as pay-for-performance (P4P), so providers focus not on volume, but on caring for patients more holistically to improve their health. It also requires technology and more and better evidence about what really works, which places greater emphasis on the gathering of real-world post-market data.

Context

Dr. Galvin facilitated a conversation between Professor Reinhardt and CMS Administrator McClellan on innovation versus access.

Key Conclusions

- **Price setting for drugs and medical devices could discourage innovation and would not necessarily lower costs.**

  Government price setting could discourage R&D if manufacturers feel they cannot realize a profitable return on their investment (79% of the audience agreed). If the government were to set prices in the U.S., it is uncertain whether powerful pharmaceutical companies and device manufacturers would succeed in getting the government to set prices high enough to recoup investment and encourage further innovation, or if Congress would set them low to maintain or increase access. So, price controls could hurt innovation based on the level where prices are set, but may not decrease health costs.

- **Even more important than the level of health care prices is how payment takes place.**

  Medicare currently pays based on volume, not quality or outcomes. Thus, even if a price is low, if utilization is high the overall cost is high. But, Medicare is moving toward paying for care that improves health. Personalizing care and looking at health costs more holistically (not just at individual procedures)—although challenging—result in better value. Medicare is getting away from paying for expensive treatments with inconsistent benefits, and is encouraging investment in technology to streamline and individualize care (e.g., using EHRs to avoid duplicate testing).

> *"Medicare pays a lot for treatments that probably don't add a lot of value."*
> — Mark B. McClellan, MD, PhD

- **More evidence is needed to determine value, especially evidence gathered in real-world settings.**

  Limited evidence ties the hands of payers, providers, and consumers. Many insurers won't cover treatments because they lack adequate data about the treatment's effectiveness. The makers, however, say the costs of gathering such data are prohibitive. The current R&D process focuses on getting products to market and reducing the costs of development.

  Since many questions cannot be answered during the development phase, post-market evidence from real-world settings is needed (e.g., how a drug works in a patient with a comorbidity who likely would have been excluded from a clinical trial). Public and private health plans have the opportunity to evaluate how treatments work, augmenting clinical studies with evidence from various settings and populations. Some private and public groups are evaluating how to pool information from multiple sources to build a more substantial evidence base. However, the government should spend more on post-market research as a public good, because private funders have little incentive to invest in research that becomes public property and offers no competitive advantage. CMS leans toward public-private partnerships to develop the evidence base.

- **Covering costly new treatments with marginal benefits is a sensitive issue.**

  The question is whether and how payers and governments make rationing decisions for costly treatments of questionable benefit. Given the hypothetical example of an expensive drug that would provide terminal cancer patients with 6 more weeks of life, the majority of WHCC delegates felt this should not be covered, but that individuals should have access to the drug and be able to pay out of pocket. Dr. Reinhardt thinks we'll have to determine a cost/benefit formula (cost per life-year) for such treatments, drawing a line beyond which Medicare does not pay, as has been done in England. Today Medicare pays for most FDA-approved drugs and devices—an approach which ensures that the most expensive treatments are not available exclusively to the rich—and then seeks to gather data on new, expensive, and experimental treatments through clinical trials and patient registries to determine their benefits.

- **Quality measurement must be translated into actionable information.**

  CMS is among many payers using P4P and tying P4P measures to compensation. The data gathered in these efforts must be interpreted into information that can be used to inform decision making at all levels. CMS measures numerous quality indicators, including patient satisfaction, health outcomes, and complications, and recognizes the challenge of turning information into action.

Other Important Points

- **Part D pricing.** Medicare's Part D prescription drug coverage relies on competitive market pricing. Beneficiaries can shop for the plans with the best prices and realize the savings—something they could not do with a set-price system.
- **IT investment.** Much IT investment has aimed at maximizing providers' Medicare reimbursement. The government is more interested in supporting IT for high-quality, high-value care.

Consumer Choice

Overview

Consumers feel confident when they can make informed choices and get value for what they pay for. This is true in all industries, even in the complex financial services industry. Yet in health care there have been systemic barriers that have prevented consumers from making decisions that are medically and economically right for them. But with the growth in consumer directed health plans, the demand is rising for tools and information to help consumers make more informed choices. The systems and information are not yet integrated in such a way as to provide consumers with what they need, but progress is taking place.

Context

The CEOs of UnitedHealth Group and The Vanguard Group and the president of Consumers Union discussed the impact of consumer choice on health care and what tools and information the industry can make available to promote informed choices.

Key Conclusions

- **In the emerging age of consumerism the health care industry needs fundamental change.**

  UnitedHealth's William McGuire observed that all constituents of the health system know the problems—these problems are systemic and require a new way of thinking. It does not matter *who* pays for health care; what is important is how well the system works as a whole, and how well it provides the necessary tools, resources, and access for all participants.

  The system needs to be built so more personalized, individualized care can be anticipated and delivered. This system of the future needs to address the goals of quality, affordability, accessibility, and usability. It should be linked through technology in a way that works for providers and users of care.

  What needs to be examined are individuals' personal requirements—their health and social circumstances, and their environmental factors. This information is available today. Interoperable IT systems will allow this data to be aggregated, mined, and acted upon to guide patient care. This aggregated data can also be used to develop evidence on what works best and to assess provider performance.

  > *"Everything to make a better system is available today, but we haven't put the pieces together."*
  > — William W. McGuire, MD

- **The evolution of 401(k) plans provides an analogy for what can happen when consumers have a choice.**

  A quarter of a century ago retirement plans were fragmented, uncoordinated, hard to understand, and associated with high costs. That has changed. The introduction and evolution of consumer-driven 401k plans has resulted in a $2 trillion market. The key has been empowering people to make choices. John Brennan, Vanguard's chairman and CEO, attributed his firm's success to the bedrock, "People, if given good information and tools, will make good choices for themselves."

  Mr. Brennan believes four factors drove development of the consumer-driven retirement plan market, all of which are relevant as health care becomes increasingly consumer driven.

  1. *Effective education and communication*. The industry needed to move away from dense, complicated messages and materials to straightforward, easy-to-read information.
  2. *Technology enablement*. Technology made information available in real time. This began with toll-free 800 phone numbers, expanded to monthly statements delivered just days into a new month, and evolved as the Internet made accessing information and engaging in transactions easier.
  3. *Choices*. The market grew because consumers had real choices, which provided ownership and empowerment.
  4. *Willingness to observe, learn, and adapt*. Consumer-driven businesses are a wonderful lab. Companies that succeed listen to consumers, watch their behavior, and adapt.

  > *"It [the history of the 401(k) business] is a great story about empowering people...to make decisions and choices that are good for them."*
  > — John J. Brennan

- **People want to make choices but need trusted information.**

  For the past 70 years, Consumers Union has helped consumers make informed purchase decisions by making comparative information available on a broad range of products/services. Increasingly, consumers are interested in information about health care to assist them in making more informed choices. While making choices about health care is different than buying a toaster, the lessons about how consumers make decisions are the same across product/service. These include:

  - *Clarity*: Consumers want information that is clear, accurate, readily accessible, relevant, and helpful.
  - *Objectivity*: For information to be valuable, it must be unbiased, independent, and based on sound research.
  - *Completeness*: Information must be complete, transparent, and readily available.

  Mr. Guest believes that currently the health care industry is a long way from providing complete, accurate, and valuable information to assist consumers with their health care choices.

Other Important Points

- **Delegate attitudes.** Of WHCC delegates, 44% said they would consider consumer driven health plans; 24% said no, and 32% said maybe. In regard to the most important positive impact on the plans, 41% said consumer sensitivity to improved use of care; 19% noted increased use of quality information; 15% cited price transparency; 14% saw increased responsiveness to consumer preferences; and 10% saw increased demand for a single-payer system.

Leading Change

Overview

Health care in the 21st century will be radically different. It will be global, information led, and will focus on early health, rather than late disease. It will require wrestling with challenges such as obesity and caring for the chronically ill.

GE Healthcare is committed to improving clinical outcomes and making health care more cost-effective. It will do this through strategies that include making health care more integrated and holistic, and shifting the emphasis to prevention.

The changes that are possible in health care require leadership, which has often been lacking. Existing leaders should make it a priority to invest time and resources to develop tomorrow's leaders.

Context

GE's vice chairman presented his company's health care vision, and discussed GE's mission and strategies to lead change. Dr. Tichy discussed the leadership required to change health care.

Key Conclusions

- **21st century health care will be dramatically different.**

  In the 21st century, GE sees health care as:

  - *Global*: 20th century health care focused on the developed world. Today, the health care market is global, with major opportunities in China and India. In developed countries with an aging population, a chronic care burden exists. In the U.S., employer-led insurance coverage is being reduced. In China, a key challenge is diagnosing the huge portion of the population that resides rurally.
  - *Information led*: Lessening reliance on medicinal chemistry, a focus on the development and sharing of information will drive new innovations and targeted solutions.
  - *Biology, bytes and broadband*: Looking beyond devices for diagnosis and treatment, health care will rely on new clinical and technological advances that promote research, facilitate information sharing, and lead to enhanced care.
  - *Early versus late*: Previously, health care treated disease late in its cycle and tried to cure sick patients. In the 21st century, health care will use new knowledge and technology to provide care for the individual, and will promote "early health" rather than "late disease."

  Health care faces important realities, such as obesity, demographics, the costs of chronic disease, and the threat of a pandemic. The realities that must be confronted also include social and economic challenges and the need to change the view of health from a cost or liability to an asset.

  > *"Society needs to view good health as an investment in productivity and wealth creation."*
  > — Sir William Castell

- **GE Healthcare's vision focuses on the transformation of health care from "late disease" to "early health."**

  The mission is "To be a great and good company." This mission involves achieving better outcomes for individuals, more cost-effective and efficient health care for society, solutions relevant and accessible around the globe, and use of biomedicine.

  GE's Healthcare's vision involves driving clinical efficacy and overall system efficiency. This vision involves moving from a systemic focus on "late disease," which is symptom based, data starved, manages illness, and provides therapies for what works "on average" for a population, to "early health," which is focused on prevention, uses detailed patient information, provides early diagnosis, and delivers highly targeted therapies.

  The company's strategy combines "strategic platforms" linking social drivers (i.e. access to information), clinical demand, and technological enablers. Executing the strategy involves:

  - *Stepping stones*. Incremental solutions that leverage technology to go from treating disease to early patient care.
  - *A long-term holistic approach*. Health care will shift from interventions with devices and drugs to genetic profiling and risk factor management, non-invasive imaging, targeted therapies, and IT-based disease management—a more preventive, holistic approach with higher survival rates.
  - *Advocacy opportunities*. Technology is not enough. GE will work in partnership with others to educate consumers, create transparency, and change medical practice.
  - *Localization*. This involves developing products and services to meet the needs of emerging markets.

- **The promise of 21st century health care will not be realized without leadership.**

  Dr. Tichy remarked that change won't occur without leadership.

  > *"Nothing will happen in health care if we don't raise high the bar on leadership."*
  > — Noel M. Tichy, PhD

  In Dr. Tichy's view, good leaders are not born; they are selected, developed, and trained. Just as clinicians train other clinicians, leaders must develop other leaders. This requires:

  - *The commitment of existing leaders*. Developing leaders takes a considerable commitment and investment of time. At Pepsico, CEO Roger Enrico personally developed and led the company's leadership development, believing this was the best investment of his time and delivered the most value to the company. When leaders say they lack time for leadership development, they need to reassess their priorities.
  - *A teachable point of view*. A leader who is developing other leaders must be able to convey clear ideas, values, and emotional energy and edge.
  - *Real projects*. Leadership is not developed in a classroom; it requires real opportunities and relevant assignments with real-world risk.

Impact of Health Care Costs on the U.S. Economy

Overview

The growing portion of GDP devoted to health care for Americans threatens the U.S. economy and is especially worrisome because U.S. patients are not getting better outcomes than those in countries that spend considerably less.

The Bush administration believes the core problem is the disconnect between the person receiving the care and the entity paying for it. The proposed solution: using Health Savings Accounts (HSAs) and other devices to involve patients more immediately in the cost of their care, therefore making them better buyers of medical services.

Context

Secretary Snow outlined the economic problems associated with rising health care costs and shared the Bush administration's philosophy for mitigating the problem.

Key Conclusions

- **Health care has an extraordinarily long-range impact on the U.S. economy.**

  The importance of health care should be measured not just by the total outlays, but by the impact of those outlays on other elements of the economy. For instance, the greater expenditures on health benefits by U.S. companies compared with their overseas rivals puts U.S. business at a competitive disadvantage. And health care costs are changing the basic nature of the labor bargain in this country as exploding health care and insurance costs have increased the portion of compensation devoted to health benefits, and have hurt wage growth.

> *"It seems that all conversations of domestic policy quickly get to health care."*
> — Gerald F. Seib

- **The quality of care delivered in the United States is not commensurate with the high spending.**

  There are aspects of our health system where the U.S. is the best in the world: training doctors and nurses; conducting medical research; and developing new diagnostic and treatment technology. But there is a breakdown in linking those areas of excellence with the care provided. Despite spending far more per capita than other industrialized countries—in some instances twice as much—outcomes in the U.S. are not measurably better. And far too large a portion of the population is without any coverage at all, forced to pay health costs out of pocket, to forgo care, or to burden the system by not paying.

- **It is vital that the country pursues ways to make the health care industry more cost efficient.**

  The annual growth in health care spending is unsustainable: if unchecked, Medicare and other unfunded obligations of the federal government will eat up the entire federal budget. This cannot be allowed to happen.

> *"Health care is making an increasingly larger claim on the resources of the U.S."*
> — John W. Snow

Yet, most don't see an end in sight. When asked about the expected rate of health care inflation over the next five years in comparison to the overall inflation rate, no WHCC delegates thought health inflation would be lower; 52% thought health costs would rise twice as fast as overall inflation; and 16% thought it would grow at three times the inflation rate.

One way to stop the spiraling health care costs is to make providing care more efficient by encouraging more widespread adoption of information technology by providers.

In addition, the amount of care being provided has to be reduced by stemming procedures that arise from defensive medicine based on the fear of lawsuits, and by making patients more personally responsible for outlays.

- **The Bush administration believes HSAs along with high-deductible insurance will mitigate the cost problem.**

  Much of the problem with rising health care costs comes from patients choosing expensive diagnostic or treatment options that are far from medically necessary and hold little prospect of improving health. The Bush administration believes that much of this overuse stems from the fact that patients do not pay, and if they did have a financial stake they would choose more wisely, seeking more cost-effective treatments and rejecting costly procedures of dubious health significance.

  The premise is that HSAs, termed by Secretary Snow as "IRAs on steroids," coupled with high-deductible insurance coverage will lower health care costs by changing purchase behaviors. Americans will begin to act as intelligent consumers, just as they do in making other purchase decisions. The Administration projects that if its proposals to enhance HSAs and the tax savings associated with them are passed by Congress, 20 million Americans will use this option by 2010. In particular, they believe that small businesses that cannot afford coverage for their workers will be at the forefront of the movement.

> *"HSAs are not a panacea. There is no one panacea. A whole range of things needs to be done."*
> — John W. Snow

- **Employers will continue to play a major role as providers of health insurance, but it will be a diminishing role.**

  It is an accident of history and tax policies that the present employer-centered insurance system evolved, but it is now the core of U.S. health coverage and is not realistically going to be jettisoned any time in the foreseeable future. But as employers shave their outlays, the role of employer-provided coverage will diminish. Almost 80% of WHCC delegates believe that in 10 years the percentage of health care costs born by employers will be less than it is today; Secretary Snow agreed with that assessment.

The Administration's Health Reform Plan

Overview

The Bush administration's policies focus on addressing the problems of affordability and availability of health care by creating a more consumer driven system. The premise: if consumers spend their own money, they will seek the best value, which will create a more efficient system. HSAs are a vehicle to bring about this system, and more transparent information is required on provider pricing and quality. Other important policies include changes to Medicare and Medicaid, legal reform, and supporting the development of an electronic medical record.

Context

In a short video address President Bush laid out his administration's health care philosophy and priorities, and Allan Hubbard expounded on the key aspects of the Administration's plans.

Key Conclusions

- **President Bush's health care vision centers around consumer directed health care.**

  The United States has the finest health care system in the world, but this system faces serious challenges of affordability and availablity. Costs, deductibles, and co-pays have all risen sharply, which has suppressed wages. People are worried about finding quality health care, and there are 46 million people without insurance. The status quo is unsustainable. The country either moves toward a single payer system where the government sets prices and rations services, or adopts a consumer directed model.

  The President's philosophy is that health care should be run by doctors and consumers—not the federal government. The health system can be transformed by changing incentives so consumers, not third-party payers, make decisions about their own money and lives to get the best value, just as consumers do in purchasing other products. The lack of a consumer marketplace has caused consumers to behave as if health care is free. Consumers want unlimited health care, and providers charge high prices and operate inefficiently. Consumer directed health care will create value and efficiency.

  But, the government does have a role. It is to care for seniors and the poor. In this regard, the government has strengthened and modernized Medicare, which includes the first-ever prescription drug benefit, and has changed Medicaid to give states greater flexibility to design and provide benefits to best meet the needs of the citizens of those states.

- **The centerpiece of the Administration's policies are HSAs.**

  Consumer directed care can be brought about by combining tax-free Health Savings Accounts with high deductible insurance. This places spending decisions for routine matters in the hands of consumers. People are using HSAs to decrease their health care costs, and the public's reception is evident as HSAs have tripled to three million in the past year. One third of those with HSAs did not previously have health insurance, and one third of the employers that are offering HSAs did not previously provide insurance for their employees. Further legislative enhancements are needed to improve HSAs. These include: allowing individuals to pay for HSAs tax free, just as employers can; allowing people to contribute to HSAs tax free an amount up to their out-of-pocket maximum; and making HSAs portable so that people keep them even when they leave a job. It is estimated there will be 14 million HSAs in 2010; with these enhancements in place, that could grow to 21 million.

- **For consumer directed health care to take hold, greater transparency regarding price and quality is required.**

  With consumers exercising greater control over health and spending decisions, they need better information about price and quality to make good decisions.

  > *"To be a smart consumer you need to be an informed consumer."*
  > — President George W. Bush

  Mr. Hubbard argued that "the American people deserve price and quality information about medical providers." Some WHCC delegates argued that the concept of transparency is good, but measuring quality and having apples-to-apples comparisons is difficult and impractical. Mr. Hubbard understood the difficulty in arriving at effective ways to measure quality, but advised the health care community to figure out how to measure quality and create transparency so that transparency is not forced through legislation, which is awkward and not preferable.

- **Other key elements of the Administration's health care policies include supporting IT and legal reform.**

  While consumer directed health care, HSAs, and transparency are the central elements of the Administration's health care focus, other elements include:

  - *Support for IT.* The President has stated a goal of having an EHR for each citizen by 2014.
  - *Community health centers.* Under President Bush, the federal government has opened or expanded 800 community health centers to provide primary care services for the poor and uninsured.
  - *Eliminating junk lawsuits.* Medical liability reform legislation is needed to eliminate the practice of defensive medicine, which costs the system $60 billion each year.
  - *Association health plans.* Legislation is required to help small businesses band together to cover employees without health insurance.

Other Important Points

- **Chronically ill.** The 2-5% of the population with high-cost, chronic illnesses are the country's largest health care challenge. Two proposals: allowing companies to contribute extra money into HSAs for the chronically ill, and providing DHHS funds for innovative ideas for the chronically ill.
- **Bundled pricing.** Providers need bundled prices with an "all in" cost for a particular treatment.

Closing Keynote Address: The Politics of Health Care

Overview

The passage of the Medicare Modernization Act (MMA) marked a fundamental change in the country's entitlement policies. The emphasis is to provide vehicles that push greater responsibility to consumers. However, consumers are not yet well informed or equipped to make good health care decisions.

Due to dissension on Capitol Hill, it is unlikely that any health care legislation will pass this year, but it is likely that health care will be a prominent issue in the next presidential election.

Context

Representative Stark and former senator Durenberger—coming from different parties—held similar perspectives on MMA and the climate for future legislation surrounding health care.

Key Conclusions

- **Passage of the MMA signals an important ideology change in terms of income security and health system policy.**

  While the prescription drug benefit gets the press, MMA represents a significant shift in ideology and is a major reform of entitlements. Durenberger (a Republican) commented that the Republican leadership in Congress pushed through this legislation with an ideology of personal responsibility and financial accountability. MMA ends entitlement programs as we know them, replaces welfare with an "ownership society," and pushes the have-nots to the states. Stark termed the MMA and other Republican-led legislation as "an effort to dismantle Medicare; to privatize it."

  > *"The MMA is the most clearly focused ideology of system change and entitlement program reform in our history."*
  > — David Durenberger

  In terms of income security policy, an MMA goal was to avoid raising taxes and solve entitlement bankruptcy. The push by Republicans is for programs to become more consumer oriented and privatized, which would result in the financial services industry and private health plans taking on greater roles, putting huge amounts of public funds into play.

  On the health system policy side, CMS's goal is to see that Medicare becomes a national health financing program, with CMS providing policy direction. Medicaid will become a state/federal defined-contribution or premium-support program, with funding pools for managed care organizations. Also, emphasis is placed on shifting financial responsibilities to consumers through higher deductible or catastrophic plans.

- **The Administration's policy aims to empower consumers to drive "value," but doing so is not realistic for now.**

  With HSAs shifting financial responsibility to consumers, the intent is that payment will shift from volume-to value-based.

  However, the notion expressed by the President's chief economic advisor that "well-informed consumers will shop for the best [health care] deals" is not seen as a reality. Consumers are not "well informed" as they lack basic information about price and quality. (Providing this information will be difficult because in many health care facilities there is a tremendous amount of cross subsidization.) And, even if consumers were well informed, those who represent a large share of health costs (i.e. the fragile elderly with chronic illnesses) would not be able to shop, nor would those in urgent or acute situations.

  > *"They use language of 'choice' and 'consumers' and 'transparency'... it might have some impact [on GDP], but I'm not sure for the 20% of the population that generates 80% of the costs."*
  > — David Durenberger

  Another challenge related to HSAs is that they threaten to "disaggregate" the provision of care and decrease coordination as consumers pick and choose what care to purchase.

  One way to drive value is to change how providers are paid. More than 40% of care is not necessary but is paid for because providers bill based on volume. This results in tremendous variations in costs and frequency for the same procedures in different parts of the country. Today, those who have demonstrated value and promoted quality are penalized by receiving lower payments; this needs to be changed.

  > *"There is no outcomes research. We are last in health IT. There is no way to rate doctors."*
  > — Pete Stark

- **Congress is unlikely to pass health care legislation soon.**

  The panelists concurred that the current political climate is hostile and lacks any collegiality or cooperation across the aisle, as was previously seen when developing health care legislation. Stark predicted that no major health care legislation would be forthcoming this term.

  It was agreed that health care would be a central issue in the 2008 presidential election. With Mitt Romney, Massachusetts' Republication governor, likely running for president, based on his success in leading passage of the health legislation in his state it won't just be Democrats talking about health care.

Other Important Points

- **No leadership.** Senator Durenberger said there is no leadership on "quality." If the Administration were serious about quality, they would appoint a leader as they have done for IT.
- **Uninsured.** The Administration's policies fail to deal with the large and growing number of uninsured Americans.
- **Prisoner benefits.** Stark, who has introduced legislation to make health care a right for all citizens, joked that the only citizens for whom health care is a right are prisoners.

Key Themes from the 2006 Executive Congress

Overview

There is general agreement on the problems facing health care—excessive cost and inferior quality. Across the Executive Congress, panelists agree that improving quality can result in lower costs. Quality can be improved through a more connected IT infrastructure, by better engaging consumers in their own care, and by measuring and incenting providers based on quality.

There is also agreement that going forward, through the use of sophisticated information technology and genomics, medicine will become more targeted, personalized, and proactive. Models exist from other countries and even other industries that provide valuable learning.

Context

Sessions in the Executive Congress covered a range of subjects, including global best practices, improving and rewarding quality, personalized medicine, and the status of Medicare Part D. This summary ties together key themes across the Executive Congress.

Key Conclusions

- **The quality of the health care that is delivered is inadequate, but there are actions that can be taken to improve quality.**

  Most providers believe they provide good quality care, and that the statistics indicating voids in quality don't apply to them. But, those voids are glaring. As is widely quoted, only about 55% of patients receive the care that is recommended, and providers adhere to quality indicators 75% of the time, at best.

  The first challenge is simply defining quality. There are a growing number of organizations putting forth quality standards, but often there still is not agreement on what "quality" means.

  The prevailing view is that improved quality can be achieved through better information and incentives. The goal is to aggregate performance information to enable providers (and consumers) to be able to assess each provider's performance. Providers want to know what the measurements are, how they stack up, and what they need to do to improve their ratings. Pay-for-performance provides a critical financial incentive—which has been demonstrated to work—that helps motivate providers to change their way of practicing. Leadership by CMS, as the largest payer of health care, is necessary to drive major change.

- **Improving health care requires an interconnected technology infrastructure.**

  Use of technology is a global best practice, seen in Taiwan, in the UK, and increasingly in the United States. Information enables knowing exactly who each patient is and what his or her medical history is, and then providing the right, evidence-based treatment. Technology allows for sharing information, increasing efficiencies, and mining the data stored to identify particular patients (such as those with chronic diseases) and to intervene accordingly.

- **The future of health care will be about personalized medicine.**

  In the near term, more personalized medicine will involve care managers and coaches who coordinate the specific resources required by each patient based on his or her specific situation. In the longer term, the combination of information technology and genomics will enable delivering targeted treatments to each individual, in some instances even before the individual presents symptoms. Personalized medicine, based on an individual's genetic profile, will become increasingly preventive and proactive.

  Getting to the vision of personalized medicine will take time, continued investment, and innovation. It is important that despite the cost pressures being experienced there is significant commitment to innovation. And following innovation, challenges remain in getting scientific advances into actual practice.

- **Medicare Part D, the new prescription drug benefit, is meeting its overall enrollment goals but has not yet enrolled the number of low-income individuals that were anticipated.**

  At the time of the World Health Care Congress, 29 million people had enrolled in Part D, and CMS is confident that the 2006 targets will be achieved. But, enrollment levels for low-income seniors are behind target. CMS is applying the learnings generated to date to provide clearer information to beneficiaries about plan options and more assistance in enrolling.

- **There are a variety of success models the United States can look to in reforming its health care system.**

  In Taiwan, a single-payer system, health care represents only about 6% of GDP, consumer satisfaction is extremely high, and the quality of care is good. The system, which is underpinned by modern, state-of-the art IT, has provider competition and gives providers incentives based on outcomes measures. All citizens carry Smart cards which contain summary medical information, and all providers have Smart card readers. Taiwan aims to have a full electronic medical record in place in 2008.

  In the UK, efforts are being made to use IT to break down the silos that plague health care. Examples of how IT is being used include putting medical imaging online, enabling more providers to review the medical imaging results for their patients in their own offices. Also, patients in the UK can increasingly access their own records and use IT to make choices about their care and even schedule their own appointments.

  At Apollo Hospital Group in India an integrated IT system with universal patient identifiers enables effective and efficient care. Apollo is also using telemedicine technology to deliver care to the 70% of the Indian population living in rural locations.

  Finally, the principles and deep consumer understanding used by Intuit to guide consumers through the complex tax preparation process could be applied to help guide consumers through the even more complex health care system.

Global Best Practices for a Sustainable Health Care System

Overview

Countries are struggling with the rising costs of health care, regardless of whether they have privately or publicly funded systems. Expensive medical technology and drugs for chronic disease are driving up costs. But technology can also save money and improve health. Innovations that maintain health rely on IT to personalize care and encourage holistic approaches that prevent disease. Using technology effectively requires investment and long-term vision. To realize the promise of IT, health systems must create a digital infrastructure that breaks down geographic barriers.

Context

Representatives of a public health care system (the UK's National Health System), a major private hospital system in India, and a leading pharmaceutical company discussed effective international and domestic models for improving health and reducing costs.

Key Conclusions

- **Technology and innovation can rescue a system in distress.**

  Models predict a worldwide health system on the verge of disaster, with demand rapidly outstripping supply. Similar warnings existed in the 1700s when economist Thomas Malthus predicted global famine, as population growth would outpace the capacity to produce food. But technology and innovation enabled fewer farms to produce more food, averting disaster. Technology and innovation can also rescue health care.

  Today technology is viewed as a cost driver, and not a solution to keeping down costs. By focusing on the costs of treating disease, we overlook the savings realized by maintaining health. As much as 75% of health spending goes to managing chronic illness. To improve health, we must explore new ways to promote wellness.

- **Personalized approaches improve health and bring down health costs.**

  Pfizer has launched partnerships to reduce costs with a personalized, holistic approach. Aided by software, care managers identify high-risk, chronically ill patients, educate them about their conditions, help coordinate their care, and offer advice and assistance on self-management. These care managers go beyond traditional health concerns to tap community resources in addressing needs that affect health such as lack of housing or food, access barriers, and emotional issues.

  In Florida, Pfizer worked with 160,000 Medicaid patients with heart disease, diabetes, asthma, or hypertension. Care managers offered solutions—sometimes as simple as purchasing a scale to track weight. So far, outpatient costs and drug use are up, while ER visits and inpatient costs are down, saving Medicaid 5%.

  Pfizer is also working with London's Royal College of Medicine to apply this model in a low-income neighborhood with high health costs, is piloting the program in a Medicare demonstration project, and has applied it to its employees and their families.

  A holistic approach recognizes that maintaining health requires more than just treating disease. Lifestyle changes can incorporate alternative approaches. India's Apollo Hospitals Group has established programs for meditation, music therapy, exercise, yoga, Reiki, ayurvedic therapy, and homeopathy. Post-surgical patients who take part in and stick with these programs have shown improvements over those who don't. Combining alternative therapy with Western approaches has positive results.

  Reducing costs through case management and lifestyle changes requires a long-term view of health. Early intervention can seize opportunities to maintain health and prevent disease, allowing the system to devote fewer resources to treating and managing chronic disease.

  > *"The motivation for preventive care for the individual is living a healthy life. It's a long-term view, and it's not as visible as treating disease."*
  > — Joseph M. Feczko, MD

- **Integrated technology is a global best practice.**

  In the UK, the NHS is implementing IT in clinical settings by putting medical imaging online for providers. Approximately one hospital per week is going digital, enabling more providers to view medical imaging results for their patients in their offices. This widespread access saves money by reducing redundant testing and patient appointments. It also decreases patient exposure to radiation.

  > *"Putting in a digital infrastructure has been the starting point [for the NHS]. By the end of this year, we will have the largest VPN globally."*
  > — Richard Granger

  In India, Apollo is providing care equivalent to that in the U.S. at a fraction of the cost. Their IT infrastructure is a key reason. Apollo has instituted universal hospital identification numbers for all patients in their system. Also, Apollo invested significantly in telemedicine technology to improve the care they provide for roughly 70% of the Indian population that lives in rural areas.

- **Technology can break down silos.**

  Health IT has been uniquely provincial, varying by country, provider, and even by function in large organizations. The NHS is striving to break down these barriers by adopting a more universal system. The "Choose and Book" system lets patients make choices about their care. The NHS is providing patients with greater access to their own records. While there is some resistance, the hope is this will fade as more users have access.

Other Important Points

- **Medical Tourism.** More than 25% of patients at Apollo come from overseas. Medical tourism is a growing business for Asian countries, not just for savings, but also because they offer a pleasant, spa-like environment for recovery and incorporate lifestyle intervention.

Personalized Medicine

Overview

The future of personalized medicine comes straight from science fiction: genetic analysis that allows providers to diagnose and treat individuals before they ever develop a symptom. But before this vision can become reality the following must be addressed: the high costs of research and technology; the challenge of educating patients, providers, and payers about personalized medicine; the barriers to integrating care and sharing information; and potential ethical dilemmas.

Context

These speakers gave an insiders' perspective on how medicine seeks to use advances to target how and when to treat patients.

Key Conclusions

- **Genetic research is leading us into a new age of medicine.**

  In the traditional medical paradigm, patients developed symptoms and sought treatment. Research using large, population-based studies determined what treatments were most effective for the largest number of patients, and those treatments were applied to most patients. Symptoms were treated, but underlying causes were often not understood, much less addressed.

  Genetic research can now pinpoint the precise cause of some conditions, leading to screening techniques that can identify those who are most likely to develop specific diseases. The same research may reveal how to reverse or prevent the effects of disease. One can envision a new paradigm where individuals learn about their disease risk and how to manage it—without ever experiencing symptoms.

  > *"If you intervene early, you can prevent the irreversible events that drive chronic disease."*
  > — Elias A. Zerhouni, MD

  For example, about 7 million seniors are at risk for macular degeneration. NIH research found two genes that explain about 70% of all cases and two supplements that can prevent this condition in those with one of the two genes. Thus, with genetic screening and counseling, providers can help prevent a leading cause of blindness among seniors.

  Through screening techniques that determine which patients will benefit from which treatments, improvements are being seen in areas such as treating epilepsy and providing chemotherapy for breast cancer. As Dr. Zerhouni said, medical care is becoming predictive, personalized, and preemptive.

- **Targeted care requires extensive coordination and infrastructure.**

  Although we've seen tremendous advances in cancer treatment, the death rate from cancer has remained steady for 50 years. Clearly, not all patients benefit from the same treatments. Particularly for those with advanced cancer, providers are challenged to match the best treatment to the individual patient. Increasingly, genetic and molecular analysis are being used to guide this treatment matching process, but this process is very complex and difficult, and requires remarkable coordination among providers to gather and assess as much information as possible about the course of a patient's condition over months or even years. One organization engaged in these activities is TGen, which uses sophisticated, expensive IT to analyze data and personalize treatment. Prospective clinical trials and economic models are being developed to assess this approach.

  > *"Patients are individuals, and so are their tumors."*
  > — Jeffrey M. Trent, PhD

- **High initial costs should not deter innovation.**

  History has shown that technology costs decline over time. Phones and computers were initially expensive, cumbersome technologies with limited application. Yet cell phones and PDAs are now cheap and widespread. In medicine, the cost of DNA testing has dropped considerably since its debut.

  More data is needed to demonstrate the effectiveness and cost-effectiveness of genetic analysis in targeting treatment. Ideally, data will prove the technique is not just another layer of costly diagnostic testing but is a way to eliminate unnecessary tests and treatments in favor of those that work best for a given individual.

  > *"We need research that tells us the value [of new technology] in the context of all the other workups available. We're tired of paying for technology that is additive, not supplantive."*
  > — Reed V. Tuckson, MD, FACP

- **Providers must put science into practice.**

  The challenge is to incorporate scientific advances into practice. The IOM says 45% of patients don't get the recommended treatment, and 11% receive treatment that is not recommended or even harmful. For example, Herceptin is an expensive treatment targeted to breast cancer patients with a specific gene. However, 11% of the time physicians prescribe it for patients who lack this gene. Clearly, some providers are not putting existing research and techniques into daily practice, despite strong evidence.

- **Personalized care must be patient-centered.**

  The patient lies at the center of a complex interaction of science and genetic research, clinical care, care coordination, social support, prevention, lifestyle management, and decision making. Most people are not well prepared to interpret the complicated information that is part of a difficult health choice. Even many health professionals feel overwhelmed by conflicting data and desire help identifying and applying best practices. Few people are trained to offer genetic analysis, and no efforts are underway to encourage more people to enter the field.

  Many issues surrounding genetic analysis have yet to be resolved. How much do individuals want to know about their risk for certain diseases, and when do they want to know? Are families entitled to information, or just the individual? Can employers or others use genetic factors to decide who to employ or insure? Anti-discrimination legislation is needed before genetic screening and counseling becomes mainstream.

Consumer Engagement and Personal Health Records

Overview

Taiwan's amazing national health system and Intuit's successful TurboTax product provide two very different but powerful models that the U.S. health care system can learn from. Taiwan is a single-payer system where consumers have complete flexibility in choosing their providers. The system is built on state-of-the-art IT, including Smart cards that contain summary personal medical information. Providers are increasingly measured and rewarded based on outcomes. Quality and satisfaction are high; cost is low.

Intuit has revolutionized the way Americans prepare their taxes. Based on a deep understanding of consumers, Intuit radically simplified the tax preparation process. While health care is far more complex, many of the same principles that led to Intuit's success can be applied to addressing the problems in health care.

Context

Mr. Chang described Taiwan's successful health system. Mr. Cook explained the principles behind Intuit's success in developing tax preparation software and how those principles apply in health care.

Key Conclusions

- **Taiwan's single-payer system, supported by strong IT, delivers high quality and low cost.**

  Taiwan's National Health Insurance (NHI) is a single-payer system where citizens pay $20 per month for coverage. While there is just one payer, the provider market is competitive as citizens have complete choice of providers, and the NHI has implemented a program to pay providers based on outcomes. There are no waiting lists, no gatekeepers, and minimal co-pays. The benefit package is generous. Public satisfaction is extremely high and health costs are low, as health care represents only 6% of GDP, one of the lowest rates in the world and far below the U.S.'s 16%. The costs to administer the NHI are less than 2% and have declined continuously over the past decade.

  > *"[Taiwanese] businessmen traveling in China said they would take the next flight home for any operation, and 80% said they would choose to come home even for an acute disease or emergency."*
  > — Hong-Jen Chang

  The system's success is based on an advanced IT underpinning. From its inception in 1995, NHI has had electronic claims processing with a uniform reporting procedure and format; a standardized coding was phased in over 2-3 years; and broadband is available. Electronic claims processing has resulted in a comprehensive database that can be mined to profile providers and patients, and can be used for decision support.

  Beginning in 2001 the NHI initiated a Smart card system, which provides citizens with a portable personal health record. By 2004, every provider had a card reader, and every individual (22.4 million Taiwanese) carried a Smart card. In addition to basic identifying and insurance information, the card contains medical data for each individual's six most recent visits and prescription medicines for chronic diseases. It includes: dates and locations of visits; providers; diagnoses; prescriptions; preventive services; allergies; and vaccination information. Taiwan is aiming to implement a full-blown EHR in 2008.

  > *"Introduction of the Smart card further improves the performance of the system, especially on the management of chronic diseases."*
  > — Hong-Jen Chang

  The investment required for the Smart card totaled $191 million over 3 years. This investment has paid off. A recent study estimated that just by preventing fraud and abuse, the Smart cards will save the country $1.2 billion over 10 years.

- **The principles Intuit used in revolutionizing tax preparation have relevance in thinking about how to change health care.**

  There are few systems more complex than the U.S. tax system. The tax code is so complex that nearly half of all Americans pay someone else to do their taxes. By developing a deep understanding of the tax system and how consumers prepare their taxes, Intuit created TurboTax software, which has improved tax preparation for millions.

  > *"The starting point is understanding that the consumer is lost."*
  > — Scott Cook

  As technology has evolved, so has TurboTax. Users can download financial information (bank account interest, wages, investment dividends) directly from their financial providers. Tax forms can be filed, taxes paid, and refunds received electronically. Intuit's Quicken product offers similar convenience for personal financial management. Intuit's success comes from intensive focus on how customers use and would like to use their products. Not only has this improved the lives of consumers, but it is easier for the financial institutions to share information, has increased customer loyalty for these institutions, and has saved the IRS $600 million. Among the key lessons Intuit's experience illustrates are:

  - *Understand the consumer.*
  - *Consumers will engage in technology when it benefits them.* Intuit's software helps users manage their own personal information in a meaningful way.
  - *Electronic customers are more loyal.*
  - *Customers will adopt user-friendly technology.* (This applies to Taiwan's experience with Smart Cards as well.)
  - *It is possible to connect multiple sources.* Intuit pulls in information from thousands of financial institutions.

  Health care is more complex than taxes. There are more players, greater privacy concerns, and no clarity about data ownership. Still, Intuit believes the lessons it has learned from TurboTax are applicable in health care, and is working with partners to try to address some of the problems in health care.

  > *"We're applying the same principles we used to create TurboTax and Quicken to solving some of the problems in health care."*
  > — Scott Cook

Rewarding Quality: Physician and Employer Perspectives to Improve Quality on a National Scale

Overview

The American health system suffers on two fronts: costs are rising with no end in sight, and quality is inconsistent. Rewarding quality through value purchasing and pay for performance (P4P) initiatives aims to bring down costs by getting the right care at the right time. But there is not consensus about what constitutes quality, and providers will have to sacrifice freedom in the name of account-ability. Rewarding quality requires better information and tools to assess quality, as well as incentives for providers to change their practices and for consumers to take more control of their care.

Context

Mr. Lee explained why purchasers believe rewarding quality is effective, and Dr. Tooker described challenges and efforts underway to do so. Mr. Millenson outlined the barriers to change.

Key Conclusions

- **Rising health costs threaten America's economic strength.**

  Spiraling health premiums are reflected in lower earnings and employee compensation. In some cases, employers could be driven out of business. Other employers will stop subsidizing insurance, leaving an underclass of working, uninsured people with limited access to health care. Both scenarios are occurring. Insurance coverage among workers at the highest and lowest income levels has been stable for about 15 years. But among middle-income earners coverage has dropped about 10% since 1987. Health care purchasers must find ways to address this.

- **Improving and rewarding quality sounds easy, but quality is not easily defined.**

  The current system pays for volume, which increases costs and offers no incentive for improvement. Only about 55% of patients get the recommended care. At best, providers adhere to quality indicators 75% of the time. For many conditions, they are even less likely to follow evidence-based guidelines.

  Most providers think they deliver quality care. But providers are reluctant to have their performance measured as they do not agree on what constitutes quality, who should measure it, how good quality should be rewarded, and how bad quality should be addressed. The chair of the AMA Board of Trustees called P4P "the newest scam dreamed up by multimillionaire CEOs…to reduce payments to the vast majority of physicians." Many providers simply do not believe the data about poor quality—and don't believe it applies to them.

  > *"Most doctors believe they provide quality care, and so do their patients, and as a result, so do their Congresspersons."*
  > — Michael Millenson

- **Implementing P4P requires national leadership.**

  There is no national roadmap to define quality or P4P. As the largest purchaser, CMS can and must lead the way to reward value. Establishing performance measures and reporting procedures will drive improvement and lead to standardization across the health system. Demonstration projects are already showing positive results.

  > *"CMS's Physician Voluntary Reporting Program looks like the precursor to a national Medicare P4P program."*
  > — John Tooker, MD, MBA, FACP

  The AQA, a coalition of more than 125 stakeholders including medical societies, industry groups, and government agencies, developed 25 core quality measures. CMS's 2006 Physicians Voluntary Reporting Program includes 16 quality measures, most of which dovetail with the AQA core measures.

  Quality care should be a goal in itself, with P4P serving as a divi-dend. However, small practices need more support to change how they practice. They don't have the capital to invest in high-tech tools for QA and performance improvement.

- **As a country, we must recognize the trade-off between autonomy and accountability.**

  There are fundamental questions that have not been raised or debated, such as: Are providers willing to accept performance measures? Will they tolerate public reporting that identifies who does not meet quality standards? Will consumers accept that they must pay more if they have not made good lifestyle choices or have been unable to manage their own care?

  Malpractice concerns also influence assessing quality. Competing legal interests both encourage and discourage sharing provider information. There are concerns that defining quality specifically opens the door for litigation by patients who claim their care did not meet quality standards. Some argue that litigation drives poor performers out of practice; others say it only drives up costs.

- **Information and incentives will spur better performance.**

  P4P gives providers incentive to change their practices. But they also need information telling them where they stand and need tools to help them assess and improve their care. Likewise, consumers need tools and incentives to make better choices.

  - *Consumers need better tools.* Every large purchaser offers tools to employees to help them compare plan costs. Evaluating quality has been more difficult. The NCQA publishes quality measures to help consumers assess hospital care. The industry has long held that such tools cannot be applied to medical groups or individual physicians, but there are emerging examples of payers that are collecting and sharing performance ratings for individual physicians.

> *"In 2005, 11 million consumers said they used physician quality information to change their behavior. I don't know what tools they're using; the ones out there right now are cruddy."*
> — Peter V. Lee

- *Turning information into action*. Once armed with data, consumers need help interpreting it. That's where decision-support coaching comes in. Employers want payers to take the lead here.
- *Certification can be a physician incentive*. The American Board of Medical Specialties, which certifies doctors in 24 specialties, will require that physicians demonstrate use of performance measures and improvement to recertify. The Accreditation Council for Graduate Medical Education now requires candidates to learn how to do practice-based learning and improvement before they can sit for their boards.

Other Important Points

- **Medicare contradiction.** Physicians believe that Medicare's formula for determining reimbursement rewards volume, not quality. Until Congress addresses this, meaningful quality improvement will not be realized.
- **Gaming the system.** Once performance measures are defined, it is inevitable that some providers will manipulate the data. P4P initiatives should recognize this, but it should not prevent P4P from moving forward.
- **Reward to punishment.** The P4P carrot will soon become a stick, as some Medicare hospital providers will face penalties for *not* publicly reporting performance measures. Effective in 2007, failure to report will result in a 2% reduction in reimbursement.

Medicare Reform Implementation

Overview

Medicare Part D is providing seniors with much-needed drug coverage. The first wave of Part D enrollees opted for plans with broad formularies and low utilization management, and with low or no premiums or deductibles. However, many low-income seniors are not yet enrolled. While CMS believes Part D's structure will keep drug prices stable, AARP argues the government may have to control costs. CMS has learned that consumers want clarity and that procrastination to enroll is inevitable.

Context

Ms. Block provided data about Part D enrollment and described what CMS has learned so far, while Mr. Rother expressed AARP's views on areas requiring improvement.

Key Conclusions

- **CMS is meeting its Part D enrollment goals, but may not be reaching those who would benefit most.**

  So far, 29 million people have enrolled in Part D, and CMS is confident it will reach its 2006 targets. Enrollment breaks out as:
  - 6.4M in stand-alone plans.
  - 5.8M covered under both Medicaid and Medicare, automatically enrolled.
  - 5.7M in Medicare Advantage plans.
  - 6.2M have employer-based drug coverage.
  - 3.5M covered under the Federal Employees Health Benefit Plan.
  - 1.9M covered under TRICARE.

  CMS is not meeting expectations for enrolling low-income seniors—the group that can benefit most. About one-third of seniors are low-income; the coverage offered to them is worth about $3,200 per year. Only about 20% of those AARP thought would be eligible for Part D low-income coverage have enrolled.

  Low-income seniors must complete extensive Social Security Administration paperwork, which may contribute to the low enrollment. The paperwork is an asset test that penalizes those who have amassed some savings. CMS is planning outreach efforts; AARP says reaching these individuals requires face-to-face contact to address language barriers.

  > *"The asset test is a major disincentive, and I think it does not belong in a social insurance program."*
  > — John Rother

- **Many beneficiaries opted for broad, open formularies with low initial costs, but future drug prices remain a concern.**

  About 80% of enrollees chose plans with formularies containing at least 1,000 drugs, and about the same percentage selected plans with little utilization management. Most enrollees chose plans with little or no deductible and low premiums.

  While costs are important, Part D does not address cost containment. CMS believes the current prices are relatively stable, but AARP questions whether they are artificially low. The initial costs are lower than projected by the Congressional Budget Office, and the plans have substantial buying power that will help negotiate low drug prices going forward. However, because some plans may have underpriced initially to draw consumers, AARP favors giving the Secretary of Health and Human Services authority to intervene if a plan raises its prices dramatically.

  While some favor locking in formulary prices to ensure stability, this has drawbacks. For example, manufacturers could take advantage of their captive audience and raise prices after the drug plan has negotiated and fixed its price for plan members. At present, CMS individually reviews every formulary change request. Some changes are necessary and appropriate, such as when a generic drug becomes available or a safety issue is raised.

- **CMS is applying the lessons learned from the first wave of enrollees.**

  Consumers were confused by plans offering very similar options. Next year, when a plan offers more than one package, CMS expects those options to be clearly differentiated for consumers.

  > *"We've heard about enrollees' confusion, and we want to make sure consumers understand the differences in the products offered and can make clear, informed choices."*
  > — Abby Block

  Procrastination is common among Part D enrollees. Some waited until New Year's Eve to enroll for benefits taking effect January 1. CMS is cooperating with drug plans to encourage beneficiaries to enroll early so they will have their cards in hand and their information will be available at their pharmacy when filling their first prescription. As the open enrollment period draws to a close, CMS is beefing up phone support for the expected surge of inquiries and is encouraging drug plans to do the same.

  CMS is also addressing system integration and information exchange issues and is monitoring plans to ensure they meet CMS's customer service standards. In particular CMS is monitoring the handling of appeals and the management of provider relationships, especially with pharmacists.

- **Part D is here to stay but will likely evolve to include fewer drug plans and more consumer focus on price.**

  CMS's data on enrollment will probably affect what the market offers. There will likely be fewer drug plans, and the programs within plans will be more distinct. As the costs of drug plans increase, individuals will focus less on access to broad formularies and more on cost-effective choices. Five years from now, CMS sees Part D so entrenched that it's taken for granted. However, if drug prices skyrocket, Congress may intervene.

Other Important Points

Political pressure. The deadline for open enrollment (May 15, 2006) will likely spur action. With elections looming, it is possible Congress may reconsider the 7% penalty for enrolling after the deadline. CMS would like Part D to remain stable for the next few years and hopes Congress does not tinker with it.

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