QUARTERLY HEALTH CARE REPORT

September/October 2008 Vol. 15

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

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Baldwin-Wallace College is pleased to offer its Quarterly Health Care Report by Professor Tom Campanella, director of the Health Care MBA program, as a courtesy to those in the health care sector. In it, Professor Campanella summarizes and comments on what's new on the critical issues of health care costs, quality and access to care at the national and international levels, as well as health care news of interest in Ohio and the Northeast Ohio region.

You can access and view the current report on our website by clicking here, by cutting and pasting the following link: http://www.bw.edu/academics/bus/programs/hcmba/nl/, or via any of the links below. We strongly recommend reading the Quarterly Health Care Report online as this format provides direct access to some interesting and relevant Health Care websites.

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SOURCES

Sources cited in this Quarterly Health Care Report are listed at the end of each article.

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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If you have any comments or observations concerning this Quarterly Health Care Report or you are interested in more information on Baldwin-Wallace College's Health Care MBA Program, you can contact Tom Campanella by e-mail at: tcamp@bw.edu

INTRODUCTION

This issue of the Quarterly Health Care Report focuses specific attention on the real drivers of health care costs and poor quality. As part of this review, we will also delve into some of the proposed solutions to address these drivers including the specific proposals of Obama and McCain.

Costs

What are the Real Drivers of Health Care Costs?

Tom's Comments:

Health care costs continue to rise at an alarming rate and something needs to be done to stop this trend. Where and when have we heard this refrain before? Except for a short reprieve in the 1990s, fears over health care cost inflation have been a constant refrain from government (federal and state) and employers since the 1960s. During that time-period, most consumers (except those that fall in the underinsured ranks) have been relatively insulated from these cost increases, at least up until the last eight years. Once health care costs resumed their upward spiral, employers started to either cut back on benefits, increase employee cost-sharing or eliminate their health care coverage all-together.

Clearly, health care cost and access issues, as they exist today, are not just limited to the have-nots, and the problem is growing.

- See link below: **(**http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=367876)

- In the April/May 2007 issue we also discussed the health cost trends that will result in a doubling of spending by 2016; "Health Care Spending to Double by 2016," **(**http://www.bw.edu/academics/bus/programs/hcmba/nl/archives/April07.pdf);

There has been much hype about creative approaches to reduce the health cost trend to a more manageable growth percentage, but to-date all of these approaches have failed to live up to their expectations, including Consumer Driven Health Products (CDHP). We have cited studies in prior issues of the Quarterly Health Care Report, including May/June 2008, under "Consumer Drive Health Care" (http://www.bw.edu/academics/bus/programs/hcmba/nl/QHCR_May_-_June_2008.pdf) relating to CDHP, which have shown that these products' real impact, as constructed today, are mostly accomplished by cost-shifting to employees. While employees definitely need to be more accountable for their health care purchasing decisions, the real impact on health care cost trend of CDHP is minimal. For further evidence see the chart below and compare CDHP trends to those of the other products other than indemnity.

The real drivers of health care cost trends are noted below. I have also attached links from prior issues of the Quarterly Health Care Report that further explore these drivers.

The Major Health Care Cost Drivers

- **The high cost of technology;** See January/February 2008 article under "Medicare" http://www.bw.edu/academics/bus/programs/hcmba/nl/archives/QHCR_January-February_2008_updated_final.pdf

- **End of life issues;** See May/June 2008 QHCR "Cost of Medical Treatment" (http://www.bw.edu/academics/bus/programs/hcmba/nl/costs/)

- **Medicare/Managed Care Organizations physician and hospital payment methodologies that incent overutilization and do not reward quality or prevention;**
  1. See this issue of the QHCR, "Payment Reform and Chronic Diseases"
  2. See October/November 2007 QHCR "Creating Payment Systems to Accelerate Value-driven Health Care: Issues and Options for Health Care Reform"

  http://www.bw.edu/academics/bus/programs/hcmba/nl/archives/QHCR_Oct-Nov_2007.pdf

  3. See January/February 2008 QHCR under "Medicare Care"
  http://www.bw.edu/academics/bus/programs/hcmba/nl/archives/QHCR_January-February_2008_updated_final.pdf

- **Unhealthy life-styles;**
  1. See January/February 2008 QHCR under "Life-style Diseases"

  http://www.bw.edu/academics/bus/programs/hcmba/nl/archives/QHCR_January-February_2008_updated_final.pdf

  2. See July 2006 QHCR "73 Million have Diabetes or at Risk in the U.S." (http://www.bw.edu/academics/bus/programs/hcmba/nl/archives/quarterlyhcreportjuly2006.pdf)

- **Chronic diseases;**

1. See July 2006 QHCR "Employers Focus on Chronic Ailments" (http://www.bw.edu/academics/bus/programs/hcmba/nl/archives/quarterlyhcreportjuly2006.pdf)
2. See May/June 2008 QHCR "Variations in Clinical Practice Patterns" http://www.bw.edu/academics/bus/programs/hcmba/nl/quality/
3. See this issue of the QHCR "Payment Reform and Chronic Diseases"

- **An inefficient fragmented health care system that often results in a stagnating tug-of-war between the health care stakeholders (e.g. hospitals, physicians, Managed Care Organizations, government, employers, consumers, etc.);**
  1. See January/February 2008 QHCR articles under "Electronic Medical Record" http://www.bw.edu/academics/bus/programs/hcmba/nl/archives/QHCR_January-February_2008_updated_final.pdf

- **Clinical practice pattern variation that has had a negative impact on cost and quality;**
  1. See May/June 2008 QHCR "Variations in Clinical Practice Patterns" (http://www.bw.edu/academics/bus/programs/hcmba/nl/quality/)

- **The lack of real engagement of the consumer in the health care purchasing decision;**
  1. See January 2006 QHCR "Should There be Limits on the Tax Exemption of Health Care Benefits" http://www.bw.edu/academics/bus/programs/hcmba/nl/archives/january_2006.pdf

- **The lack of a coordinated and comprehensive primary care system that is focused on wellness and prevention;**
  1. See this issue of the Quarterly Health Care Report under "Primary Care"

What we need is a comprehensive short and long-term national plan that focuses on achieving the optimum balance of cost, quality and access to care. This plan must also address each of the above drivers of high costs and poor quality in health care in a coordinated manner. There is no simple answer to these problems nor is there just one approach (government, market system, hybrid, etc.) to addressing these issues.

What we do know is that we cannot continue to address these issues in a piecemeal fashion with no real sense of direction or purpose.

Health Care Cost Trends

First, the good news: The annual medical trend rate for health care in 2008 increased by its lowest percentage since 2001. The bad news: The average increase is still in the double digits and is three times the Labor Dept.'s Consumer Price Index, according to results of a study released Aug. 11 by Aon Corp. Health plan actuaries surveyed by Aon expect costs will increase an average of 10.6% during 12-month rating periods that begin between April and September of this year. A year ago, AON forecasted a 10.9% increase from the prior year. And in 2002, the first year of the study, the company predicted a 16% increase (see table, below).

Bill Sharon, senior vice president at Aon and director of the study, attributes the decrease in trend rate to a growing number of employers that have launched wellness and health promotion programs, shifted more financial responsibility to employees, and placed greater attention on the use of generic medications.

"Over the past six to eight years, employers have become more aggressive with tactics such as the management of chronic conditions, wellness programs and greater focus on pharmacy costs," he tells *HPW*. "Employers have put more pressure on health plans to focus on areas like utilization management." In turn, he adds, insurers are putting more pressure on providers to control costs.

Despite rising health coverage costs, health benefits have become thinner over the past several years, and employees are being asked to take on more financial risk in the form of higher deductibles, larger premiums and bigger copayments. But employers can shift costs only so far before it affects their ability to attract and retain employees, Sharon says. Once employers reach that point, the next stage is to target wellness and disease management, he explains.

To see a copy of the study, visit http://aon.mediaroom.com/.

Projected Annual Coverage Cost Increases (with Rx)							
	2002	2003	2004	2005	2006	2007	2008
HMO	16.2%	16.4%	14.1%	13.2%	12.2%	10.9%	10.6%
Point of Service (POS)	16.0%	16.1%	14.1%	13.0%	11.9%	10.8%	10.5%
PPO	16.0%	15.7%	14.2%	13.0%	12.4%	11.2%	10.7%
Indemnity	18.3%	17.2%	15.3%	14.6%	14.4%	12.7%	12.4%
Consumer-Directed	N/A	N/A	14.1%	12.7%	12.5%	10.7%	10.5%
Projected Annual Coverage Cost Increases (without Rx)							
HMO	14.6%	14.7%	13.4%	12.9%	12.0%	11.0%	10.8%
POS	14.5%	14.5%	13.5%	12.7%	11.8%	10.9%	10.5%
PPO	14.6%	14.4%	13.5%	12.7%	12.3%	11.3%	10.9%
Indemnity	17.1%	16.4%	14.7%	14.6%	14.4%	13.1%	12.6%
Consumer-Directed	N/A	N/A	13.3%	12.4%	12.3%	10.7%	10.3%
SOURCE AND METHODOLOGY: Aon Corp., August 2008. Based on Aon's annual spring survey of more than 70 large health plans, which collectively represent 100 million covered lives.							

("Lower Medical Cost Trend Rate is Good News, Bad News for Health Plans and Employers," AIS Health Business Daily, August 25, 2008) http://www.aishealth.com/Bnow/hbd082508.html

Can Pay-for-Performance be Linked to Measures that have True Economic and Clinical Value?

Tom's Comments:

Many of the so-called "pay-for-performance" programs focus on incentives that reward uniform processes that may or may not have a sufficient positive impact on health care costs or quality. The research noted below attempts to identify performance measures that have true economic and clinical value. The identification of such measures in some ways is the easy part, the collection and analysis of the data needed to implement an economically/clinically based incentive system could be overwhelming. The authors recognize this dilemma, and they strongly recommend that payers (government/employers/managed care organizations) and foundations play an aggressive role in funding systems (e.g. electronic medical records, etc.) that would facilitate the collection and analysis of the data related to key measures. These measures would then be the foundation for a payment system that would have true economic and clinical value.

The Value of Ambulatory Care Measures: A Review of Clinical and Financial Impact from an Employer/Payer Perspective

In 2007, for the first time in its history, the Medicare program tied a portion of a scheduled increase in physician fees to performance on a standard set of ambulatory care measures. This change in reimbursement strategy was prompted by (1) a recognition that measuring the value of Medicare physician spending has been, and continues to be, elusive; (2) a strong private sector movement to tie a portion of physician payment to demonstrated performance in delivering quality care; and (3) an acknowledgment that consumers deserve transparent information on the competence of physicians to meet certain quality thresholds.

In a 2-part study, the authors reviewed 62 ambulatory care measures **(See Table 1 and Figure 1 below)** proposed for a specialty organization's recertification program and for a pay-for-performance initiative. These measures were selected by an expert panel, and 50 of them were endorsed by the National Quality Forum (NQF), the Ambulatory Care Quality Alliance (AQA), and/or the NCQA. The measures span primary care, including coronary artery disease (CAD), heart failure (HF), diabetes mellitus, osteoarthritis, asthma, major depression, hypertension, and acute-care conditions. The first part of the study consisted of ranking each measure according to an index that combined clinical and economic value, and the second part consisted of conducting detailed actuarial analyses of the subset of measures that had the highest index score.

RESULTS

From the list of 62 metrics, only 20 (each of which is endorsed by the NQF, AQA, or NCQA) received high combined scores for clinical and economic support in our ranking scheme. Of these 20, most were shown to be cost-saving in actuarial modeling. The low scoring measures did share one important element—they tended to be process measures with distant relationships to outcomes. Although practices such as taking the patient's medical history and performing a physical are time-honored parts of the medical evaluation and may be prerequisites to interventions of proven clinical or economic benefit, they do not reduce morbidity or mortality directly—which is the measure of output that is important to payers and purchasers—and as a result have little or no actuarial value.

Table 1. Clinical Effectiveness, Cost-effectiveness, and Combined Scores by Metric

Measure	Clinical Effectiveness Score	Cost-effectiveness Score	Combined Score
Blood pressure <140/90 mm Hg (HTN)	6	5.5	33
Systolic blood pressure <140 mm Hg (HTN)	6	5.5	33
Diastolic blood pressure <90 mm Hg (HTN)	6	4.5	27
Blood pressure <140/90 mm Hg (DM)	6	4.5	27
A1C >9% (DM)	6	4.5	27
A1C <7% (DM)	6	4.5	27
LDL-C <100 mg/dL (DM)	6	4.5	27
LDL-C <130 mg/dL (DM)	6	4.5	27
LDL-C <100 mg/dL after discharge for AMI, CABG, or PCI (CAD)	6	4.5	27
LDL-C <130 mg/dL after discharge for AMI, CABG, or PCI (CAD)	6	4.5	27
LDL-C <100 mg/dL with any CAD	6	4.5	27
LDL-C <130 mg/dL with any CAD	6	4.5	27
Weight reduction (HTN)	5	4.5	23
BB use in HF	5	4.5	23
ACE inhibitor/ARB use in LVSD (HF)	5	4.5	23
BB post-MI with prescription 7 days after discharge (CAD)	5	4.5	23
BB post-MI with prescription 6 months after discharge (CAD)	5	4.5	23
Antiplatelet therapy in CAD—aspirin only (CAD)	5	4.5	23
ACE inhibitor/ARB in CAD with LVSD (CAD)	5	4.5	23
Back pain—bed rest >4 days (ACCs)	5	3.5	18
Upper respiratory infection—no use of antibiotics (ACCs)	5	3.5	18
UTI—antibiotic use for <7 days (ACCs)	5	3.5	18
Use of warfarin in HF and atrial fibrillation	4	3.5	14
Retinal eye screening (DM)	4	2.5	10
Microalbuminuria screening past year (DM)	4	1	4
Microalbuminuria screening (DM)	4	1	4
Use of appropriate medications in AST	4	1	4
Pharmacologic therapy (AST)	4	1	4
Effective acute-phase treatment in DEP	4	1	4
Decongestant used <4 days in nasal congestion (ACCs)	4	1	4
Effective continuation-phase treatment (DEP)	3	1	3
Assessment of volume overload (HF)	3	1	3
History taking for "red flags" in ALBP	2	1	2
History taking for cauda equina symptoms in ALBP	2	1	2
ALBP—physical exam	2	1	2
Optimal practitioner contacts (DEP)	2	1	2
Foot examination (DM)	2	1	2
Measurement of serum creatinine (HTN)	2	1	2
Avoiding contraindicated medications (ALBP)	1	1	1
Avoiding contraindicated physical treatments (ALBP)	1	1	1

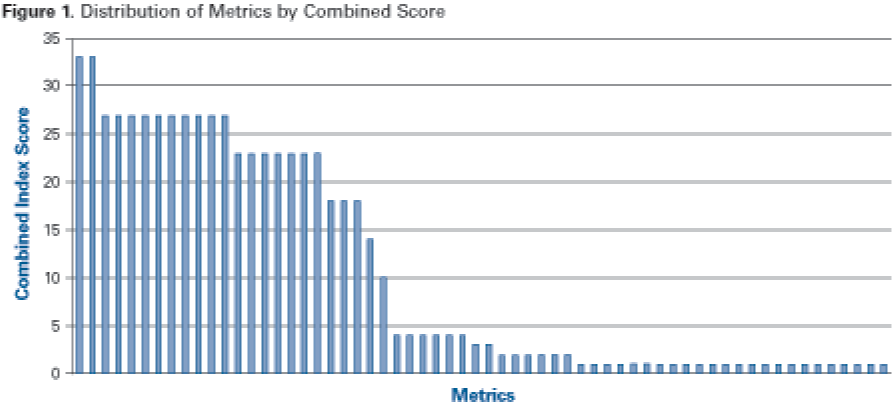
(Continued)

Table 1. Clinical Effectiveness, Cost-effectiveness, and Combined Scores by Metric *(Continued)*

Measure	Clinical Effectiveness Score	Cost-effectiveness Score	Combined Score
Classification of asthma (AST)	1	1	1
Lung function testing (AST)	1	1	1
Influenza vaccination for asthma (AST)	1	1	1
Lipid profile (CAD)	1	1	1
LDL-C drug therapy (CAD)	1	1	1
Evaluation of activity level and anginal symptoms (CAD)	1	1	1
Annual A1C (DM)	1	1	1
Lipid profile (DM)	1	1	1
Assessment of left ventricular function (HF)	1	1	1
Weight measurement within last 6 months (HF)	1	1	1
Weight measurement (HF)	1	1	1
Activity level documentation (HF)	1	1	1
Plan of care (HTN)	1	1	1
Measurement of serum potassium (HTN)	1	1	1
Electrocardiogram (HTN)	1	1	1
NSAID and analgesic use in OA	1	1	1
Assessment of function and pain (OA)	1	1	1
History taking for knee pain (pain)	1	1	1
UTI—documentation of flank pain, fever, and dysuria (ACCs)	1	1	1
UTI—documentation of vaginal discharge (ACCs)	1	1	1
UTI—Bactrim as first-line therapy (ACCs)	1	1	1
Sodium restriction (HTN)	1	1	1

HTN indicates hypertension; DM, diabetes mellitus; A1C, glycosylated hemoglobin; LDL-C, low-density lipoprotein cholesterol; AMI, acute myocardial infarction; CABG, coronary artery bypass graft; PCI, percutaneous coronary intervention; CAD, coronary artery disease; BB, β-blocker; HF, heart failure; ACE, angiotensin-converting enzyme; ARB, angiotensin receptor blocker; LVSD, left ventricular systolic dysfunction; MI, myocardial infarction; ACCs, acute-care conditions; UTI, urinary tract infection; AST, asthma; DEP, depression; ALBP, acute lower back pain; NSAID, nonsteroidal anti-inflammatory drug; OA, osteoarthritis.

Figure 1. Distribution of Metrics by Combined Score



REAL-WORLD IMPLICATIONS

As payers continue to develop incentive and reward programs for physicians, and as attention is increasingly focused on the aggregation of claims data, other administrative data, and medical record data, we all should consider the selection and weighting of performance metrics carefully in light of this analysis, and determine the actual return that might be realized by the monies spent on different types of data aggregation. Payers should find ways in their incentive and reward

programs to emphasize the small set of metrics that have high economic value. Public foundations and other contributors to data aggregation should consider the importance of and return on investing in data collections where the data will yield a far greater return than the cost of collection. Purchasers should continue to encourage their third-party payers to include a specific allowance in their incentive and reward programs for the adoption and use of electronic medical records, in recognition of the importance of having a systemic way of collecting, measuring, and scoring the performance of physicians on metrics that are both clinically and economically effective. ("The Value of Ambulatory Care Measures: A Review of Clinical and Financial Impact from an Employer/Payer Perspective," Francois de Brantes, MBA; Paula S. Wickland, FSA, and John P. Williams, MD, The American Journal of Managed Care, June 2008
http://www.ajmc.com/Article.cfm?Menu=1&ID=10423

Payment Reform and Chronic Diseases

Tom's Comments:

We have discussed issues of hospital, physician and ancillary provider payment reform in many issues of the Quarterly Health Care Report, including this issue. During this Presidential campaign year, both candidates have talked about their "comprehensive health care reform plans" that would address issues of health care cost, quality and access to care in the U.S. As one would expert in a political year, there is much more talk than substance. In this issue of the Quarterly Health Care Report we identify some of the "real" drivers of health costs as well as poor quality.

In reviewing this list of drivers, one will see that that the root causes of many of these drivers is our provider payment system. When one combines a payment system that incents over-utilization and does not reward quality, prevention and primary care you can better understand why we have not effectively addressed the needs of people with chronic diseases.

The payment reform issue is exacerbated by the following factors:

- Lack of good cost and quality data for consumers and employers to make real choices
- Lack of consumer accountability as a result of not having a financial stake in the transaction
- Government's (Medicare/Medicaid) willingness to pay for health care services no matter the value received, which results in billions of dollars of wasted spending. See May/June 2008 QHCR: "Cost-Effective Health Care Treatment" (http://www.bw.edu/academics/bus/programs/hcmba/nl/costs/)

If McCain or Obama want real health care reform they need to initially address payment reform, otherwise it will be just an exercise in frustration, which we no longer have the time or the will to endure.

Getting What We Pay for: Innovation Lacking in Provider Payment Reform for Chronic Disease Care

Despite wide recognition that existing physician and hospital payment methods used by health plans and other payers do not foster high-quality and efficient care for people with chronic conditions, little innovation in provider payment strategies is occurring, according to a new study by the Center for Studying Health System Change (HSC) commissioned by the California HealthCare Foundation. This is particularly disconcerting because the nation faces an increasing prevalence of chronic disease, resulting in continued escalation of related health care costs and diminished quality of life for more Americans. To date, most efforts to improve care of patients with chronic conditions have focused on paying vendors, such as disease management firms, to intervene with patients or redesigning care delivery without reforming underlying physician and hospital payment methods.

While there is active discussion and anticipation of physician and hospital payment reform, current efforts are limited largely to experimental or small-scale pilot programs. More fundamental payment reform efforts in practice are virtually nonexistent. Existing payment systems, primarily fee for service, encourage a piecemeal approach to care delivery rather than a coordinated approach appropriate for patients with chronic conditions. While there is broad agreement that existing provider payment methods are not well aligned with optimal chronic disease care, there are significant barriers to reforming payment for chronic disease care, including (1) fragmented care delivery; (2) lack of payment for non-physician providers and services supportive of chronic disease care; (3) potential for revenue reductions for some providers; and (4) lack of a viable reform champion. Absent such reform, however, efforts to improve the quality and efficiency of care for chronically ill patients are likely to be of limited success. ("Getting What We Pay For: Innovation Lacking in Provider Payment Reform for Chronic Disease Care," Ann Tynan, Debra A. Draper, Center for Health System Change, Issue Brief No. 6, June 2008) http://www.hschange.com/CONTENT/995/

The Future of Long-term Care Funding

Tom's Comments:

The article below is a thought provoking analysis of a very important issue. We in the U.S. have a propensity of delaying critical and sensitive decisions to another time or even another generation, especially as they relate to health care. We as a society can see the writing on the wall, or should I say numbers on the wall, in that we have a pending crisis relating to long-term care financing. One needs not to be a mathematician or an economist to recognize that based on the demographics of our aging society our current system of long-term care is both inadequate and on a shaky financial foundation.

Long-term care in the U.S. is primarily funded by the government through Medicaid (50%) and Medicare (20%) see Exhibit I below. Out-of-pocket (18%) insurance (7%) and other payments (5%) represent the balance of funding. One does not have to work in the health care industry to realize that Medicaid and Medicare as they exist today cannot continue to fund long-term care to meet the demands of our aging population.

The author does a good job of evaluating the various models for funding long-term care. Some combination of private and governmental insurance appears to be the most viable source of funding for long term care. As the author states, "Long-term care experts agree that a solution that is both politically and economically viable will include some mix of public and private insurance. The challenge will be finding the proper balance between the two models." We cannot continue to put off this challenge; there needs to be a sense of urgency in developing a model that makes sense for the U.S. and allows it to lay the financial foundation in order to meet the needs of our aging population.

See QHCR January 2006 issue under "Is Long-term Care Insurance a Good Investment" for additional discussion relating to long-term care insurance. http://www.bw.edu/academics/bus/programs/hcmba/nl/archives/january_2006.pdf

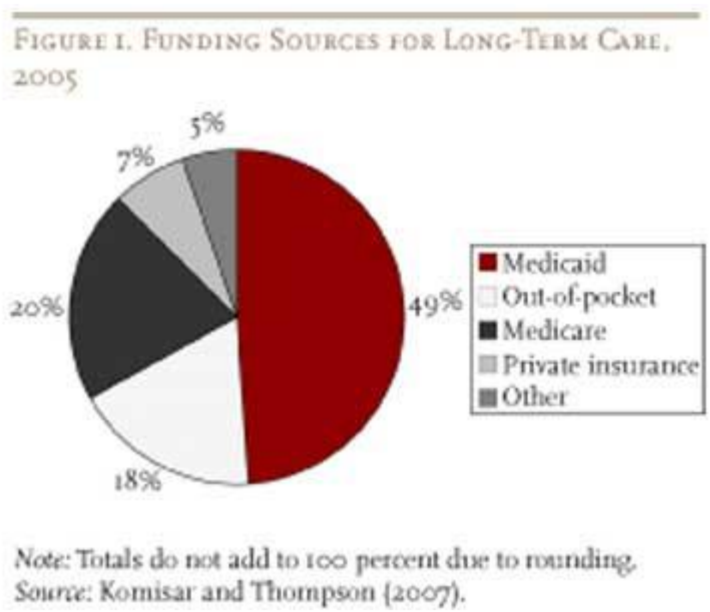
How Can We Improve Long-term Care Financing

This research brief focuses on several options to finance long-term care. These options include enhancing private long-term care insurance, replacing the current welfare-based system with a public social insurance program, and introducing a hybrid public-private system.

In contrast to acute medical care, long-term care assists those with chronic illnesses in managing their daily lives. Such care, which provided to both the aged and the disabled, includes assistance with eating, bathing or toileting, and cooking or eating. It is provided at home, in a nursing home, or in an assisted living facility. About two-thirds of those who turned 65 in 2005 will need long-term care in their lives, and they will require assistance for an average of three years. Currently about 10 million Americans receive some form of long-term care.

As shown in **Figure I**, about half of paid long-term care is funded by Medicaid, another 20% is financed by Medicare, and the balance is paid out-of-pocket or through private insurance

Figure I. Funding Sources for Long-term Care, 2005



Proposed changes to the long-term care system take one of three approaches. The first would use tax subsidies and other incentives to enhance private insurance. The second would create a new social insurance program, much like that in Germany, Japan and most of the industrialized world. The third solution would meld public and private insurance.

Enhance Private Insurance

Proposals to enhance private insurance would largely leave the current structure in place. Those with low incomes would continue to receive Medicaid, while those with higher incomes would be encouraged to purchase private insurance. Most of the proposals would focus on enhancing private insurance through federal and state tax subsidies.

In an effort to expand private insurance in a more comprehensive way, three researchers have designed a plan called Medi-LTC. Under this proposal, private carriers could sell three simplified benefit packages through Medicare, similar to the way Medicare Supplemental (Medigap) health insurance is marketed today. Unlike Medigap, however, benefits could be customized, although each package would have to provide at least basic coverage. Carriers would be permitted to underwrite policies and, thus, could reject applicants based on health status.

In one important feature, private insurers would pay for the nursing home and home health benefit now provided by Medicare. In return for transferring this risk to private insurers, Medicare would use its cost savings to subsidize premiums. The Medi-LTC proposal has several advantages. It would cost the government relatively little. Direct marketing through Medicare would likely increase demand for private policies. And competition among plans could lower prices.

The major fault with any of the proposals to enhance long-term care insurance revolves around underwriting. Any market-based system must be carefully designed to avoid cherry-picking, where carriers set rates to encourage the healthiest buyers and discourage those most likely to claim. Similarly, where underwriting is permitted, government assistance would need to be made available to those who are uninsurable.

Create a Social Insurance System

A far more ambitious idea is to replace the current welfare-based system with social insurance. The program could be managed as a new Medicare benefit or through a new independent, quasi-government entity.

An enhanced Medicare structure would add a new Part E. One prototype plan, proposed by Urban Institute researchers Leonard Burman and Richard Johnson, would provide both home care and nursing home care to the frail elderly and younger disabled who are unable to perform at least two activities of daily living (ADLs). The home care benefit would be limited to 100 hours per month. Beneficiaries would pay a $500 annual deductible and 20% copayment up to $5,000 per year. These costs would be reduced for low-income beneficiaries. Providers would be paid according to a fixed fee schedule.

Several funding options are available for this social insurance approach. Germany's universal system is financed through a 1.7% payroll tax. Another option would be to introduce a new value added tax (VAT). A third financing alternative is the income tax, which would rely on an across-the-board increase in individual tax rates equal to one percentage point, which would raise an estimated $55 billion in 2007.

To avoid tax increases, the American Association of Homes and Services for the Aging (AAHSA), a trade group that represents not-for-profit long-term care providers, designed an alternative. Under the AAHSA plan, coverage would be universal or nearly so, and the vastly larger insurance pool would allow people to purchase life-time benefit for relatively low cost.

One model plan would provide a life-time daily cash benefit of $75 after a five-year vesting period for an annual premium of about $1,270. Both benefits and premiums would be indexed to wage growth. Individuals would purchase the insurance beginning at age 21 and pay premiums to an independent quasi-government entity outside the federal Treasury. Low-income individuals would receive a subsidy.

Meld Private and Public Insurance

A third approach would create a hybrid public-private system. It would require individuals to purchase long-term care insurance, but through a government program. In many ways it would resemble the Medi-LTC proposal described above. However the Medi-LTC plan is voluntary, while participation in this system would be mandatory.

In a hybrid program, such as the one proposed by the Brookings Institution's William Galston, purchase would be mandatory beginning at age 40 and insurers would be required to accept all buyers without underwriting. A prototype policy would cover $150-day for the first five years of care. Additional care would be government financed. Purchasers would pay market premiums, although subsidies would be available to low income buyers. As with Medigap, insurers could offer a range of standardized benefits, though they could continue to compete on price. By taking advantage of the sick pool concept, premiums would fall significantly from today's market price.

Conclusion

Successful reforms must make long-term care insurance more widely accessible. This goal may be achieved either through social insurance or private coverage. To make private insurance more affordable and reduce the need for underwriting, the number of those insured must be greatly expanded. In addition, the nature of assistance for the poor must shift from the welfare-type Medicaid to an insurance model.

Each design discussed above is flawed, yet each has the potential to improve our existing system. Long-term care experts agree that a solution that is both politically and economically viable will include some mix of public and private insurance. The challenge will be finding the proper balance between the two models.

("How Can We Improve Long-term Care Financing? Center for Retirement Research at Boston College, Howard Gleckman, June 2008)

http://crr.bc.edu/images/stories/Briefs/ib_8-8.pdf

QUALITY

Telemedicine

Tom's Comments:

As the article notes below, there are many advantages in using telemedicine in health care. We are very much aware of the increased use (especially inappropriate use) of technology as one of the key drivers of health care costs. Telemedicine is one form of technology that potentially has unlimited benefits for the world of health care from a cost, quality and access perspective.

Telemedicine, especially when it is tied into Electronic Medical Records, can lay a foundation for future efficiencies in our health care system. Payers, government, managed care and employers, can all potentially reap the benefits of telemedicine if they become facilitators of its growth rather than impediments. This article identifies only a few of the obstacles that impede the growth of telemedicine, there are many other obstacles that are imbedded in payers medical policy edits that are linked to MCOs claims payment systems. The government should take a lead role in finding ways to facilitate the growth of telemedicine and managed care organizations (MCOs) will likely follow suit. If MCOs continue to be short-sighted in this regard the government may need to use its clout to "encourage" their cooperation.

Physician Care and Telemedicine

The use of information technology in diagnosing, treating and monitoring patients – known as telemedicine – is adding a new dimension to modern health care. Entrepreneurs are using the telephone, the Internet and personal computers for innovative solutions to traditional problems of health care delivery. These advances are not only making care more accessible and convenient, they are also raising quality and containing medical costs.

Telemedicine can improve adherence to protocols and increase the convenience of treatment for patients with chronic ailments. For instance, patients can use an electronic device to monitor vital signs at home and transmit the data via computer modem to self-report their health status to medical staff. A study of patients with congestive heart failure found that those who used remote monitoring required rehospitalization only half as frequently as those who depended on traditional office visits.

Additionally, transmitting data via the Internet allows U.S. health care providers to collaborate with qualified, low-cost providers in other countries who perform labor-intensive tasks that do not require the physical presence of a physician, such as interpreting ultrasounds, CT scans and MRIs. Increasingly, information technology will make distance irrelevant, and medical personnel will be able to provide medical services regardless of their location.

Obstacles to Wider Use of Telemedicine. An antiquated third-party payment system is the primary obstacle to the growth of telemedicine. Because 87% of medical costs are paid by someone other than the patient (such as insurers, employers or government), providers have little incentive to create innovative services that benefit patients directly. Additionally, state laws and regulations prevent physicians licensed in one state from practicing in other states. This impediment keeps doctors from providing crucial medical services, such as writing prescriptions or completing follow-up consultations remotely, to patients who have left the state. Similar regulations keep foreign doctors from providing telemedicine services. Telemedicine can improve the quality and increase efficiency of patient care, but these barriers must be lowered in order to realize its full potential. ("Physician Care and Telemedicine," Devon Herrick, National Center for Policy Analysis, August 21, 2008) http://www.ncpa.org/pub/ba/ba624/ba624.pdf

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Price and Quality Transparency

Tom's Comments:

There has been much discussion relating to health care price and quality transparency. The advocates of these initiatives hope that consumers, once armed with user-friendly price and quality data, would become prudent purchasers of health care services. This newly engaged prudent purchaser would then be the catalyst for provider (hospital, physician, ancillaries, etc.) competition. It is then hoped that providers would respond to competition by providing better value (in the form of lower costs and higher quality) in the health care market place.

On paper all of the above rationale supporting price and quality transparency makes sense. There are a number of factors that have prevented this initiative from achieving these results. The article below identifies a number of those factors that have prevented price and quality transparency from being a reality.

Ultimately to be effective, price and quality transparency data would need to be user-friendly, timely and credible. The user of this information (the consumer) must also need to be financially engaged enough to want to use the data.

Most Americans receive their health care benefits either through the employer or through the government (Medicare or Medicaid). The bulk of the health care costs are then paid for by a third party to the health care transaction that occurs between the consumer and the provider of health care services.

The real cost of health care services are then being paid by third-parties (government/employers). These payers obviously have a vested interest in addressing the overall value received based on the health care transaction.

Many believe that it will be very difficult for consumers to be able to truly evolve to prudent purchasers of health care services. The April 2007 issue of the Quarterly Health Care Report discusses this issue in detail in the article "Health Care Price Transparency and Price Competition" (http://www.bw.edu/academics/bus/programs/hcmba/nl/archives/April07.pdf).

Under my commentary related to the April 2007 article on price transparency, I discuss the potential merits of having managed care organizations act as facilitators to link cost-effective quality providers to lower co-pays, etc. Similar to drug formularies, there would be a tiering of providers based on their overall cost and quality indicators that were developed by the MCO, etc.

As one would expect, this approach to price and quality transparency would have many critics, especially the lower-tiered providers. While there are many problems with this approach relating to reliability of data, etc., it may have a greater likelihood of success vs. allowing the consumer to tread through mountains of data relating to price and quality.

Health Care Price and Quality Transparency

Responding to large employers' interest in greater health care price and quality transparency, health plans are developing consumer tools to compare price and quality information across hospitals and physicians, but the tools' pervasiveness and usefulness are limited, according to findings from the Center for Studying Health System Change (HSC) 2007 site visits to 12 nationally representative metropolitan communities.

Many large employers view price and quality transparency as key to a broader consumerism strategy, where employees take more responsibility for medical costs, lifestyle choices and treatment decisions. Some health plans believe providing price and quality information to enrollees is a competitive advantage, while others are skeptical about the benefits and are proceeding cautiously to avoid potential unintended consequences.

Health plans are in various stages of making price information available to enrollees. Plans generally provide some type of price information on inpatient and outpatient procedures and services from data based on their own negotiated prices or through aggregated health plan claims data obtained through a vendor; few plans provide price information on services in physician offices. However, the information provided often lacks specificity about individual providers, and its availability is often limited to enrollees in specific geographic areas.

Health plans generally rely on third-party sources to package publicly available quality information instead of using information gleaned from their own claims or other data. Health plans' ability to advance price and quality comparison tools to the point where a critical mass of consumers trust and use the information to choose physicians and hospitals will likely have considerable influence on the ultimate success of broader health consumerism efforts. ("A Health Plan Work in Progress: Hospital-Physician Price and Quality Transparency," Ann Tynan, Allison Liebhaber and Paul B. Ginsburg, Center for Studying Health System Change, Research Brief, No. 7, August 2008)
http://www.hschange.com/CONTENT/1008/1008.pdf

ACCESS TO CARE

Health Care Reform

Tom's Comments:

In the report below, Buck Consultants objectively analyzes the fundamental differences between McCain's and Obama's health reform plans. As part of this analysis, Buck, asks some pointed questions concerning key components of each of the presidential candidates plans.

Of particular interest are the following questions relating to each of the candidate's plans:

- Would McCain's proposal to establish refundable tax credits ($2,500/individuals; $5,000/family) spell the demise of employer based health care coverage? As part of this reform package, McCain proposed to revise the tax law further, requiring that the cost of employer-sponsored coverage less the proposed tax credit and any employee contribution be imputed to employees as income. Given the above tax law changes, would healthy employees jump to the individual market and less healthy employees remain in employer plans? If employers' health care costs rise as a result of the loss of healthy employees, would employers be more likely to eliminate their coverage? Also if employers recognize that employees can receive subsidized coverage through tax credits in the individual market, would employers be less likely to feel financially obligated to provide coverage?

- A core part of Obama's plan to cover the uninsured would require employers to provide health insurance to their employees or pay a tax. Does an employer "pay or play" mandate, as advocated by Obama, make it more difficult for U.S. companies to compete globally?

- The foundation of McCain's plan is the expansion of Consumer Driven Healthcare Plans (CDHPs). CDHPs would play a small role in Obama's plan which relies on the government playing more of a facilitation role. Which direction would best serve in addressing our health care cost, quality and access concerns?

  A number of past issues of the Quarterly Health Care Report focused on the real impact of CDHP. These research driven articles, definitely down-played the positive incremental impact of CDHPs on health care cost trends. Most of the cost reduction related to CDHPs, per these articles, is the result of cost-shifting to employees. See the following QHCR articles located at:

  1. April/May 2008 QHCR; under the caption "Consumer Driven Health Care Product"
  (http://www.bw.edu/academics/bus/programs/hcmba/nl/costs/)

  2. July 2006, QHCR; "The Impact of Consumer Driven Health Plans on Cost Trends"

(http://www.bw.edu/academics/bus/programs/hcmba/nl/archives/quarterlyhcreportjuly2006.pdf

We evaluated Obama's, McCain's and Clinton's health care reform plans in detail in the January/February issue of the Quarterly Health Care Report:
(http://www.bw.edu/academics/bus/programs/hcmba/nl/archives/QHCR_January-February_2008_updated_final.pdf)

We also discussed an "Innovative Approach to Health Care Reform" in the October/November 2007 issue of the Quarterly Health Care Report that merits rereading.
http://www.bw.edu/academics/bus/programs/hcmba/nl/archives/QHCR_Oct-Nov_2007.pdf

In this issue of the Quarterly Health Care Report, we identified the drivers of health care costs and poor quality. In evaluating both McCain's and Obama's health care reform plans (as well as others), one needs to determine how each of those plans address these major drivers. Given the U.S. precarious economy, it is more critical than ever, that we focus on these drivers of high cost and poor quality.

The Obama and McCain Health Care Platforms: A Guide for Employers

In published statements and spoken comments, John McCain and Barack Obama have offered voters visions of health care reform. This *InsightOut* provides a broad overview of their platforms and focuses on three particular aspects that would have profound impact on employers: portability, mandates, and consumer-directed health.

Obama favors eliminating pre-existing conditions limitations and medical underwriting on individual insurance plans and establishing a new national health plan, which would compete head-to-head with privately insured products. Obama's national plan has been described as similar to the Federal Employees Health Benefit Program (FEHBP), the program covering federal employees including members of Congress. The FEHBP offers a range of plan options from Consumer-Directed Health Plans (CDHPs) with HSAs through co-pay-based HMO plans.

He also proposes a National Health Insurance Exchange, a public agency that would create rules and standards for participating insurance companies. The Exchange would ensure that the coverage offered is at least as generous as the national health plan and those premiums are fair, stable, and not based on health status. The Obama camp claims that these initiatives would broaden the array of coverage choices for people not eligible for employment-based benefits and assist them in navigating the insurance markets.

McCain proposes a Guaranteed Access Plan (GAP), which would be available to anyone not eligible for coverage through traditional insurance markets. He envisions GAP coverage being provided by a non-profit corporation(s) that would contract with insurers to cover individuals who have been denied coverage.

One of the more controversial aspects of either candidate's platform is McCain's proposal to establish refundable tax credits ($2,500/individual; $5,000/family) to offset the cost of health insurance. These tax credits would be paid directly to the provider of coverage, whether it is a private insurer or an employer. McCain would revise tax law further, requiring that the cost of employer-sponsored coverage less the proposed tax credit and any employee contributions be imputed to employees as income and, possibly, for payroll tax purposes. Under current law, employees pay neither income nor payroll tax on the cost of employer-provided coverage.

Proponents of the McCain tax credit proposal argue that eliminating the favorable tax treatment for those covered by employer-sponsored health plans will level the economic playing field with individual policies, enabling employees to choose more freely between the two. Experts opposed to the McCain tax credit speculate that healthy employees will jump to the individual market and less healthy employees will remain in employer plans. This would drive up employers' costs and could cause many to discontinue their plans. The McCain camp counters this theory asserting that most employers will have to offer health coverage to remain competitive in the labor market.

Questions underlying this aspect of the debate would include:

- Would employers prefer to be out of the health insurance delivery business or is providing coverage a tax-effective way to compensate employees and a practice most employers would like to continue?

- If employers are not the primary source for medical coverage, will they still be inclined to promote health and wellness in the workplace? If not, would the government fill the void?
- Would enhanced competition between employer plans and individual insurance, as McCain advocates, drive young, healthy employees into the individual markets, leaving the least healthy, most costly employees in employer plans? Would that conceivably doom the employer-based system?
- Will McCain's proposal eventually result in employers discontinuing coverage and potentially increase the uninsured population, or will it help to decrease the number of uninsured through a more robust individual market?

Mandates: Are They the Only Way?

Obama advocates an employer mandate and a partial individual mandate (young people to age 25 could remain covered under a parent's plan). Under his "pay or play" proposal, employers would be required to meet minimum standards for health coverage or contribute a percentage of payroll toward a new national health plan. This money would be used to fund the proposed national plan, in which both individuals and employers could enroll.

The Obama proposed mandate would most significantly affect small employers not currently offering health coverage, employers with large uninsured segments of their workforces, particularly low-paid, uninsured workers, and those not meeting the yet-to-be-defined minimum coverage standards. It is not known at this time whether the mandate would apply to part-time workers, but industries, such as retail, could also be affected significantly.

McCain rejects employer and individual mandates. He focuses instead on improving access and affordability through tax incentives and free market initiatives. His platform advocates measures that would foster competition among individual insurance and employer-based coverage (as described in the previous section), insurance carriers operating across state lines, walk-in clinics and traditional physician offices, and domestic and international pharmacies.

Questions underlying this aspect of the debate would include:

- Is broadening access and affordability as McCain advocates enough to achieve coverage expansion goals or are mandates as Obama proposes necessary?
- Is a free market solution as advocated by McCain preferable, even if a large number of Americans remain uninsured or if coverage expansion goals take many years to achieve?
- Does an employer "pay or play" mandate as advocated by Obama make it more difficult for U.S. companies to compete globally? Is coverage expansion through mandates worth the potential cost to the U.S. economy?

Consumer-Directed Health Plans: What Does the Future Hold?

Since CDHPs were unveiled in early 2000 and HSAs were legislated into existence in 2003, employers have gradually, but steadily, adopted CDHPs. According to the *Kaiser/HRET Annual Employer Health Benefit Survey*, 18 percent of organizations with 1,000 or more employees offered CDHPs in 2007, and 25 to 30 percent more say they are somewhat to very likely to do so in the future. The Kaiser survey reports that, as of spring 2007, roughly 7.9 million people or five percent of those enrolled in employer-sponsored health plans were covered by CDHP.

Questions abound with regard to CDHPs including:

- Are the plans suitable for low income workers?
- Do they effectively control medical trend?
- Can patients really manage their own health care and successfully negotiate price with providers?
- Do CDHPs discourage patients from receiving the necessary care?

McCain and Obama appear to be on entirely different pages with respect to CDHPs. McCain advocates solutions that put individuals more in control of health care spending and decision-making. He openly expresses support for HSAs. In his call for a refundable tax credit (described earlier) to offset the cost of health insurance, he proposes that the balance of the credit would be deposited into an HSA if innovative, less costly coverage were obtained.

By contrast, the Obama platform does not mention CDHPs. His call for a mandate speaks of employers making a "meaningful contribution to the cost of quality health coverage." Whether a CDHP would qualify as "quality health coverage" would likely become part of the debate. It is perhaps noteworthy that Obama proposes a national health plan similar to the FEHBP. As mentioned earlier, the FEHBP offers a range of plan options, including a CDHP option, but the Obama platform does not specify whether, to qualify, a plan would be required to include all, some, or only the most generous FEHBP options.

In the Final Analysis …

The demise of the Clinton health reform plan in 1994 and employee reaction to changes in employer-sponsored plans occurring both before and since cast light on the biases and expectations of Americans with respect to health care. Despite the consequences, Americans seem to favor a system in which:

- Government plays a limited role,
- Patients have free choice of providers and care settings,
- Third parties stay out of health care decisions,
- Heroic life saving treatments are available to all,
- Patient out-of-pocket expenses are limited.

Most reformers and economists would agree that these values are substantially opposed to a sustainable health care system. Some might go further, arguing that so long as health care delivery remains in the hands of independent businesses driven by revenue growth and profit motive, any effort at reforming the existing public-private system is merely a band-aid.

It is probably a safe bet that neither John McCain nor Barack Obama will be promoting the idea of "nationalized health care" between now and Election Day. Although Obama's platform leans more heavily on public sector initiatives, neither he nor McCain advocate the sweeping role of government envisaged by the Clinton plan or the rigid structure and tight controls it sought to impose.

Stay tuned for the election of 2016, however. If medical trends continue at historic levels, we may be paying twice as much for health insurance by then. That would put the average cost of family coverage around $25,000 per year! Who knows what may be possible at that point. ("The Obama and McCain Health Care Platforms: A Guide for Employers," By Anthony P. Riezi and Chantel Sheaks, Buck Consultants' Insight, 2008) **http://buckconsultants.com/buckconsultants/Portals/0/Documents/PUBLICATIONS/white_papers/WP_Health_and_Productivity/wp_insight_health_reform.pdf**

Primary Care

Tom's Comments:

Both Presidential candidates have identified some of the following objectives relating to their health care reform platforms:

- Providing a coverage "safety net" for the uninsurable
- Making coverage more affordable for low-income individuals
- Expansion of efforts to address chronic diseases
- Expansion of wellness initiatives
- Initiatives to address access to adequate health care services, etc.

All of these initiatives, plus many others need to be built upon the foundation of a primary care workforce. As the authors state, "The success of any health reform effort will entail more than achieving universal coverage: it must include a robust and evenly distributed primary care workforce, along with adequate safety-net infrastructure and financing for those who are medically underserved." Primary care work force, for this discussion, is defined as primary care physicians, nurse practitioners, physician assistants, and certified nurse midwives.

Community Health Centers play a special role in meeting the needs of the uninsured. Community Health Centers are a vehicle to provide basic cost-effective quality care to those in need of health care services. Many of the Community Health Centers' efficiencies are result of their team approach to providing health care services.

As the report discusses, there is a major shortage of primary care providers to adequately staff Community Health Centers in the U.S. There is also a major shortage of primary care physicians, and this shortage is increasing.

I continue to work with the medical students at Ohio University College of Osteopathic Medicine. Many of the students convey a passion for practicing in one of the primary care areas of medicine, but this passion is many times squelched by the reality of large medical school loans, relatively low pay vs. other physician specialties, and quality of life issues relating to primary care's long hours.

The authors of this report did a good job in identifying a number of proactive strategies to address the shortage of primary care providers to staff Community Health Centers. Over and above this shortage, more proactive incentives are needed to address the overall shortage of primary care physicians, which are the foundation for wellness, prevention, chronic disease management of our population.

In the last issue of the Quarterly Health Care Report, we discuss further the issue concerning the shortage of primary care physicians: May/June 2008; under the caption "Primary Care Reform" (http://www.bw.edu/academics/bus/programs/hcmba/nl/quality/)

For additional information see The National Association of Community Health Centers website which can be found at: http://www.nachc.com/research-data.cfm

Building a Primary Care Workforce for the 21st Century

Pressure to reform the U.S. health care system is mounting in the face of growing numbers of uninsured individuals, widening health care disparities, and the rising cost of care – factors that fuel increasingly restricted access to needed health care for millions of people. **Yet the success of any health reform effort will entail more than achieving universal insurance coverage; it must include a robust and evenly distributed primary care workforce, along with adequate safety net infrastructure and financing for those who are medically underserved.**

The national trend so far indicates that we are not only falling short of that goal, but retreating from it. Indeed, what we face is a crisis of distribution in terms of the primary care workforce to meet local health needs. In short, there are not enough doctors, nurses, and other primary care professionals in the communities where they are most needed.

The current supply of primary care professionals is already being outpaced by rising demand, and our national health care system is notorious for providing America's most vulnerable and chronically ill limited access to primary health care. In our previous report, *Access Denied*, we presented evidence that 56 million Americans lack adequate access to primary health care because of shortages of such physicians in their communities. These "medically disenfranchised" individuals represent one in five Americans, and still millions of others face additional barriers to primary care.

Evidence suggests that a further disappearance of primary care services will inevitably contribute to a worsening of health outcomes, a widening of health disparities, and a rising price tag on the cost of health care. Achieving access for the underserved therefore hinges on meaningful health policy advances that can tackle this worsening primary care workforce crisis. **Building on the success of the federal Community Health Centers Program could anchor primary care practices in communities unable to attract or sustain sources of stable and high quality health care.**

Moreover, as our *Access Granted* report revealed, health centers already save the health care system billions of dollars annually while pumping economic returns into the very communities that need them most. Recognizing that significant unmet health care needs persist for the millions of individuals without a regular source of care, and with an established and innovative model for primary care delivery, health centers are aiming to reach 30 million patients by the year 2015 under their ***ACCESS for All America*** plan. This requires producing the workforce needed to staff current and new delivery sites.

The plan envisions that health centers will eventually reach all 56 million medically disenfranchised individuals for a total of 69 million patients. Health centers have achieved record growth since 2000, thanks to a bipartisan initiative spearheaded by President Bush with Congressional support. Between 2000 and 2006, the number of primary care physicians at health centers grew 57%, while the combined number of nurse practitioners, physician assistants, and certified nurse midwives grew by 64%. At the same time, the number of nurses grew 38%.

Even so, health centers across the country are experiencing significant clinical vacancies and challenges in recruiting clinical staff. Consequently, the success of any effort to expand health centers in order to increase the availability of care for the medically disenfranchised and underserved will necessarily require more effective policies to address the production and placement of an adequate primary care workforce.

Given the current primary care workforce crisis, we determined the workforce required to achieve these ambitious goals. From our analyses, we project the following:

• Health centers are increasingly challenged to meet their primary care workforce need. Health centers currently need 1,843 primary care providers, inclusive of physicians, nurse practitioners, physician assistants, and certified nurse midwives. On top of this need, they are 1,384 nurses short.

• **To reach 30 million patients by 2015, health centers need at least an additional 15,585 primary care providers**, just over one third of whom are non-physician primary health care providers. Health centers also will need another 11,553 to 14,397 nurses.

• **To reach 69 million patients, health centers will need at least 51,299 more primary care providers over the current number**, as well as an additional 37,981 to 44,522 nurses.

• **Any workforce solution must specifically address the factors driving primary care imbalance in staffing patterns and need that exist across states.** Robust staffing patterns allow for a comprehensive approach to meeting a community's health care needs, including the full range of preventive and chronic care services and those services that facilitate access to care and address socio-economic conditions that lead to poor health.

• Addressing these deficits will involve more than a continuation of current workforce policy. **Policymakers must consider a series of targeted interventions that boost the overall U.S. primary care professional workforce, while also ensuring increased placement in medically underserved areas.** A multi-faceted national and state course of action must strengthen the pipeline of would-be primary care professionals even before they begin formal medical education, expand training opportunities and placement incentives for locating in underserved areas, and ensure adequate reimbursement for primary care services. In particular, successful programs like the National Health Service Corps, which places primary care professionals in underserved areas, can and must be expanded, as should others that train nurse practitioners, physician assistants, certified nurse midwives, and physicians.

Primary care professionals are undeniably needed in underserved communities today. To meet this workforce need, policies must address the location and career choices among practicing and future professionals that cause an oversupply in some areas and an acute shortage in others. This report lays out the workforce needed to reach these goals, as well as a multi-faceted policy approach that will strengthen the nation's primary care system and minimize health disparities, making it possible to ensure that every American can have access to vital primary health care. ("Building A Primary Care Workforce For The 21st Century," National Association of Community Health Centers, Robert Graham Center, The George Washington University School of Public Health and Health Services," August 2008)
http://www.nachc.com/client/documents/ACCESS%20Transformed%20full%20report.pdf

INTERNATIONAL HEALTH CARE

China's Healthcare System

Tom's Comments:

The article noted below provides the reader with some interesting insight into China's health care system and the expanding role of health insurance. China is a country of contrasts, with one foot entrenched in the past and one foot firmly planted in the future. There is no better example of this phenomenon than the world of health care.

Chinese traditional medicine, which is based on thousands of years practice, continues to play a major role in health care within both their rural and urban settings. Western medicine has also played an increasing role in China, especially in the major urban venues. In fact, integrative medicine, which is a combination of Chinese traditional medicine and Western medicine is becoming more common throughout China. Interestingly, as the U.S. debates the expanding role of government in health care, China is looking to the expanded role of private insurance in their health care market.

It is obvious, as noted below, that the introduction and expansion of the role of health insurance in China will mean increased profits for health insurance companies, the open question is how it will impact the Chinese people. China addressed many of the basic health care needs of their people living in rural areas during the Mao years by the use of "Bare-foot Doctors." These dedicated providers would travel throughout China, caring for the needy. Some fear that the expanded role of health insurance would have a major negative impact on the poor in China.

There is a role for health insurance in China, but it is also important that it is part of an overall national health care program that focuses on health care cost, quality and access to care for all of its citizens.

The Role of Health Insurance in China

With one of the fastest-growing economies in the world, a growing affluent customer segment, a high savings rate and rapidly expanding consumer spending, the People's Republic of China has become an attractive market for U.S. health insurers.

Aetna Inc. is the latest insurer to enter the market, opening a representative office in Shanghai a few months ago. Wellpoint, Inc. opened its representative office in Beijing this year, while UnitedHealth Group opened its office in Beijing last year. CIGNA Corp. has been in the China market since 2003 and is already turning a profit.

To do business in China, a company must first open a representative office and partner with a Chinese company. The office must be open for two years before the company can apply for a license to sell products and services. Insurers typically use that time to conduct research, explore strategic options and identify a joint-venture partner. CIGNA and others say that finding the right partner is crucial for success.

Aetna is looking at the group insurance market, while Wellpoint and United are exploring opportunities in health administration, risk management and care coordination. CIGNA is focusing on selling individual accident and hospital indemnity products along with life insurance.

According to the U.S. Department of Commerce, the Chinese government is interested in developing its health care and pension insurance sectors in order to sustain announced reforms and provide for the nation's aging population.

U.S. health insurers say they are focusing on three primary business lines: health insurance products and services for employees of multinational and other companies doing business in China; direct sales of health insurance products to Chinese nationals; and administrative, care coordination, medical management and related services to health care providers and other entities. ("U.S. Health Insurers Go for the Gold in China, but Could Face Hurdles in Complex Emerging Market," AIS Health.com, August 15, 2008)
http://www.aishealth.com/Bnow/hbd081508.html

Medical Tourism

Tom's Comments:

The link below will connect you to an article that discusses Medical Tourism. The demand from U.S citizens for Medical Tourism services is relatively small but it continues to grow for a number of reasons:

- The number of the uninsured and underinsured continues to expand in the U.S.
- The growth of large deductible Consumer Driven Benefits incent consumers to evaluate options for healthcare services
- Americans have increasingly recognized that other countries are able to meet and sometime exceed the U.S. in producing quality products and services outside the healthcare arena (automobiles, computers, etc.)
- The awareness by Americans that healthcare services are being increasingly outsourced to other countries by U.S. healthcare providers (egg. radiology, transcription, etc.)
- International travel relating to cosmetic surgery (egg., Brazil) has had a relatively long history for Americans
- The increased cost of healthcare services in the U.S. tied to the economic challenges that are being faced by our employers and our citizens

- Sophistication of the delivery system infrastructure in the U.S. that acts as middleman for Medical Tourism (egg., managed care organizations such as Aetna, some Blue Cross and Blue Shield plans and a number of niche players (egg, IndUSHealth, etc.)
- An acceptance in the U.S. that many of our finest doctors are both born and educated out of the U.S.

A report published in July of 2008 by Deloitte Consulting, predicts that the number of Americans traveling abroad for treatment will soar from 750,000 in 2007 to 6 million by 2010 and reach 10 million by 2012. Its authors reckon that this exodus will be worth $21 billion a year to developing countries in four years' time. The average price at good facilities abroad for a range of common medical procedures is, by Deloitte's reckoning, barely 15% of the price a patient would have to pay in the United States.

Not everyone would buy-in to the above predictions, but there is a widespread recognition that the trend is continuing. Regina Herzlinger of Harvard Business School, stated in the article below that "The medical travel market is a bit over-hyped today, but economics dictate why it will be huge over time: If a supplier has very high prices and erratic quality, it creates an opening for nimbler rivals."

As the authors of this article state, as far as America is concerned, there will be limits to the impact of medical tourism. Many medical procedures cannot be done abroad safely, concerns about legal liability and malpractice will always linger, and the medical lobby may yet try to blunt this trend. ("Globalization and Healthcare: Operating Profit," Economist.com, August 14, 2008)
http://www.economist.com/business/displaystory.cfm?story_id=11919622

STATE HEALTH CARE

Fast Facts:

Tom's Comments:

The Kaiser Family link below provides the reader with some interesting health care related data at the state level.

- Kaiser Family State Facts: (http://www.statehealthfacts.org:80/)

NORTHEAST OHIO

Baldwin-Wallace College Center for Innovation and Growth

Innovation is a non-discretionary 21st century mindset and skill set
Dr. Peter Rea, Burton D. Morgan Chair in Entrepreneurial Studies and Director of the Center for Innovation and Growth

In the 21st century, innovation will determine countries', companies' and communities' prosperity. Certainly, innovation will determine the prosperity of a health care organization.

If innovation was simply an analytical exercise, then the analytical brain power found in a health care organizations would have this figured out. Yet, the drivers of innovation are talent and culture. Innovation is a team sport. A siloed mentality is the downfall of innovation. Social capital, teams and collaboration makes innovation possible.

While most health care managers are often hired to solve clearly defined problems, innovators need to address unknown problems with novel solutions. The reason there is a dearth of innovators who can create new products, open new markets or develop new business models is most people lack innovative opportunities guided by experienced mentors.

Ultimately, leaders need to create cultures that encourage innovation. The degree to which a culture promotes or inhibits innovation is based on characteristics such as:

Innovative Leadership:

Cultures that promote innovation	Cultures that inhibit innovation
• Opportunity driven; open to change • Quick to market; customer driven • Focus on execution and possibilities • Systematic growth for new product/market/process • Collaborative and Civic minded • Explore partnerships – win/win • Global in outlook • Create • Accept responsibility • Manage risk	• Bureaucratic • Slow; internally driven • Focus on obstacles • Reluctance to change that stifles innovation and growth • Territorial • Uninterested or lack partnerships • Parochial in outlook • Protect • Avoid responsibility • Risk averse

Innovation is best learned from experience and mentoring. As an institution, B-W has as one of its cornerstones a belief that leaders learn best by applying what they learn to live projects guided by professors and practitioners.

B-W's Center for Innovation and Growth offers customized designed programs to promote individual innovative leadership and to consult on ways to launch new innovations. Please contact Peter Rea for additional information (prea@bw.edu).
http://www.bw.edu/academics/bus/mba/entr/

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 2009 contact Barb Peterson at 440-826-2064 or e-mail her at bpeterso@bw.edu

Keep track of upcoming events in the Business Division of Baldwin-Wallace College on our website: http://www.bw.edu/academics/bus/events/

MBA Open Houses

Learn about the B-W Health Care MBA Program.
Visit our website for current MBA Open House Information

MBA Open Houses
6 p.m. / October 27, 2008
Landmark Center
25700 Science Park Drive #100
Beachwood, OH 44122

Or

MBA Open Houses
6 p.m. / October 29, 2008
Strosacker College Union
120 E. Grand St. Berea, OH 44017

Please call for more information 440-826-2392