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Cost, Quality and Access-to-Care Issues in the U.S. / Ohio / Northeast Ohio

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Tom Campanella joined Baldwin-Wallace College as Director of the Health Care MBA Program in 2003. He is also an attorney (of counsel) with the law firm Baker Hostetler, Cleveland, in health care law and has over 20 years' experience in the health care industry. He was vice president of healthcare finance and care management at Blue Cross & Blue Shield of Ohio and Medical Mutual of Ohio from 1989 to 1997 and was associate dean of the Ohio University College of Osteopathic Medicine and manager of its physician clinics in Athens, Ohio, from 1997 to 2000.

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INTRODUCTION

This issue of the Quarterly Health Care Report provides the reader with a wide spectrum of articles under the heading of cost, quality and access to care. In addition, this issue will specifically focus on the importance of providing and receiving value in healthcare.

COSTS

Health Care Spending to Double by 2016

Although growth in U.S. health care spending slowed slightly in 2006 for the fourth straight year, overall healthcare expenditures are expected to

double by 2016, when they will consume almost 20% of gross domestic product (GDP), predicted economists at the Office of Actuary at the Centers for Medicare & Medicaid Services.

Beyond 2006, the growth in health care spending is projected to remain relatively steady at 6.9% per year through 2016, and will grow an average of 2.1% points faster per year than the economy. National health care expenditures will reach $4.1 trillion by 2016; nearly double the 2006 projection of $2.1 trillion.

The authors further stated that the rise of "consumer-driven" strategies to contain health care cost growth is a topic of most recent interest. To date, enrollment in High Deductible Health Plans (HDHPs) remains small, inclusive of people who were already enrolled in these plans prior to the passage of any tax incentives. Estimates of spending changes that result from shifting from a standard provider organization (PPO) - type plan to a standard HDHP, coupled with a health savings account (HSA) or health

reimbursement arrangement (HRA), are fairly modest.
This does not mean that rising cost sharing has not influenced recent growth; the use of cost-sharing requirements through tiering has been effective in slowing the growth of drug spending.

The decade-long projection detailed in this document expects that nearly 20 cents of every dollar spent will be devoted to health by 2016. Such a projection indicates that our society will continue to address the key issues regarding the potential to sustain our current path, the possibility that we will have to make important sacrifices to pay for health care, and the constant assessment of the value we associate with our health care investment**.** ("Health Spending Projections Through 2016: Modest Changes Obscure Part D's Impact," Poisal, Truffer, Smith, Sisko, Cowan, Keehan, Dickensheets, and the National Health Expenditure Accounts Projections Team, Health Affairs, February 21, 2007)

Tom's Comments:

In the above report, the economists at the Office of Actuary at the Centers for Medicare and Medicaid Services made a number of important observations. First, and most importantly, "At the present pace of healthcare spending we as a society will need to make important sacrifices (or choices) to pay for health care, we need to make a constant assessment of the value we associate with our health care investment."

A familiar quote we often use is that, "Life is about choices." Clearly spending that helps provide better overall health for our people is a worth while choice for our society. We also have many other equally important societal priorities including education, public safety, financial assistance to those in need, national defense, our overall economy, etc. In all of these areas, including healthcare, we need to ensure we are optimizing the "value" of our investment. We will talk further about value in healthcare within this issue of the Quarterly Health Care Report.

Health Care Price Transparency and Price Competition

A good source of health care research and public policy information is the National Health Policy Forum (which is part of George Washington University (www.nhpf.org). One of their research papers focused on health care price transparency and price competition.

The author of the report, Mark Merlis, did a good job of providing the reader with an overview of the steps that insurers and others have taken to make better price information available. The paper also looks into the role that government has in promoting transparency as well as to simplify price comparisons. Finally, the author assesses the likely effects of these efforts on consumer behavior and provider competition.

In the concluding paragraph the author states the following: "Whatever the progress toward price transparency (and its elusive companion, reliable quality reporting), it may be a very long time before consumers are really well equipped to make complex decisions about price and quality in medical care."

The author further states, "Some observers hope that health plans could evolve to assume the "trusted agent" role once occupied by personal physicians. Does this conflict with the goal of consumerism? One analyst argues that, while people don't use agents when they want to buy cereal, they often do when they want to buy mutual funds; agency and consumer autonomy are not necessarily incompatible. Still, to the extent that interest in consumerism has been driven in part by the "managed care backlash," fixing the troubled marriage of health plans and enrollees may be a long process." ("Health Care Price Transparency and Price Competition," National Health Policy Forum, Mark Merlis, March 28, 2007, (www.nhpf.org)

Tom's Comments:

The author made a valid conclusion when it comes to both the practicality and usefulness of price transparency information. The author is also somewhat suspect of the role that managed care organizations could have as agents for the consumers. While I can understand his concerns, I would not automatically write-off the potential role that MCOs could have guiding consumers through the healthcare maze.

We actually have some precedent with this agency role when it comes to prescription drug formularies. Currently three tier, and in some cases, four and five tier formularies exist. While the system is somewhat flawed, third party experts (Pharmacy Benefit Managers) use cost and quality information to designate the various drugs into the appropriate tier. Each tier would be linked to a specific fixed or percentage co-payment. Consumers have the ability to choose their drug, but the "experts" hope to persuade them by means of the co-payment system to select the drug that provides the best value in terms of cost and quality.

As I stated previously, there are flaws with the formulary system (egg. rebates from drug manufacturers that incent PBMs to place drugs into a preferred tier, etc.). The theory behind formularies could indeed apply to the medical side, although it would be much more challenging.

MCOs could develop "High-Performance Networks" which are discussed next in this issue of the Quarterly Health Care Report. MCOs could also focus on medical conditions. MCOs could incent/educate consumers to specific providers that are in the best position to manage their medical condition. This would especially be pertinent when it comes to managing chronic diseases. Michael Porter's book, "Refining Health Care," discusses the importance of focusing on medical conditions, specifically along the continuum.

In healthcare, as well as most industries, the 80/20 or even 90/10 rule applies. Some examples of this phenomenon is the following: 1% of the utilizers in any large group usually impacts 30% of the annual healthcare costs; 10% of the utilizers in a large group usually impacts 70% of the healthcare costs; certain disease conditions have the greatest impact on health care costs (egg., heart, cancers, etc.). MCOs do not need to micro-manage this process but, by targeting key medical conditions, they could have a very positive impact on both costs and quality of care for the patient.

MCOs have expertise, technology, data and resources to play a critical role in facilitating the decision-making process for consumers when it comes to finding the appropriate providers to care for their medical condition. Also, through various mechanisms, MCOs could develop incentives (similar to the drug formulary approach) through the use of cost-sharing mechanisms that help direct the consumer to the best value from a cost/quality perspective.

Ultimately, MCOs would then be competing between themselves as value agents to best meet the needs of payers and consumers, similarly to how stockbrokers compete today in the marketplace. MCOs need to rise to this challenge and not just be driven by short-term profits. Their sustainability and long-term profits will be determined by how they manage their role in bringing value to the health care marketplace.

High-Performance Health Plan Networks: Early Experiences

Health plans have introduced high-performance networks to encourage use of network providers - predominately physician specialists - deemed high performing on efficiency and quality measures. Health plans analyze claims data to assess network physicians on the basis of efficiency using costs per episode of care, such as treatment of low back pain, and on measures of quality that can be assessed with claims data, such as hemoglobin A1c blood testing for a diabetic.

The exact specifications of high-performance networks differ across plans. The most common model uses tiered-provider levels, with corresponding enrollee cost-sharing differentials. The first tier consists of the high-performing providers; the second tier consists of the remainder of in-network providers; and the third tier consists of out-of-network providers.

Plans most often target physicians - generally specialists - for high-performance networks, hospitals usually are not included. While most plans do not target hospitals for high - performance networks, hospitals are relevant to judgments about physicians because total claims cost per episode of care, including hospital costs and prescription drugs, are used to assess physicians' efficiency.

Employer groups, such as the Business Roundtable, have pushed for legislation giving insurers access to Medicare Part B data with physicians

identified to facilitate more accurate assessments of physician costs and quality through larger samples of patients. Several respondents to the survey noted that unless there is greater uniformity in the industry, any performance information provided to physicians and consumers will be confusing and of little use. Physicians will be less likely to respond positively, by improving efficiency and quality, if different health plans rate them differently. ("High-Performance Health Plan Networks: Early Experiences," Center for Studying Health System Change, Debra Draper, Allison Liebhaber and Paul Ginsburg, May 2007)

Tom's Comments:

Most of my comments relating to "High Performance Networks" are detailed in my previous commentary under "Price Transparency and Price Competition." Medicare has always had an open access approach when it comes to seniors accessing health care providers. Medicare is in the position, more than any MCO, to evaluate the cost and quality of hospitals and physicians. Medicare could also develop a "High Performance Network" for seniors and require/financially incent seniors to utilize that network. Politically, Medicare would have a difficult time implementing such a network since, as a result of their great market power; many providers/services that are not in the "High Performance Network" could not financially survive.

Indirectly Medicare may be using Managed Care Plans through programs such as Medicare Advantage to accomplish this task. MCOs could develop "High-Performance Networks" that are provider focused or medical condition focused, which otherwise could not be politically implemented by Medicare. By using MCOs as their agents, Medicare's market power would be diluted which would be financially less radical to the providers. There are still some barriers to effectively implement such networks but, given the financial pressures of Medicare, the use of MCO agents may be an approach that is politically expedient.

The message to providers in all of this is that it is critical to be able to demonstrate real value (in the form of cost and quality) to both payers and consumers. Health care providers are now stating that they should be the ones defining quality in health care. I agree with this ownership approach in theory but, unless quality and in turn value meets the needs of payers and consumers, it will be perceived as being only driven by provider self-interest. While process initiatives and guidelines are an important tool to achieve better outcomes, ultimately actual quality outcomes and cost efficiencies must be demonstrated.

As stated in the prior section, MCOs hopefully will respond to this opportunity to be a player in the Medicare arena with a long-term focus, rather than driven by short-term profits. Their success, like that of providers, needs to be driven by their ability to provide value in the marketplace. If MCOs are unable to demonstrate that value, they may not only be losing the Medicare market, but it could set the stage for advocates of a one-payer system.

Prescription Drug Spending Growth Rate is Expected to Increase in 2008 and 2009

Prescription drug costs increased at a slower rate in 2006 than in 2005, but the growth rate is expected to increase in 2008 and 2009 because of fewer generic drug releases and higher spending on specialty drugs, according to Express Scripts' annual drug trend report. Express Scripts found that drug prices rose 8.2% in 2006, compared with 9% in 2005. In 2006, several blockbuster drugs went off patent, and lower drug spending resulted from patients switching to generics.

Medications to treat diabetes did experience a major price increase of 15.5% in 2006. Express Scripts expects the costs of diabetes medications to continue to grow at double-digit rates for the next four years. Spending on specialty medications - high-cost, often injectable drugs - is experiencing the fastest growth rate. Spending on those drugs is expected to reach $99 million by 2010, nearly double the $54 million spent in 2010. Specialty drugs are predicted to represent 25% of pharmaceutical costs by 2010. ("Report says prescription drug prices rise at a slower rate," St. Louis Post-Dispatch, Mary Jo Feldstein, April 26, 2007)

Fast Facts:

- Per a 2006 study from the Kaiser Family Foundation (www.kff.org) the percentage of companies that self-insure their healthcare benefits vary by size of employment: "News Briefs," Managing Benefits Plans, May 2007, Issue 07-05, Page 9 (www.IOMA.COM/HR)

	Size of Company	Percentage Self-insured
1.	< 200 employees	13%
2.	200 to 1,000 employees	53%
3.	1,000 to 5,000 employees	77%
4.	> 5,000 employees	89%

- The California HealthCare Foundation recently published a report titled, "Health Care Costs 101." This report provides the reader with high level trend cost data in a graphical format. The report provides general background on U.S. health spending. ("Health Care Costs 101," California HealthCare Foundation, www.chcf.org)

QUALITY

Health Insurers Expand Palliative Services to Improve Quality of Care and Slow Expenses

Some health insurers are expanding palliative care services in an effort to improve quality of care and quality of life, and slow the utilization of inappropriate or even harmful services. Palliative care is intended to provide comfort to patients with serious, sometimes life-limiting illnesses, by easing pain and other symptoms and filling psychological, social and spiritual needs. Services may be delivered at home or in a hospice center, a hospital or a skilled nursing facility.

In a study published in the February 2007 issue of the peer-reviewed American Journal of Managed Care, Blue Shield of California compared utilization among enrollees with life-limiting illnesses who received either "patient-centered management," which has a strong palliative care component, or usual care management. The ones who received more intensive case management had fewer inpatient admissions and emergency department visits, more home care and hospice days, and 26% lower overall medical costs, compared with the controlled group. The study was conducted in 2003 and 2004. As a result of the study, Blue Shield of California, the patient-centered management model, has been expanded to all underwritten commercial members and to its Medicare HMO population.

The Minnesota Blues plan will be expanding their benefits effective January of 2008 to offer palliative care that would include all symptom management as well as some psychological and psychosocial elements of care such as counseling, chaplaincy visits and bereavement services.

Currently Aetna, Inc. is conducting a pilot study to provide more intensive end-of-life care services to certain enrollees. The pilot expands program eligibility to patients with life expectancies of no more than 12 months and allows them to seek curative as well as palliative treatments. The initial results of the pilot showed a doubling of hospice use, and the average number of days spent in a hospice rose from 27 to 34. "Health Insurers Expand Palliative Services to Improve Quality of Care, Slow Expenses," AISHealth.com, April 5, 2007.

Tom's Comments:

During the last four years, I have had an opportunity to take my Health Care MBA students from Baldwin-Wallace College to visit The Hospice of the Western Reserve. We have always been impressed with their patient focused approach. The Hospice of the Western Reserve, like other fine hospices, is driven by its mission and passion. It is clear that there are no barriers or silos when it comes to meeting the needs of the patient and their family.

Hospices clearly represent value in healthcare. Their focus on integrated quality of life services provided in a team approach not only allows the patient to die with dignity, it does so in a cost-effective manner, especially when compared to more invasive end-of-life procedures/services.

MCOs and self-insured employers need to provide hospice benefits to their members. These services should also not be provided in a piecemeal fashion, but should be allowed to be provided in a packaged team approach as it exists today under Medicare.

Pediatric ICUs Make Headway Against Infection

For the sickest infants and children, pediatric intensive-care units provide the highest level of medical care, treating children after complicated surgeries, severe illness or accidents. But the very catheters, intravenous

lines and invasive medical procedures used to keep children alive are also putting them at higher risk of bacterial infection.

Now, with mounting alarm about the high rate of hospital-acquired infections, critical-care specialists are taking new steps to protect the smallest and most vulnerable patients, challenging prevailing wisdom that infections are simply inevitable in a busy and stressful intensive-care environment.

The nonprofit National Association of Children's Hospitals and Related Institutions, with 208 member hospitals in the U.S. and overseas, is leading an ambitious effort to eradicate bloodstream infections, the most severe infectious threat in pediatric ICUs. In the first six months of a three-year project, 29 participating hospital units have slashed infection rates by close to 70% by adhering to a rigid set of measures shown to prevent infection in children, including far more rigorous care of catheters, higher sterile precautions, and constant assessment of the need for keeping catheters in place.

Dr. Jana Stockwell, a critical care physician at Children's Healthcare of Atlanta wrote in the March issue of Journal of Pediatric Critical Care that infections can strike as many as 16% of children in pediatric units - a higher rate than in many adult ICUs - and increase the risk of death by up to 20%.

Per Dr. Stockwell, "The old mindset was that these are critically ill children and infections are going to happen. Now that's changed to a mindset that says, 'Let's avoid anything that prolongs their hospitalization and makes them sicker.' We have the means to that now." ("Pediatric ICUs make Headway," The Wall Street Journal, Laura Landro, April 18, 2007)

Tom's Comments:

This article reinforces the message from the last issue of the Quarterly Health Care Report that addressed hospital based infections. As stated above, we cannot stand by and allow preventable hospital based infections to continue. Hospitals and their staff can make a significant difference in regards to hospital-based infections, which currently adversely impacts both lives and costs in healthcare.

Companies Plan to Invest More in the Health of Their Employees

Hewitt Associates' survey of approximately 450 major U.S. employers covering more than 8 million employees revealed that almost two-thirds (63%) plan to take more aggressive, multiyear steps to help employees improve their health. These steps include increasing education efforts, implementing condition management programs, and using data analysis and other cutting-edge programs to improve health and productivity, while holding participants accountable for their behaviors.

An increasing number of companies are also taking a closer look at the health risks and needs of their employee population, and offering condition management and wellness programs designed to drive participation, trigger positive changes in consumer behavior, and provide patients with additional support and guidance.

More than three-quarters (77%) of responding companies are profiling the chronic health conditions prevalent in their workforce in 2007, compared with just 43% in 2006. Over 70% of companies gave employees, or planned to give them in 2007, access to targeted condition management or wellness programs through health plans or focused programs. Almost half (48%) also offered or planned to offer incentives to employees who participate in wellness or other health-related initiatives, compared with just 38% in 2006. "Hewitt Study Shows Companies Plan to Invest More in the Health of Their Employees" Hewitt Associates, April 20, 2007

Tom's Comments:

Employers have a vested interest in investing in the health of their employees. Wellness and disease management initiatives have both a short and long-term positive impact on the health of the participant. Since most employees, especially those with chronic diseases, tend to stay with an employer for a relatively long duration, employers will be able to see the payback for the investment.

Employers also have a vested interest in making available their wellness and disease management programs to the dependents of their employees. Wellness and disease management programs focused on the family can be especially effective. Programs that address nutrition and exercise that are family focused, for example, could increase the

likelihood of long-term sustainability since the family mechanism could reinforce the goals of the respective programs.

Covering Smoking Cessation as a Health Benefit

While the portion of Americans who smoke has dropped from 42.4% in 1965 to 22.5% in 2002, smoking is still the leading preventable cause of disease and death in the United States. Smoking adds well over $165 billion to healthcare and disability costs each year. If smokers quit, the savings would go a long way to solving today's healthcare cost crisis. Much of the healthcare savings would accrue directly to smokers' employers.

Employers pay for most of the health insurance coverage for workers and their dependents, and they pay for group life insurance coverage. In this report by Milliman Consultants and Actuaries, the authors show how employers can quickly realize reduced medical and life insurance costs when employees quit smoking, even when the assessment is limited to direct short term health care savings. Per this report, smoking cessation programs work, and the authors demonstrate that covering these programs costs employers little. This report by Miiliman provides information so that employers can make informed choices based on the costs and benefits of smoking cessation programs, and compare these to other routinely provided benefits.

Some data from this report include:

- Smoking cessation programs are low cost. A comprehensive and effective smoking cessation program will cost less than $0.50 per member per month (PMPM).
- Each employee or dependent who quits smoking reduces annual medical and life insurance costs by at least $210 almost immediately.
- We all know the smoking causes cancer, but cancers can take years to develop. Quitting smoking has also been shown to have these short-term clinical benefits on the following medical conditions:
    1. Coronary heart disease and stroke
    2. Adult pneumonia
    3. Low birth rate babies

4. Childhood respiratory diseases including asthma, pneumonia, bronchitis and otitis media

An employer wanting to provide smoking cessation benefits to its employees has a variety of options to administer these benefits, including:

- Its existing health benefits carrier or insurer
- Behavioral carve-out companies, Employee Assistance Plans (EAPs) or special wellness programs

Some employers have also charged smokers a higher health insurance premium if they do not quit. Charging smokers higher premiums is well-established for life insurance. However, some jurisdictions may regulate how this can be done for health benefits, so an employer should consult a benefits attorney. ("Covering Smoking Cessation as a Health Benefit: A Case for Employers," Milliman Consultants and Actuaries, Kate Fitch, Kosuke Iwasaki and Bruce Pyenson, December, 2006).

Tom's Comments:

The facts speak for themselves, both insurers and self-insured employers should include smoking cessation programs within their healthcare benefits. Some employers are going one step further by including in their pre-employment physical nicotine lab tests. If a prospective employee is determined to be a smoker, they are not hired.

Fast Facts:

- The Center for Disease Control and Prevention reports that 1.7 million Americans die and 25 million are disabled each year by chronic diseases caused or made worse by unhealthy lifestyles.
- The New England Journal of Medicine predicted that average life expectancy in the United States would decline in the next 20 years as a result of unhealthy lifestyles, reversing a trend dating back to the 1850s.
  ("Teaching Doctors to Teach Patients about Lifestyle," International Herald Tribune, Kate Murphy, April 17, 2007)
- According to the National Cancer Institute, we are making progress in some areas of cancer treatment and falling behind in others.
  1. Some successes include:
     - Death rates for the four most common cancers (prostate, breast, lung, and colorectal), as well as for all cancers combined, continue to decline.

- Cancer incidence has been relatively stable since the mid 1990s
- Some preventive behaviors have shown improvement. Adult smoking is down dramatically since the 1960s, although rates fell only slightly in the 1990s. Alcohol and fat consumption are headed down, although fruit and vegetable consumption are up only slightly since about 1990.
- Youth smoking was on the rise during the 1990s, but has shown declines since 1997.
- The use of screening tests for breast and cervical cancers is high and remained stable between 2000 and 2003. Screening for colorectal cancer remains low, despite its proven effectiveness, though it is increasing.
- People are doing slightly more to protect themselves from the damaging effects of the sun.

2. Some failures include:
    - The incidence of cancers of lung, bladder, and brain in women, and of prostate and testis in men, is rising. And for both men and women, the incidence of leukemia, non-Hodgkin's lymphoma, myeloma, melanoma, and cancers of the thyroid, kidney, pancreas, liver, and esophagus is rising.
    - Childhood cancer is increasing slightly.
    - Lung cancer death rates in women continue to rise, but not as rapidly as before.
    - Death rates for cancer of the esophagus, thyroid, and liver in men are increasing.
    - People are increasingly overweight and obese, and leisure time physical activity is increasing only slightly.
    - Spending on cancer treatment continues to rise.
    - Unexplained cancer-related health disparities remain among population subgroups. For example, African Americans and people with low socioeconomic status have the highest rate of both new cancers and cancer deaths. ("Managing Cancer Treatments Begins Before Diagnosis," Managed Care Magazine, Martin Sipkoff, April 16, 2007)

ACCESS TO CARE

Fast Facts:

- How many uninsured? 46.6 million or 15.9% of the population.
- Who are the uninsured?
    1. 13.4% of native-born residents are uninsured
    2. 17.9% of naturalized citizens are uninsured
    3. 43.6% of non-citizens are uninsured
    4. 32.7% of Hispanics are uninsured
    5. 29.9% of American Indians are uninsured
    6. 17.9% of African Americans are uninsured
    7. 17.9% of Asians are uninsured
    8. 15% of Caucasians are uninsured
- What is the income of the uninsured?
    1. 24.4% of those in households earning less than $25,000 are uninsured
    2. 20.6% of those in households earning between $25,000 to $49,999 are uninsured
    3. 14% of those in households earning between $50,000 to $74,999 are uninsured
    4. 8.5% of those in households earning more than $75,000 are uninsured
- What percentage of the uninsured work? Of the uninsured ages 18 to 64, 72% worked full or part time during the year
  (Source: U.S. Census Bureau, U.S.A. Today, March 15, 2007 (Page 2A)

Tom's Comments:

As one looks at various state and federal initiatives relating to universal access, it is important to understand the makeup of the uninsured. The demographics of the uninsured may dictate the type of reform package that would optimally address this population.

State Healthcare Initiatives

Governor Strickland expands PASSPORT Program

Governor Strickland issued a directive to the Ohio Department of Aging in March to reopen access to PASSPORT services for 1,100 Ohio's seniors currently on the waiting list. Per June Taylor, Executive Director of the Ohio Association of Area Agencies on Aging there are currently 26,385 seniors on the PASSPORT program as of January 31, 2007.

Eligible PASSPORT participants are 60 or older, financially eligible for Medicaid institutional care, frail enough to require a nursing home level of care, and able to remain safely at home with the consent of their physician. Applicants go through a screening process to determine eligibility for PASSPORT. If determined eligible, caseworkers work with the consumers to develop and monitor the in-home services that will be provided. (The Hannah Report, March 8, 2007, Vol. 127 - No. 48)

Tom's Comments:

The State of Ohio is struggling to find a way to address its many budgetary needs (egg. K through 12 education, higher education, uninsured, long-term care, public safety, etc.). The Governor hopes that the expansion of home health services may be a more cost-effective approach to meet the needs of our Medicaid eligible elderly population. Currently there is a tug-of-war occurring in Columbus between the various stakeholders that are impacted by the Medicaid budget. It is hoped that all sides will recognize that short-term fixes are not working, and together we need to find a way to more effectively address the needs of the various populations that depend on Medicaid reimbursement.

NORTHEAST OHIO

Bioscience and Northeast Ohio

Health care has long been recognized as one of Northeast Ohio's most distinctive assets. The region is home to nationally and internationally renowned clinical systems and institutions. Due in no small part to the research and clinical strengths, and a broad, existing biomedical industry, the region strives to become a leader of bioscience innovation and commercialization.

All together, the region's institutions conduct nearly $500 million annually in health care research. Ohio's Third Frontier Program has awarded regional institutions and companies $200 million to establish centers of research and commercialization in areas such as neurostimulation, cardiovascular innovation, ophthalmology, medical imaging, genetics and regenerative medicine.

Northeast Ohio is also home to a large, diverse, and growing bioscience industry. Today, over 460 firms that produce goods or provide services into the health care industry exist in the region. Together these firms employ more than 15,000 across the region.

Since 2003, more than 50 health care start-ups in Greater Cleveland have attracted over $400 million in new equity funding and another 35 have attracted $55 million in NIH grants. "Northeast Ohio - The Nation's New Bioscience Innovation Destination" BioEnterprise www.bioenterprise.com

Tom's Comments

It is critical that Northeast Ohio leverage its existing healthcare industry to diversify its overall economic base. Health care has played a major role in our economy to date, but we cannot sit back and allow it to stagnate.
We have a window of opportunity to exploit our healthcare base to allow us to diversify into other healthcare related industries. The government, at all levels, also must continue to support these investments in our economic future.

MARK YOUR CALENDAR

If you are interested in possibly enrolling in the Health Care MBA program at Baldwin-Wallace College for the session starting in January of 2008 contact Barb Peterson at 440-826-2064 or e-mail her at bpeterso@bw.edu

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