Promoting Value and Expanded Coverage:

Good Health Is Good Business
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The Blue Ridge Academic Health Group

Mission

The Blue Ridge Academic Health Group seeks to take a societal view of health and health care needs and to identify recommendations for academic health centers (AHCs) to help create greater value for society. The Blue Ridge Group also recommends public policies to enable AHCs to accomplish these ends.

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Founders

The Virginia Health Policy Center (VHPC) at the University of Virginia and Ernst & Young LLP are the founders of the Blue Ridge Academic Health Group. VHPC convenes the group and serves as the locus of its operations. Ernst & Young provides core funding and facilitation for the group.

*Chair
**Editor
Perfection of means and confusion of ends seem to characterize our age.

—Albert Einstein

There is a destiny that makes us brothers: none goes his way alone. All that we send into the lives of others comes back into our own.

—Edwin Markham
American workers, business owners, taxpayers, policy makers, and health care professionals and organizations, face an issue of such magnitude and complexity that it remains unsolved after a century of effort. Despite being a nation of wealth, 43 million people in this country lack health insurance and often go without needed health care services. Moreover, the number of uninsured has been increasing despite a robust economy, an increasing number of firms offering health insurance coverage, and expansion of some public health insurance programs. While the number of uninsured has been growing, the mechanisms that enable health care organizations to provide at least some health care to the uninsured have been eroding. The current approach of relying on cross-subsidies to pay for care to uninsured individuals does not serve the best interests of the United States. It results in implicit and irrational rationing of health care resources, poorer health than is necessary for the uninsured, hidden costs for those who pay for health insurance, and lower national productivity.

Many current proposals for addressing the uninsured issue represent incremental expansions of existing programs (e.g., expansion of Medicaid). This appears to be politically prudent in light of past and more recent experience. Following its analysis of the uninsured issue, the Blue Ridge Academic Health Group (Blue Ridge Group) concluded that phased implementation of programs aimed at expanding coverage is reasonable and likely necessary. It also concluded, however, that incremental approaches that simply extend coverage to more people and perpetuate current behaviors and resource allocation patterns are inherently incomplete and will not produce desired results.

The uninsured issue is juxtaposed against a health care system that currently consumes a trillion dollars a year and is projected to consume twice as much within the next decade (Smith et al., 1998). This very expensive health care delivery system achieves only mixed results. Not surprisingly, the nation is resistant to additional increases in health care spending for expanded health insurance coverage without commensurate benefits. Indeed, the nation may not support additional investment to expand health insurance coverage even for increases in health status or productivity. As a result, improving our health care system is intertwined with eliminating the uninsured problem.

Only if we improve the effectiveness and efficiency of the health care system, can we afford to extend coverage to all residents. At the same time, only with universal coverage can strategies aimed at maximizing the nation’s health while managing health care costs be effective. Further, because health ultimately depends on a variety of factors, universal coverage is necessary, but not sufficient, to improve the health of the uninsured and those currently insured. Other strategies must be pursued. Thus, the issue of the uninsured ultimately must be addressed in the context of what the U.S. health care system should become in the next century.

The Blue Ridge Group based its recommendations for addressing the uninsured issue on three premises. First, universal coverage is good for the health of individuals and for the nation’s productivity. Second, the United States urgently needs a value-driven health system that maximizes the bene-
fit of spending on the nation's health status. Third, universal coverage and a value-driven health system must be linked. (See Exhibit 1 for the Blue Ridge Group's Recommendations.)

Progress in six areas is necessary to move toward a value-driven health system. First, health insurance coverage for basic effective services must be extended to all U.S. residents. Second, public health resources allocated to managing the health of the population must be maximized. Third, health risks must be addressed comprehensively by communities, health care organizations and professionals, and individual patients and citizens. Fourth, academic health centers must advance the understanding of population health management through research and education. Fifth, all health care delivery organizations must measure their performance and demonstrate accountability for resource use within their organizations and to their communities and regions. Finally, the potential of information technology to manage health care knowledge for delivery organizations, professionals, and patients must be fully exploited.

In producing this report, the Blue Ridge Group seeks to advance understanding of, complement the efforts of other groups addressing, and stimulate progress toward the development of a sound solution for the complex uninsured issue. This report is directed to policy makers at the federal, state, and local levels, business leaders, and the health care community. The report describes the uninsured problem and its implications, defines a value-driven health system, and through its recommendations identifies initial ways in which progress can be made toward such a system. Two of the foundational elements of a value-driven health system are not addressed in this report, but have been or will be addressed by the Blue Ridge Group. The issue of increased accountability is addressed in its first report, Academic Health Centers: Getting Down to Business (Blue Ridge Academic Health Group, 1998). Information technology and knowledge management will be addressed in a third report (Blue Ridge Academic Health Group, anticipated 1999).

For a description of the Blue Ridge Academic Health Group, see Page 33.
Exhibit 1. Blue Ridge Academic Health Group Recommendations

RECOMMENDATION 1. By 2001, Congress should pass legislation that mandates health insurance coverage, whether privately or publicly funded, for all residents as a national objective. By 2005, Congress should pass legislation that creates the framework and authorizes funding for insurance to be extended to all residents. This insurance should provide access to a minimum set of effective health services, including preventive, health maintenance, and acute and chronic illness care.

RECOMMENDATION 2. The Department of Health and Human Services, state and local health departments, health care provider organizations, schools of public health, private foundations, and other public and private health-related organizations should make population health management the primary objective of public health.

RECOMMENDATION 3. Each community or region should assume responsibility for improving the health of its residents. Each health care delivery organization (public or private) within the community or region should help to initiate (if necessary), actively participate in, and support through their clinical and service programs, these efforts to advance the health of residents of the community or region. Federal and state legislators and agencies should support community and regional efforts by developing policies (including distribution of resources) that create incentives for individuals, local agencies, health care organizations and professionals, and employers to adopt strategies that measurably advance health.

RECOMMENDATION 4. In addition to participating in community or regional efforts to advance the population's health, each academic health center (AHC) should provide leadership through research and education of current and future health professionals on population health management and a value-driven health system as fundamental strategies for health care delivery in the next century.
A Long-standing Problem

For close to a century the United States has been debating the merits of providing health insurance to its citizens (Starr, 1982). Universal or national health insurance was pursued in the 1910s, 1930s, 1940s, 1960s, 1970s, and 1990s. Each time it was derailed. As a result, on the eve of the 21st century, a substantial segment of the U.S. population is uninsured or underinsured – an estimated 43 million and 40 million respectively (Reinhardt, 1998; Washington Post, 1998).

Current public policy does not require Americans to carry personal health insurance. Research shows that the nation pays high hidden costs in reduced health status that affect all groups. The implications of these data for personal happiness, as well as societal strength, stability, and productivity, are compelling.

The majority of uninsured Americans live in families with one or more working adults (Kaiser Family Foundation, 1998). Low and moderate income families are at greatest risk for gaps in coverage. The majority of uninsured working adults are employed by firms that do not offer health coverage or that require workers to pay substantial shares of premium costs for coverage (Gabel, Hunt, and Kim, 1998). Purchase of health insurance on the open market without employer contributions can be staggering: approximately 30 percent of income for near-poor workers. Despite the fact that the proportion of small firms (i.e., fewer than 200 workers) offering health coverage has increased since 1989, the proportion of employees enrolled in small-employer plans has decreased. This decline is most likely the result of a sharp increase in the amount of contributions required from workers (Ginsburg, Gabel, and Hunt, 1998). Workers who decline coverage and are uninsured are more likely to be young, Hispanic or black, unmarried, have low wages, or have low levels of education (Cooper and Schone, 1997).

Most strikingly, the sickest people surveyed are the most likely to have problems getting the medical care they need. The vast majority of uninsured adults in poor health had difficulty getting care. This finding directly contradicts the conventional wisdom that truly sick people can always get care when they need it.

— Kaiser Family Foundation, 1996
Workers between the ages of 35 and 54 are most likely to be insured. Young adults (19-34) have the highest uninsurance rates; they account for one-quarter of the total non-elderly population, but 40 percent of the uninsured population (Cunningham, 1998). The high rate of uninsurance for this group can be attributed to loss of eligibility for Medicaid or coverage under parents' private insurance, lower labor force participation, working at jobs where health benefits are not offered, and lower take-up rates of health insurance when offered.

Between 1987 and 1996, the percentage of workers under age 25 offered insurance declined, as did the percentage of workers under age 25 who had access to insurance through another family member's coverage (Cooper and Schone, 1997). After age 34, many young adults move into situations where health benefits are offered, and higher incomes and expected benefits make it more likely that they will accept coverage when offered.

Older adults (60–64) have relatively low rates of uninsurance, but may have the most difficulty obtaining insurance coverage as fewer than half of this age group are employed or have an employed spouse (Cunningham, 1998). Uninsured older adults tend to have lower income than other age groups and are likely to face higher premiums, making it more difficult financially to purchase health insurance coverage.

While most of the uninsured are under age 65, low-income elderly are often uninsured. Medicare covers less of the total costs of care than it did in the past, and the average elderly person spends 18 percent of after-tax income on health care (Gage, 1998).

An estimated 2.8 million of the nation's 10 million uninsured children will be eligible for coverage through the State Children's Health Insurance Program (Rosenbaum et al., 1998). Yet as many as 4.7 million of currently uninsured children may already qualify for Medicaid coverage (Selden, Banthin, and Cohen, 1998). Thus, the availability of very low cost coverage is not sufficient to assure use of the coverage. Families eligible for Medicaid as a result of enrollment in Aid to Families with Dependent Children (AFDC) had higher participation than families eligible for Medicaid through expansion of the program to low income children not eligible for AFDC. Families of newly eligible children may be less aware of their eligibility, given that they were ineligible for cash assistance or that they may have resided in neighborhoods which decreased their awareness of or increased their sense of stigma associated with public assistance.

When the uninsured receive care it is often less organized, later than optimal, at greater cost, and with poorer outcomes than the insured population experiences (Weissman, Gatsonis, and Epstein, 1992). Studies have found that uninsured populations experience higher hospitalization rates for problems that generally do not require inpatient care, receive different care than the insured population, and have poorer survival rates for some conditions (e.g., breast cancer) (Weissman et al., 1991; Weissman, Gatsonis, and Epstein, 1992; Ayanian et al., 1993). (Exhibit 2 highlights some of the documented effects of lacking health insurance.)

The percentage of uninsured Americans has been increasing since 1987 (Fronstin, 1997) and is predicted to continue to grow to 22 percent of the population, or 53 million Americans, by 2000 (Holahan, 1998). Both public and private insurance trends are contributing to this increase. Despite an expansion in Medicaid for certain categories of beneficiaries (e.g.,
Exhibit 2. The Potential Impact of Being Uninsured

LESS COORDINATION OF CARE

Having a regular source of care is linked to better coordination of illness episodes and greater likelihood of provision of preventive care. Yet, one third of uninsured adults report having no usual source of care versus 12 percent of Medicaid enrollees (Rowland, Feder, and Keenan, 1998). Twenty-one percent of uninsured children have no regular source of care compared to three percent of privately insured children (U.S. Department of Health and Human Services, 1997a).

GREATER DIFFICULTY ACCESSING CARE

Forty-five percent of the uninsured versus 11 percent of the insured could not get needed care (Donelan et al., 1996).

Seventy-one percent of the uninsured versus 23 percent of the insured report postponing needed medical care (Davis et al., 1995).

FINANCIAL DIFFICULTIES

Thirty-six percent of uninsured and 12 percent of insured have problems paying medical bills (Donelan et al., 1996).

Only 37 percent of uninsured who reported problems paying medical bills received free or reduced care (Donelan et al., 1996).

Unpaid medical bills are a major source of personal bankruptcy (Bleakley, 1996).

CHILDREN LESS LIKELY TO RECEIVE PRIMARY CARE

In 1994, 25 percent of uninsured children had not seen a physician in the past year compared to 8 percent of insured children (U.S. Department of Health and Human Services, 1998b).

Uninsured children with asthma or recurring ear infections are unlikely to see a physician during the year, and more likely to experience hospitalizations or suffer permanent hearing loss from untreated infections (Stoddard, St. Peter, and Newacheck, 1994).

Children with untreated illness are less able to keep up in school; uninsured children are 25 percent more likely to miss school (Florida Healthy Kids, 1997).

Pregnant women, children under 6) in the early 1990s, welfare reform is likely to result in some mothers who are unable to replace their welfare-based coverage with private insurance. In addition, immigrants who entered the country after August 1996 are banned from receiving "federal means-tested public benefits" for at least five years. Employer-based insurance coverage has been declining for several years as the costs of health coverage have been increasingly placed directly on employees. Almost half of employees with health insurance (46.2 percent) may lose coverage while on the job through voluntary termination, an employer dropping coverage, an insurance company canceling the policy, or an insurer going out of business (Sheils and Alexxih, 1996).

Traditionally, the uninsured problem has been addressed by relying on the safety
net: health care delivery organizations that provide health care services without direct compensation. Typically, the safety net is comprised of public hospitals, community health centers, local health departments, academic medical centers, federally qualified community, rural, and migrant health centers, veterans hospitals, and Indian health facilities.

The composition, depth, and stability of the safety net vary across communities and depend largely on local culture, politics, the health care market, and delivery organization characteristics. As a result, the ability of the uninsured to obtain medical care varies across communities (Baxter and Mechanic, 1997; Cunningham and Kemper, 1998). Hospitals in highly competitive markets with substantial health maintenance organization penetration provide less uncompensated care than hospitals in less competitive markets. Those hospitals that experienced greater fiscal pressure from Medicare reimbursement provide less uncompensated care than hospitals experiencing less fiscal pressure (Mann et al., 1997).

Non-federal community hospitals provided an estimated $17.5 billion in uncompensated care in 1995 (Mann et al., 1997). Urban public hospitals and teaching hospitals provide significant levels of uncompensated care in comparison to their share of the hospital market. Shifts are underway within the safety net, with uncompensated care costs becoming more concentrated among fewer hospitals. Despite increases in the number of uninsured, there has not been a relative increase in uncompensated care provided by hospitals, but uncompensated care provided by physicians and community centers appears to have increased. In 1994, 68 percent of physicians reported providing some charity care, amounting to an estimated $21 billion in uncompensated care costs. Community health centers provided $1 billion in care to the uninsured in 1995 (Cunningham and Tu, 1997).

The strength and resilience of the safety net is uncertain. Safety net providers have relied on cross-subsidies from other revenue sources to pay for the costs of uncompensated care. As markets have become more competitive, providers report being less able to charge private insurers prices that cover the uncompensated care subsidy, and often safety net hospitals lose patients to other hospitals that offer lower charges through managed care contracts.

The spread of managed care to Medicaid populations has been devastating for some safety net providers who lose out on participating in providing services to their traditional populations (Gage, 1998).

Safety net providers rely disproportionately on local subsidies, Medicare, and Medicaid. Each of these funding sources has already been or likely soon will be reduced. Some states have eliminated rate-setting laws that provided a surcharge on all hospital bills as a funding source for indigent care. Although Medicaid revenues have risen because of the increase in disproportionate share (DSH) payments, DSH spending in both Medicaid and Medicare funding has been targeted for reduction by federal mandates.

The impact of these changes on safety net providers is likely to vary across the country. Some areas may experience minimal problems while other areas are likely to be profoundly affected by reductions in subsidies. In general, if the number of uninsured continues to grow as predicted, and private hospitals become increasingly limited in their ability or willingness to provide uncompensated care, the burden on safety net hospitals can be expected to grow. At the same time, the ability of safety net providers to absorb additional uncompensated care may well diminish.
No Easy Solutions

Health care has been on the national political agenda for much of the past decade. The most recent attempt to establish universal coverage in the United States was through the highly visible and failed 1993 Health Security Act. Efforts to improve health insurance coverage have since focused on incremental reforms by the federal government and state efforts to reduce the number of uninsured. In 1996, the Health Insurance Portability and Accountability Act introduced several measures aimed at improving deficiencies in the U.S. health insurance market and regulatory system. These include limiting the use of preexisting conditions to deny health insurance coverage, guaranteeing availability and renewability of health insurance coverage for certain individuals, increasing the tax deduction for health insurance for self-employed workers, and allowing a limited number of small businesses and self-employed individuals to contribute to medical savings accounts (Wilensky, 1998). In 1997, the State Children’s Health Insurance Program was enacted through the Balanced Budget Act. This legislation provides nearly $40 billion over 10 years to enable states to expand health insurance coverage for uninsured children (Rosenbaum et al., 1998).

Almost all states have passed small group insurance market reforms to enable more small businesses to offer health insurance to their employees. More than a dozen states have developed plans to extend coverage to the uninsured (Rajan, 1998; Summer, 1998). These programs are similar inasmuch as they subsidize the costs of health care and expand coverage beyond the income and eligibility groups defined by Medicaid. Differences among the states emerge from the groups targeted by the programs (children, families, adults, unemployed) and approaches used to provide coverage (expansion of Medicaid versus creating new programs and offering partial subsidies versus full subsidies). Total expenses (administrative and medical) per enrollee in fiscal year 1997 ranged from $969 to $2,020.

State-subsidized programs often experience lower participation rates than projected (Rajan, 1998). This is consistent with experience in federal programs (e.g., expansion of Medicaid). In an effort to increase coverage, the state of Washington reduced its premium contribution levels and doubled its participation level. Nonetheless, policies aimed at eliminating the uninsured problem must recognize that a goal of 100 percent participation is unlikely to be achieved.

The combination of small group insurance market reforms and publicly funded coverage (along with a robust economy) has reduced the number of uninsured in some states. In Oregon, the proportion of residents with no health insurance coverage has declined from 17 to 11 percent since the Oregon Health Plan was implemented in 1994. Between 1990 and 1996, the percentage of children without insurance has fallen from 21 to 8 percent (Oregon Health Plan, 1997b). Moreover, this reduction in uninsured appears to have been cost-effective. Nationally, Medicaid coverage increased by 11 percent and expenditures increased by 30 percent between 1993 and 1996. In Oregon, Medicaid coverage increased by 39 percent and expenditures increased by 36 percent (Bodenheimer, 1997). (See Exhibit 3 for an example of Oregon’s approach to expanding health insurance coverage.)
Exhibit 3. The Oregon Health Plan

Objective

Develop a coherent public policy in which resource allocations for health care would be based on explicit principles.

- Every Oregonian should have access to health care.
- Health care expenditures should be focused where they can do the most good.
- There must be accountability for resource allocation decisions.

Plan Components

Insurance Pool Governing Board (a small business insurance pool) was established to increase the number of small employers who voluntarily offer health care coverage for employees and their dependents.

Oregon Medical Insurance Pool (a high-risk insurance pool) was established to provide access to health insurance for individuals turned down for coverage in the commercial market because of their health status.

Small Employer Health Insurance legislation that mandated reforms in the underwriting, rating, and marketing policies of small group and individual insurance plans.

Medicaid Demonstration Project extended Medicaid coverage to more individuals, is more selective about services covered by Medicaid, and required Medicaid recipients to enroll in managed care programs. Specifically,

- All persons with incomes at or below the federal poverty level are eligible for Medicaid.
- The Medicaid benefit package consists of a list of diagnoses and treatments prioritized by importance and effectiveness of each service, as well as its cost.
- All newly eligible persons were required to enroll in managed care plans whenever they were available.

Results

Uninsured level has declined from 18 to 11 percent.
Infant mortality rate has dropped from 8.3 to 7.1 per 1,000 births.
Immunization rate for children has improved from 47 percent to over 70 percent.

(Bodenheimer, 1997; Oregon Health Plan, 1997a; Oregon Health Plan, 1997b)
Some states continue to pursue strategies other than expanding public insurance to cover more of the uninsured (Rajan, 1998). California county-based indigent care programs provided $2.5 billion in subsidies in 1993. New York and Massachusetts have created uncompensated care pools that reached $1.2 billion and $300 million respectively in 1996. Mississippi and Texas continue to rely on public hospitals and clinics.

Within the private sector, the American Hospital Association, and state and metropolitan hospital associations, in conjunction with 14 other associations, have initiated the Campaign for Coverage to find ways to extend coverage and access to quality care. To date 950 hospitals and health systems have joined the campaign and are committed to helping the uninsured in their communities. Strategies include using aggressive outreach programs to locate and enroll qualified people into Medicaid and other coverage programs, developing employee health plans that are affordable for small businesses, and extending coverage to part-time workers (AHA, 1998). Parkland Memorial Hospital in Dallas, Texas, is developing a third-generation managed care organization to serve low income uninsured families on a sliding scale, prospective payment system (Parkland Health Plus). This managed care organization is intended to provide Medicaid managed care enrollment in the Dallas area (Parkland Health First). Patients will be able to move between these two programs as they gain or lose Medicaid eligibility without interruption in their continuity of care.

While the success of these public and private programs is notable, their impact is localized. The mixture of approaches to the uninsured problem has resulted in uninsurance rates that vary among states, from a low in Tennessee of 7.2 percent to a high in New Mexico of 25.7 percent (Rajan, 1998). The inconsistency in opportunities for health care among the uninsured is another kind of inequity and weakness of the nation's approach to the uninsured problem. Of equal concern is that many of the current approaches increase reliance on the current medical model without offering hope for, or even seeking, better results. By funding more of the same practices, we likely will obtain more of the same health status for citizens. And we know that we cannot afford to offer more of the same to all of the uninsured. Thus, the question emerges, can we do better for our investment in terms of efficacy and efficiency?

In Europe, health systems are guided by two fundamental values. First, health care is viewed predominantly as a social or collective good in which all citizens benefit when an individual receives needed care. Second, the value of solidarity results in the cost of care being intentionally cross-subsidized to ensure that all members of society receive needed care (WHO, 1996). Most European countries provide universal coverage for their residents, spend less than the United States on health care services, and have achieved better health status for their citizens (Anderson, 1997).
The Need to Enhance Value

The United States spends more on health care than any other industrialized nation (Anderson, 1997). Spending a trillion dollars a year on health care has produced many positive results. For those who need and can access the sophisticated technology of American medicine, our system of care can be uniquely lifesaving. Its curative successes attract patients from around the globe. Yet this expensive system does not provide uniform quality. Recent poll data indicates that four in ten Americans personally have had a “bad experience” with medical care (Miller, 1998).

Nor has our health care spending produced guaranteed access to basic services for all citizens, a safe environment, or a healthy populace. The United States is one of only three developed countries in which a working family can experience economic hardship because of bad health (Anderson, 1997; Reinhardt, 1998). The mortality rate from gunfire in the United States is 28 times that of Japan, and, despite a recent decline, is the highest among all Western industrialized nations (Thompson, 1998). The health of U.S. citizens, as measured by variables such as life expectancy and infant mortality, lags behind most industrialized countries. Given the enormous level of resources allocated to health care in this country and the lack of uniformly desirable results, the United States must identify and adopt new strategies and behaviors to get the most health for the most people for its money. Simply adding more money will not secure the gains needed by the nation.

To date, most of the middle-class has been unaware of or immune from the inadequacies (e.g., lack of consistent performance, lack of access for millions of citizens) of the U.S. health care system and, as a result, has tolerated their existence. Indeed, few Americans have gone without care because of the cross subsidies operating in the system. The increasingly global economy of the late 20th century may finally compel us to confront these shortcomings. As employers cut down on health benefits to reduce costs or are unwilling to absorb health benefit cost increases, working families bear greater financial responsibility for their health insurance. As corporations restructure and downsize, employees who lose their jobs risk becoming uninsured. As managed care advances in place of fee-for-service, health care organizations explicitly allocate their revenue streams and the cross-subsidies that have supported care for the uninsured are eliminated.

Moreover, the public is increasingly aware of the link between a productive economy and their own financial wellbeing. Poor health is expensive for the individual, the family, the community, the employer, and the nation as a whole (Knowles and Owen, 1997; Ram and Schultz, 1979, Smart, Mann and Adrian, 1993; Vinni, 1983). A healthy populace contributes to sustainable economic growth by improving human resources and enhancing social stability. Moreover, a strong health care sector provides employment and develops scientific and technical knowledge that enhances global competitiveness (Bezold, Frenk, and McCarthy, 1998). Thus, business, government, and citizens alike should be more interested in promoting health as a means of maintaining a strong economy and a stable society.

A renewed broad-based interest in advancing health (in contradistinction to simply continuing to deliver medical services in the current fashion) must, however, emerge in the context of constrained resources. The U.S. health care spending
growth rate had slowed in recent years, but this trend appears to have reversed and insurance premiums have started to increase (Goldstein, 1998, Levit et al., 1998, Winslow, 1998.). For example, health insurance premiums for federal workers will increase by 10 percent in 1999. Several factors endemic to the United States, including an aging population, a violent and indulgent society (e.g., smoking, alcohol use, obesity, lack of exercise), a disposition for technological innovation, and an apparently insatiable demand for health services will continue to create pressures for increased health care spending. Faced with substantial increases in spending just to maintain the status quo, purchasers of health care are unlikely to be interested in spending even more on health care for new initiatives.

The techniques that have been used to combat rising health care costs have taken a toll on public confidence in the health care system. Public opinion surveys repeatedly report concerns about quality and the erosion of trust in the system, particularly in managed care organizations. A substantial percentage of the public attributes the high costs of health care to the greed of insurers and for-profit health care delivery organizations and believes that profits are put before quality (Miller, 1998). Within the health care community, there are concerns about professionalism in health care and the incentives created by managed care organizations for physicians (Blumenthal, 1994; Iglehart, 1998; Kassirer, 1995).

Thus, the challenges facing the health professions and policy makers are greater than in the recent past. Cost reduction alone is not sufficient to meet the health care needs of the United States. We need to enhance the value received from health care spending and this enhanced value (or improved return on investment) must appear in the form of improved health of the population.

At first glance this objective might appear to be unachievable, but a series of recent developments provide us with the tools that can make improved health a reality in an environment of constrained resources. These tools include:

- A broader understanding of the determinants of health
- Growing demands for accountability of health care organizations, professionals, and even corporations, with respect to health status and the costs and quality of services
- Increasing capabilities in the assessment and measurement of health status
- The maturing of information technology applications in health care service delivery
- The increasing effectiveness of pharmaceuticals and medical technology
- Lessons learned from the evolution of managed care
- The ever-expanding base of knowledge that supports the practice of medicine
- Examples of successful collaboration within communities to promote health
- A growing trend of individuals assuming greater responsibility for maintaining their health and managing their care

By drawing upon these assets, health care leaders and policy makers can stimulate the development of a system in the United States that is focused on health and driven by value.
A Health System for the 21st Century

A value-driven health system seeks to improve the health of the population while achieving cost savings for all stakeholders, from the individual to the community, to the nation as a whole. Key elements of such a system include explicit principles, competition, population-health management, universal coverage, and evidence-based medicine.

A value-driven health system is grounded in two principles. First, a healthy population is a paramount social good. Second, health resources should be allocated more rationally to yield better results. For the strategies of a value-driven health system to succeed (particularly rational resource allocation), citizens must trust the health system. These ethical premises must be explicit to counteract the prevailing perception that many insurers and health care organizations put profits ahead of patients and to begin the process of rebuilding confidence in the system. Moreover, use of these principles by health care purchasers to shape what they demand in the health care market will influence what health care providers supply.

Quality (i.e., health of the population) and efficiency are the basis of competition in value-driven health system (Kindig, 1997). Successful competitors are rewarded with populations to manage. To compete on the basis of the health of the population requires a fully insured population (i.e., universal coverage) so that population health management strategies can be implemented. It also requires the ability to demonstrate results achieved. The first report of the Blue Ridge Group recommended that health care delivery organizations (particularly academic health centers) use performance measures to make informed business decisions and to demonstrate accountability for public resources. Performance measures, particularly health status measures, will become increasingly important as health care delivery organizations compete by demonstrating their ability to improve the health of a population.

Population health management is the heart of the value-driven health system (Fries et al., 1998). It involves identifying health risks to populations and individuals, communicating the risks, and managing the health risks collaboratively before the onset of disease and associated treatment costs (Goldsmith, 1996). Equally important, responsibility and financial risks must be appropriately distributed (Smith, Wong, Eichert, 1996). Incentives for individual citizens (patients), employers, health care professionals, health delivery organizations, and communities to seek and maintain health are a basic tool for population health management. Health insurance premiums, reimbursement rates, and grants to communities all can be structured to reward behaviors and strategies that advance health.

For population health management to be effective it must be possible to collect data on the interventions or preventive strategies used, the health resources consumed, and the resulting outcomes for each member of a given population. It also must be possible to establish incentives that affect all members of the population so that a free-rider problem does not emerge. Individuals who choose to pursue less healthy behaviors or more expensive care approaches should do so at their own cost and not at the expense of the rest of the population. The entire population must be
Evidence-based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.

part of the health system for these two condi-
tions to be met. Universal coverage pro-
vides a mechanism for bringing everyone into the system.

In a value-driven health system, scientifically valid evidence drives decisions. Each decision point is evaluated in terms of how a finite set of resources can be optimized for the particular population or subset of the population. A basic question is asked repeatedly by all decision makers—federal, state, and local policy makers, health care provider organization managers, public health officials, health care professionals, insurers, and in some cases, patients:

*With the available level of resources, what action(s) will yield the highest benefit toward our objective for this population or individual patient?*

The actions under consideration might be preventive, clinical, or social interventions. The objectives likely will include: keep people healthy, return them to health, maximize their ability to function independently, manage their chronic pain or ease their terminal pain. The population in question could be the nation, state, region, community, insured group, or patients in a physician practice.

A value-driven health system expands the concept of evidence-based medicine from focus on the care of individual patients to include care of populations of patients. Evidence-based decision making requires the ability to:

- Define objective criteria for evaluating options (e.g., effectiveness, safety)

- Find information or evidence to apply to the criteria

- Assess the quality of available evidence

- Determine whether the evidence (or research results) can be generalized to the whole population

- Judge whether the evidence can be applied to the population of concern (Gray, 1997).

A robust information technology infrastructure that enables data collection and analysis and facilitates location of available evidence is critical to evidence-based decision making. Information technology also is needed to improve efficiency in and effectiveness of all aspects of a value-driven health system: health care delivery, research, education of health professionals and patients, administration, and financial transactions. Increased use of information technology should be explored to support patient interaction with the health system, communication with individual health professionals, patient education, and collaboration among community or regional organizations managing the population’s health. Critical aspects of information technology functionality include efficient and accurate data capture and timely availability of knowledge in an understandable form for both health professionals and patients. For example, the availability to both clinicians and patients of the costs and benefits of treatments should guide decision making in a value-driven health system.
Implications of a Value-driven Health System

A value-driven health system emphasizes the health of the public more than the current health care delivery system. Health is understood as more than medical care and in terms of the health of the population and not just of the individual. This represents a new unit of measurement (i.e., community or region) and will require new thinking from health professionals on promoting health as well as on partnering with others to facilitate health-enhancing strategies. A multi-faceted approach is needed to achieve this objective:

- Broad participation in seeking health objectives for a region or community beyond the covered lives of any specific insurance pool
- Renewed focus by the public health community on managing the population's health
- Better integration between public health and the medical system
- Training of new and current health professionals and administrators to function in the new model
- Increased research that supports the population approach to health
- Development and implementation of strategies that capitalize on all the factors contributing to health (e.g., environment, education, housing, crime)
- Recognition of the role of the community or region in health status, and allocation of resources to those community initiatives that can advance health for a given locality.

Health professionals and organizations, non-health organizations, communities, and regions need to shift investment to what makes a difference in the health status of the population. They must be willing to act on timely, accurate knowledge and to eliminate treatments and interventions that have been shown to be ineffective. This issue is of particular concern for academic health centers (AHCs) as they have an important role to play in generating, evaluating, and disseminating new knowledge. Stakeholders at all levels must become evidence-driven and work to achieve consensus on how to

Health is, therefore, a positive concept emphasizing social and personal resources as well as physical capabilities. Improving health is a shared responsibility of health care providers, public health officials, and a variety of other actors in the community who can contribute to the well being of individuals and populations.

— Improving Health in the Community: A Role for Performance Monitoring
Institute of Medicine, 1997
define, gather, use, and refine evidence. Work already completed by the Agency on Health Care Policy and Research, the Preventive Services Task Force, and Canadian Task Force on the Periodic Health Examination should provide a starting point for these efforts (Battista, 1993; U.S. Preventive Services Task Force, 1996).

The success of such a system will depend on innovation in designing and delivering services; investment of short-term savings into a long-range strategy that promotes health, lowers disability, reduces morbidity, and mortality; and streamlined administration at the organizational and system level. Elements of a value-driven health system are already in place or under development (e.g., increasing sophistication and use of outcome measures, implementation of clinical information systems that offer decision support to clinicians). But these components are fragmented. Both integration and acceleration of development and implementation are needed. This will require both public and private sectors—particularly those who purchase health services, award grants, and allocate resources to localities—to establish incentives that reward individuals and organizations for moving toward a value-driven health system.

Several fundamental issues must be addressed as part of the development of a value-driven health system. First the health care community, policy makers, and citizens must accept that explicit rationing of resources is a necessary and equitable step toward achieving universal coverage and optimizing the effectiveness of health care spending in the United States. Second, the high spending on health care in the United States combined with the mixed results demands the question: Are resources being put to their best use? This question implies that over time there will be a reallocation of resources not just within the medical infrastructure, but to other areas that are known to contribute to improved health status (e.g., literacy). For instance, approximately 50 percent of deaths can be attributed to behavioral and environmental factors, yet only five percent of the U.S. health care budget is allocated to prevention activities (McGinnis and Foege, 1993).

Third, the responsibility of individuals in maintaining their health and contributing to the costs of health insurance coverage must be confronted so that those who pursue healthy choices do not unfairly bear the costs of those who engage in behaviors that adversely affect their health. Among those behaviors is the decision to purchase or forgo health insurance. As a result, the issue of affordability of health insurance is a critical element. Finally, the nation must recognize that the value (defined by both financial and equity gains) in having a fully insured, healthy population is worthy of public investment.

Hospitals and health systems should restructure to become parts of community care networks to enhance their accountability to community health, keep people well, and create cost savings through collaboration.

— Health Networks Innovations: How 20 Communities Are Improving Their Systems Through Collaboration
Bogue and Hall, 1997
**Universal Coverage**

**Recommendation 1.** By 2001, Congress should pass legislation that mandates health insurance coverage, whether privately or publicly funded, for all residents as a national objective. By 2005, Congress should pass legislation that creates the framework and authorizes funding for insurance to be extended to all residents. This insurance should provide access to a minimum set of effective health services, including preventive, health maintenance, and acute and chronic illness care.

The arguments in favor of universal health coverage are compelling and outweigh arguments for maintaining the status quo. Access to health care has been described as one of the most important primary social goods because "disease and ill-health interfere with our happiness and undermine our self-confidence" (Green, 1976). The Blue Ridge Group firmly believes that universal coverage would be good for the nation. It can enhance productivity for a global marketplace, promote fair competition in the health care market, enable the management of health care quality and costs, and advance social equity. Moreover, it can make explicit an existing cost that is already borne by a variety of stakeholders (e.g., employers offering health insurance, privately insured individuals, government).

Yet, the politics of the issue are complex, daunting, and to date, insurmountable. The financial costs of mounting a universal coverage program (even with limited benefits), competing budget issues (e.g., Medicare, long-term care, mental health), efforts to reduce the budget deficit, the fear of big government, the impact on entrenched interests, past failures, and an ambivalent public have all made universal coverage a political morass. Experience with state programs, however, shows that increases in effective coverage can occur, with the general acceptance of the population, with apparent improvement in health status, and without large increases in cost (Bodenheimer, 1997; Oregon Health Plan, 1997b).

Universal health coverage can take many different forms, as is evident from the multitude of proposals for achieving universal coverage and the variation in approaches where it has been introduced. In some cases, these approaches are variations on the same theme, such as expansion of existing systems to cover the uninsured populations. In other instances, proposals are contradictory, such as incremental expansion of employer-based health insurance versus implementing structures to reduce the prevalence of employer-based health insurance. Rather than advance a particular universal coverage plan, the Blue Ridge Group identified a set of principles for universal coverage that would support the development of a value-driven health system and could be applied to a variety of universal coverage approaches. These principles include:

- Each legal U.S. resident has health insurance coverage for a basic set of effective health services (Reinhardt, 1998). (This would likely require a mandate, perhaps on individuals.)
The set of basic services includes preventive, health maintenance, acute, and chronic illness care. It is regularly reviewed and adjusted according to ongoing research and evidence of effectiveness.

Insured individuals are aware of the full costs of insurance and the costs of services they consume, and bear an appropriate share of those costs. Individuals are aware of how their behaviors contribute to their health and costs of their health care. Individuals are informed about the effectiveness of alternative treatments.

Insurance coverage does not depend on employment status. Risk pools exist to provide all individuals access to insurance for basic health services. As a result, risk is shared among all stakeholders. The tax code treats health insurance costs equally across all kinds of employment. Subsidies are provided to low-income families.

The performance (including costs) of the entire system, of individual providers, and of geographic populations can be objectively and accurately measured, and rewards are tied to results.

The estimated costs of universal coverage vary widely—from $20 to $150 billion—depending on the plan under consideration. Variables include the range and depth of benefits, the form of administrative structures adopted, and whether tax reforms accompany extended coverage. For example, one proposal for extending health insurance benefits to workers and family members without employer-group coverage would offer the Medicare program's basic benefit package with the addition of prenatal, maternity, and preventive care for mothers and children (Etheredge and Jones, 1998). Administration of the program is based on the Federal Employees Health Benefits program. Information on insurance options would be distributed at work and employees could pay for premiums through voluntary withholding from their paychecks. Employers would not contribute to premium costs, but would administer premium collection. Program participants could exclude 100 percent of their health insurance premiums from income taxes. Annual premium costs for an adult would be $1,175 and $3,248 for a family. For 10 million individuals, ongoing federal expenses would be $1.7 billion per year for tax assistance and estimated total start-up costs for the first five years would be $30.5 billion.

The Blue Ridge Group's view of a value-driven health system emphasizes the need to reallocate existing resources rather than immediately add more resources to the system. A recent review of health education programs designed to reduce health risks concluded that health professionals have the knowledge that "could improve population health and at the same time reduce medical claims costs by 20 percent or more" (Fries et al., 1998). The value of benefits from effective workplace health promotion programs can equal two or three times the costs of the programs. Educational programs that equip patients to manage their own care and determine when professional care is appropriate can lower service use up to 17 percent. In addition, reduction in overly intensive treatment of irreversible terminal illness could reduce lifetime medical costs by three percent or $30 billion per year.

Savings from administrative simplification are estimated to range from 10 to 15 percent of health care spending in the
United States. If such savings are achieved, however, they accrue to individual organizations rather than to the “system.” Thus, it is essential that appropriate incentives are developed that motivate health providers, organizations, and patients to seek best practices for both clinical services and administration, and that additional incentives are developed so that savings that are achieved are invested back into the health system to improve its long-term performance.

Achieving universal coverage should enable resource reallocation. Physicians and health care delivery organizations that currently provide uncompensated care would be compensated for that care. This should reduce the need for cross-subsidies and reduce pressures for reimbursement rate increases to cover uncompensated care costs. Direct reallocation of resources is most likely to be achieved by the federal and state governments, as funding that has supported the current piecemeal approach to providing uncompensated care to uninsured individuals is reallocated to new programs specifically designed to extend coverage and improve value. For example, a Florida program that provided insurance to children found that emergency visits dropped by 70 percent and saved $13 million in 1996 (Florida Healthy Kids, 1997). In addition, disproportionate share payments could be reconfigured and funds used to support uncompensated care pools could be shifted to pay for expanded insurance coverage. Additional resources to support universal coverage can be found in:

- Increasing tobacco, alcohol, firearm taxes, and other user taxes
- Earmarking corporate taxes paid by for-profit health providers and plans
- Assessing a surcharge on managed care plans
- Reform of tax expenditures for employer-based health insurance
- Collection of social responsibility contributions from employers that do not offer health insurance
- The funds established with the conversion of not-for-profit health insurers and providers to for-profit status

Such resources should be phased in gradually until coverage is complete. In the long term, it is anticipated that new incentives for consumers and providers would reduce costs and improve efficiency of health care programs.

A policy for achieving universal coverage must be developed as part of a national strategy for the evolution of health care delivery in the United States. Actual implementation of universal coverage is most likely to be accomplished through phasing, and incremental adoption by states and localities. Coverage expansion could continue the approach initiated by some federal and state programs of gradually including priority populations (e.g., children, women of childbearing age, people aged 60-64) as funding becomes available. Incremental expansion of coverage must, however, be accompanied by incentives for enrollees and health care delivery organizations to pursue behaviors that advance health.

Consistency among various approaches can be achieved by linking funding to basic principles identified in the program design. Elements of the national framework should include an agreed-upon process for estab-
lishing evidence; research funding to expand knowledge on where resources for improving health are best utilized; and programs and grants to support activities that are not traditionally associated with improving health.

The challenges associated with designing an affordable, effective way to achieve universal coverage and gaining political support to implement the resulting programs should not be understated. Thus, legislative efforts should focus first on establishing universal coverage as a national priority. Subsequently, the specifics of how universal coverage should be achieved can be debated. Some of the issues surrounding the uninsured problem are similar to those surrounding the reform of Medicare. Medicare reform efforts certainly will inform the uninsured debate, but given the public role in both of these issues, it would be prudent for Medicare reform discussions to consider their impact on the uninsured problem and their potential to serve as a model for resolving the uninsured problem. Moreover, while extending health insurance coverage to all legal residents of the United States, is an essential step toward improving health status in this country, it must be accompanied by a set of equally important actions that will provide the foundation for a value-driven health system.

The Commission urges the President, Congress, and all other stakeholders to engage in meaningful and continuing efforts to systematically reduce the number of Americans who are uninsured or underinsured. Such an effort should include specific goals and timetables and should have as its ultimate goal access to affordable, comprehensive health care for all Americans.

— Quality First: Better Health Care for All Americans
President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, 1998
Public health is what we, as a society, do collectively to assure the conditions in which people can be healthy. We need to give much more attention to putting the public back into public health.

— Creating the Future of Public Health
Barry S. Levy, 1998
Managing Population Health

Recommendation 2. The Department of Health and Human Services, state and local health departments, health care provider organizations, schools of public health, private foundations, and other public and private health related organizations should make population health the primary objective of public health.

To achieve the ultimate objective of improving the health status of the nation, there must be clearly defined responsibility for tracking progress and coordinating efforts towards that goal. The public health community is an obvious candidate for the role of ensuring that the population’s health is maximized. Building upon the current mission of public health to fulfill “society’s interest in assuring conditions in which people can be healthy” (IOM, 1988) and existing initiatives like Healthy People: 2000 and its successor Healthy People in Healthy Communities: 2010 is a logical step toward strengthening our capabilities to manage the health of populations (U.S. Department of Health and Human Services, 1997b).

Yet despite the potential for public health to contribute significantly in this area, substantial challenges must be met. The need to bolster public health has been acknowledged by a variety of groups including the Centers for Disease Control, Robert Wood Johnson Foundation, Kellogg Foundation, Institute of Medicine, and most recently, the Public Health Functions Project (Kindig, 1997; IOM, 1988; U.S. Department of Health and Human Services, 1998a). Specifically, to fulfill a pivotal role in managing population health, the visibility of public health must be heightened, alliances must be established or strengthened, and the focus and allocation of resources within public health must be realigned.

During much of this century, the personal health care system has dominated the public health system. Tension between public health officials and medical practitioners over the limits of the public health mandate began early in the century (AMA Council on Scientific Affairs, 1997; Starr, 1982). Health care financing trends in the second half of this century widened the schism between public health and medicine. Increasingly, and until quite recently, the health care delivery system emphasized personal care over population care and diagnostic technologies and curative tactics over preventive strategies (IOM, 1988, Smith, Anderson, and Boumbulian, 1991).

Despite the fact that there are 3,000 local public health agencies working on public health in this country, in addition to state and federal agencies, 97 percent of participants in a 1996 Harris Poll did not know what public health agencies do (Center for Studying Health System Change, 1996; Levy, 1998). Between 1990 and 1993, public health spending declined from 2.7 percent to 1 percent of U.S. health care. Between 1981 and 1993, total U.S. expenditures on health care increased by more than 210 percent while funding for population-based health strategies, as a proportion of the health care budget, declined by 25 percent (Center for Studying Health
System Change, 1996). Approximately two-thirds of resources in the public health system are directed to personal health services, such as direct care to individuals rather than to core public health functions (Public Health Foundation, 1996). As a result, public health is often considered to be the equivalent of publicly funded health care. Drains on public health resources have occurred as Medicaid populations have been moved to managed care contracts which often are not required to provide traditional public health services or to reimburse health departments for supplying them (Public Health Foundation, 1997).

A robust public health infrastructure will both contribute to and benefit from a value-driven health system. Once universal coverage is achieved, rather than providing services to the uninsured, public health agencies will be able to increase attention and resources to issues and activities that advance the health of the public. Moreover, as health care professionals and delivery organizations increase their focus on managing the health of populations, there is opportunity for collaboration among health care and public health professionals and for linking the medical model and public health model more visibly (Lasker, 1997).

Ultimately, for a value-driven health system to function, public health must be seen as an integral part of the health system.

Public health departments already serve population-based roles in environmental protection, public education, and outreach services to high-risk populations. Data collection and measuring population health improvement are logical extensions of public health agency functions. Further expansion could lie in coordinating efforts within communities and across the multiple determinants of health (Kindig, 1997).

New methods and tools for tracking public health functions are needed. The proliferation of health and safety programs in non-public health government agencies challenges the coordination of public health functions and the ability of public health departments to demonstrate accountability for the resources allocated to them. Indicators are needed to track whether public health agency goals are being met and how those goals contribute to the health status of a community. Moreover, the public health community needs to be a major contributor to the development and ongoing monitoring of population-based outcome and performance standards.

Funding for the delivery of health care services needs to be revamped to create incentives that encourage practitioners and patients to adopt behaviors that advance health efficiently. And funding for public health activities should be evaluated to see how such funding can be optimally used to promote health. The level of, mechanisms for, and incentives created by public health funding need to be evaluated. Much of the funding for public health services and research comes in the form of categorical grants and addresses specific issues. As a result, there is little flexibility for public health professionals to address emerging or community-specific issues and little opportunity for public health researchers to pursue interdisciplinary or community-wide approaches to addressing public health issues. Past resources for the public health infrastructures (e.g., block grants structured on per capita bases, taxing insurers), as well as potential new sources, need to be catalogued and coordinated programmatically to maximize their potential. Again, value-driven, evidence-based policy can have significant impact through reallocation of existing resources.
Confronting Risks and Assuming Responsibility

**Recommendation 3.** Each community or region should assume responsibility for improving the health of its residents. Each health care delivery organization (public or private) within the community or region should help to initiate (if necessary), actively participate in, and support through their clinical and service programs, these efforts to advance the health of residents of the community or region. Federal and state legislators and agencies should support community and regional efforts by developing policies (including distribution of resources) that create incentives for individuals, local agencies, health care organizations and professionals, and employers to adopt strategies that measurably advance health.

Many of the factors that contribute to health status lie outside the health system and are best addressed at the source rather than within the health care delivery system. In addition to insurance coverage, such factors include education level, literacy, employment status, income level, quality of housing, safety of neighborhoods, availability of transportation, and support networks for individuals and families. Since these factors largely lie within the realm of local and regional governments, it is appropriate and necessary that communities or regions be actively engaged in improving the health of citizens. This health emphasis will require action from a wide range of players responding to differing incentives. Examples of successful programs and strategies exist, but must be replicated throughout the country. Implementation will be fostered by appropriate measurement as well as collaboration and partnering of intellectual and economic capital.

According to the Institute of Medicine, "a community health improvement process that includes performance monitoring... can be an effective tool for developing a shared vision and supporting a planned and integrated approach to improve community health" (IOM, 1997). Such an effort must be iterative and evolving rather than a short-term, one-time event and should be based in a community health coalition or similar entity. Communities and regions should assess the health needs of residents, identify available resources, and develop specific strategies to address the social and environmental determinants of health in the locality. (Exhibit 4 presents an overview of the community health improvement process.)
Exhibit 4. Community Health Improvement Process

According to the IOM, the following are components of a Community Health Improvement Process that provides a framework within which communities or regions can take a comprehensive approach to maintaining and improving health. The resulting process will likely vary for each community, however, as it considers its own health concerns, resources and capabilities, social and political perspectives, and competing needs in developing a health improvement program.

- Conduct a community health profile, such as demographic and socioeconomic characteristics, health status, and health risks
- Analyze health issues
- Inventory health resources
- Develop a health improvement strategy
- Establish accountability for activities
- Develop a set of performance indicators
- Implement the improvement strategy
- Monitor the process and outcomes

The Community Care Network (CCN) offers many examples of community participation in health improvement. The CCN was developed by the American Hospital Association, the Catholic Health Association, the VHA, and the Hospital Research and Educational Trust, and is an outgrowth of the health care reform debate in 1992. The vision of the CCN is to stimulate "health care organizations to reform health care delivery locally so patients, communities, and their resources, needs, and problems drive the reconfiguration of local health care" (Bogue and Hall, 1997, p. xxviii). A major theme underlying the CCN vision is that delivery system reform is a prerequisite for addressing issues of access, quality, and costs in health care. Currently, 25 community partnerships are being funded by the National Demonstration of CCN Vision to learn how communities and their health care provider organizations can make progress toward this vision and to disseminate lessons learned.

In 1994, the Health Resources and Services Administration's Bureau of Primary Health Care established a biannual award that recognizes innovative community health programs and helps publicize them to assist fundraising and to stimulate replication in other communities (Boughton, 1998). The 1996 awards included:

- A high-risk youth program that provides services to runaway teens in Los Angeles
- A program to train farm workers to provide health services to migrant workers
- Nurse-run community health centers located in Philadelphia public housing projects
- A community clinic in El Paso that offers housing, after-school tutoring, a food co-op, and a bilingual family therapist to assist its clients.

- The Hillsborough County Health Plan (in Florida) that provides services to uninsured patients and emphasizes preventive services, education, and early detection.

Any sector of a community or region (in rural areas) can initiate collaborative efforts and lead a community health improvement process. Public health agencies, all health care delivery organizations, social service agencies, local government leaders, and individual citizens need to participate in the community health improvement process. Involvement by many sectors of a community is necessary to ensure that collaborative efforts focus on the ultimate goals of improving community health and maximizing the benefits derived from limited health care expenditures.

Community health improvement efforts cannot be limited to the public sector. Private (including for-profit) health care delivery organizations also have a responsibility to participate (Schlesinger, and Gray, 1998). Moreover, success is more likely to occur if objectives are reinforced throughout the community (e.g., physician offices, libraries, schools, employers). Employers are particularly suited to reinforce community health objectives through incentives for healthy employees and may reap direct benefits through a healthier and more productive workforce.

Citizens of Pasadena, California, participated in a process to establish 55 indices that measure quality of life in their community. The indices are grouped into 10 major categories: environment, health, substance use, education, the economy, housing, arts and culture, recreation and open spaces, transportation, and community safety. They are considered essential ingredients in making the community "healthy for human beings" and are linked to the city's budget. The objective of the program is to integrate "day to day public services with the overall synergy of the community and the resources available to create a healthy quality of life" (Weber, 1998).

Successful programs and strategies will involve public accountability through appropriate measurement and public reports, as well as collaboration and partnering of human, intellectual, and economic capital. Revenues for such programs may come through a variety of strategies, including taxes, corporate contributions, new community conversion foundations, and philanthropic support. In addition, federal, state, and philanthropic programs that support community health improvement should be increased. Other community issues, including education, safety, crime control, jobs, affordable and safe housing, and transportation also have a significant impact upon the public's health and well-being. These components of community infrastructure, along with public health services, should have guidelines (akin to HEDIS, the Health Plan Employer Data and Information Set developed by the National Committee for Quality Assurance) that foster accountability and contribute to the Healthy Communities Goals for 2000 and 2010.
At a time when communities are struggling to deal with complex issues and problems, they must draw upon the strengths and assets of all institutions, including academic health centers, as instruments of community and economic development... Communities need AHCs as partners in building healthier communities and academic health centers need community resources to support their missions of education, research and service.

— Report of the Task Force for the Initiative on the Future of Academic Health Centers
U. S. Department of Health and Human Services, 1997
Role for Academic Health Centers

Recommendation 4. In addition to participating in community or regional efforts to advance the population’s health, each AHC should provide leadership through research and education of current and future health professionals on population health management and a value-driven health system as fundamental strategies for health care delivery in the next century.

Academic health centers have a long tradition of providing patient care to the uninsured and playing a large part in the safety net. Academic health centers should transform this role into one of leadership in advancing universal coverage and a value-driven health system. For example, AHCs can educate federal, state, and local policy makers about the health impact and hidden costs of being uninsured. Like all health care delivery organizations, AHCs need to assess how they can improve community-health orientation within their own delivery systems and how they can assist in improving community or regional health status (Anderson and Boumbulian, 1995). Moreover, AHCs need to assess opportunities for serving health information and education needs of patients and their communities in the evolving health system. A special role for AHCs is to develop a new training and research agenda.

In its first report, the Blue Ridge Group recommended that AHCs develop and implement performance measures that assess AHC impact on the community and region. This recommendation presents both challenges and opportunities for AHC leadership. It requires AHCs to establish greater influence and forge new partnerships outside their walls. It requires them to commit to and invest in strategies, the impact of which will not be seen in the short term. It also requires AHCs to apply innovative capabilities to a new set of problems. Most important, it requires AHCs to view their mission in a new light and to place greater emphasis on advancing the health status of the community. Much of this effort will involve allocating more resources toward prevention, public health, and health evaluation sciences.

A critical component of ensuring the development of a value-driven health system is the education of current and future health professionals, researchers, managers, and patients. Academic health centers must allocate sufficient time in the curriculum for health professional and public health students to master skills necessary to manage the health of populations. These competencies could include understanding the illness burden of the population, epidemiology, health evaluation sciences, community action, and intervention. The Association of American Medical Colleges has recently recommended that “each medical school develop a population health curriculum, and that the Liaison Committee on Medical Education require schools to demonstrate their success in doing so” (AAMC, 1998).

Medical schools should continue to explore ways to provide medical education in a community setting, promote health, and be responsive to the needs of the at-risk population. In the past decade, many
Exhibit 5. A Community Oriented Primary Care Network

Parkland Memorial Hospital in Dallas, Texas, developed a community-oriented primary care (COPC) network to improve care for both individuals and communities. The network includes eight community health centers and 10 youth and family centers located on school-based sites, with five additional school-based clinics of a more traditional nature, two mobile clinics (i.e., vans that serve 22 homeless shelters), and clinics within two churches. The 75-member physician staff for the network belongs to a group practice, is board certified or board eligible, and has clinical faculty status. Several staff members have advanced degrees in public health or a sub-specialty board. Forty-seven percent are African-American, Hispanic, or Asian; 59 percent are women; approximately 50 percent are bilingual. Non-physician staff include: nurse practitioners, physician assistants, nutritionists, health educators, outreach workers, translators, social workers, psychologists, and dentists. The scope of primary care services includes pediatric, adolescent, adult, and geriatric medicine, as well as maternal health services.

Outreach prevention programs for cancer and AIDS have been implemented. The COPC cooperates with existing public health programs in addressing immunizations, sexually transmitted diseases, disease surveillance, health education, maternal and child health, and health maintenance examinations for public school students. Community partnerships include maternal and family planning clinics operated by the University of Texas Southwestern Medical Center being co-located with COPCs in four sites. COPC also provides pediatric services at four maternal and family planning freestanding clinics. Dental services are provided by a non-profit agency (Dallas Dental Health, Inc.) funded in partnership by the city of Dallas, Parkland Memorial Hospital, and various philanthropic sources.

Preliminary evaluation of COPC effectiveness has shown a decrease in Emergency Room utilization by COPC patients, a reduction in hospitalizations for chronic illness, a reduction in infant mortality, and shorter hospitalizations with lower costs for COPC patients.

AHCs have successfully strengthened their primary care training and service programs. Several AHCs have gone beyond the primary care model and are pursuing community responsive medicine as the academic discipline of community-oriented primary care (COPC), incorporating traditional primary care with public health services (Smith, Anderson, and Boumbulian, 1991). COPC blends curative and preventive medical services, demographics, epidemiology, community organizations, and health education for defined populations. It is a denominator-driven system that assesses effectiveness through a formal epidemiological evaluation of the population at risk.

Parkland Memorial Hospital in Dallas, Texas, has established a community-oriented primary care network. Physicians working in the COPC have clinical faculty
status at the University of Texas Southwestern Medical School and may provide attending coverage on the inpatient units of Parkland or the affiliated Children's Medical Center. This program provides unique inpatient and ambulatory teaching opportunities and enables continuity of care for both the COPC and inpatient settings (Smith, Anderson, and Boumbulian, 1991). (Exhibit 5 describes Parkland's COPC network.)

Academic health centers should consider other innovative approaches that will prepare health professionals for community involvement as part of their practice. For example, specialty residency slots may be reassigned to "community" specialists and opportunities should be created to allow current generalists to assume a leadership role in community health. In addition, AHCs should assess the merits of establishing a new education track for health professionals (not necessarily physicians) who can fill needed roles in a value-driven health system.

New research areas for AHCs include special population care costs (i.e., social

severity scale, transportation, translation, etc.), severity of health status, and effective strategies for promoting health within communities and regions. In addition, researchers can continue to explore the relationship between healthy populations and productivity, and refine calculations of the return on investment of spending to improve health of the population.

Academic health centers also can provide expertise as communities and public health agencies establish performance measures for their communities.

Funding mechanisms that support community health initiatives must aid AHCs as they pursue these changes. Disproportionate share, indirect medical education, and direct medical education payments should be analyzed to assure appropriate allocation of funds. In addition, federal agencies and private organizations must increase support for research and demonstration projects that advance the generation and dissemination of knowledge about cost-effective strategies for improving health.

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Parkland has learned over the past ten years that to truly improve health, it must address the social and economic determinants of disease such as lifestyle, education, and employment opportunities. This means working with school districts, housing authorities, police and fire departments, churches and synagogues, and employers.

— Academic Health Centers in the Managed Care Environment
Anderson and Boumbulian, 1997
Conclusion

Although the momentum of the early 1990s to reform health care in the United States has slowed, the urgency of the quality, cost, and access problems has not abated, and in the case of access for the uninsured, has actually heightened. The size and complexity of the uninsured problem means that many individuals and organizations must participate in the process of bringing the problem to the fore of the nation's political agenda. It is particularly important that both policy makers and individual citizens understand the implications and hidden costs of the uninsured issue so that they do not view it simply as someone else's problem.

Three critical and inter-related steps are needed to make real progress toward universal coverage and a value-driven health system. First, Congress must declare that universal coverage is a national priority and set a date for its enactment. Second, health care organizations, public health agencies, and local communities and regions must begin to focus on population health management and community health improvement through education, research, and demonstration projects. Third, public and private funding organizations should support efforts to build a value-driven health system.

A value-driven health depends on and is essential to achieving universal coverage in the United States. It also increasingly appears to be critical to the nation's ability to manage its health care costs and keep its populace healthy and productive. As the effects of managed care have begun to diminish, it is time to introduce a new and broader approach to health care delivery in the United States. By establishing appropriate incentives, training decision makers, investing in information systems, building databases, measuring outcomes, and expanding knowledge about all the factors and interventions that improve health and productivity, policy makers and health professionals will begin the long overdue transformation of the health care sector.

Through commitment, investment, collaboration, innovation, and appropriately structured incentives, the United States can make progress toward eliminating a fundamental weakness in its social structure and improve the health of the nation. Undoubtedly, the challenge ahead is formidable, but the potential payoff is well worth the price. Total population health insurance coverage and a value-driven health system are good for the United States. It is time to assure them.
About the Blue Ridge Academic Health Group

The Blue Ridge Academic Health Group seeks to take a societal view of health and health care needs and to make recommendations to academic health centers to help them create greater value for society. The Blue Ridge Group also intends to recommend public policies to enable AHCs to accomplish these ends.

Three basic premises underlie this mission. First, health care in the United States is experiencing a series of transformations that ultimately will require new approaches in health care delivery systems, education, research, and knowledge management. Second, the recent upheavals in health care have been largely driven by financial objectives. Yet, the potential exists for fundamental changes in health care to improve health and manage costs. Analysis and evaluation of the ongoing evolution in health care delivery must address the impact on the health of individuals and the population, as well as on cost. Third, AHCs play a unique role in the U.S. health care system as they develop, apply, and disseminate knowledge to improve health. In so doing, they have assumed responsibilities and face greater challenges other health care provider institutions do not bear. As a result, AHCs face greater risks and greater opportunities as the U.S. health care system continues to evolve.

The Blue Ridge Group was founded in March 1997, by the Virginia Health Policy Center (VHPC) at the University of Virginia and the Health Market Unit leadership at Ernst & Young LLP (E&Y). The VHPC serves as the center of the Blue Ridge Group’s operations, while E&Y provides core funding and facilitation. Both organizations provide thought leadership.

Group members were selected to bring together seasoned, active leaders with a broad range of experience in and knowledge of academic health centers and health care in the United States. Blue Ridge Group members collectively select the topics to be addressed. Before meetings, an extensive literature review is conducted and group members refine the topic by responding to specific questions.

Criteria for selection of report topics include relevance to the operation of academic health centers and to the ability of AHCs to provide value to society, the likelihood of being able to make specific recommendations that will lead to productive action by AHCs or other organizations, and the ability to frame useful recommendations during two-day meetings. Other participants are invited to Blue Ridge Group meetings to bring additional expertise or perspectives to the group’s deliberations on a specific topic.

During the meeting, participants reflect on emerging trends, share experiences from AHCs, and hear presentations on specific issues. Most of the working session is dedicated to a focused discussion of what AHCs can and should be doing in a particular area to achieve visible improvement, or a discussion of what public and private policy and philanthropic organizations can do to facilitate the efforts of AHCs to fulfill their societal mission. The results of the group’s deliberations are presented in brief reports which are disseminated to targeted audiences.
About the Core Members

Enriqueta C. Bond, Ph.D.
President
Burroughs Wellcome Fund

Dr. Bond is the president of the Burroughs Wellcome Fund. She formerly held a number of research and administrative positions at the Institute of Medicine, National Academy of Sciences; Department of Medical Sciences, Southern Illinois University's School of Medicine; and the Biology Department at Chatham College.

Dr. Bond also serves on several advisory committees and boards, some of which include the Health Science Policy of the Institute of Medicine; National Center for Infectious Diseases, Centers for Disease Control and Prevention; and the Society for Research on Women's Health.

She has authored and co-authored more than 50 publications and reports on science policy.

Robert W. Cantrell, M.D.
Vice President and Provost for Health Sciences
University of Virginia
Chief Executive Officer
University of Virginia Health System

Dr. Cantrell is vice president and provost for Health Sciences at the University of Virginia. Also a surgeon-educator and medical administrator, he is the former president of the American Academy of Otolaryngology-Head and Neck Surgery. As a captain in the U.S. Navy he served as chair of Otolaryngology-Head and Neck Surgery at the Naval Regional Medical Center in San Diego, California.

Dr. Cantrell was also the Fitz Hugh Professor and chair of the Department of Otolaryngology-Head and Neck Surgery at the University of Virginia School of Medicine. He also has been a consultant to the Surgeon General of the U.S. Navy and to the National Institutes of Health (NIH).

Dr. Cantrell is a member or fellow of 33 otolaryngological societies and has taken an active leadership role in many, including the American College of Surgeons, the American Society for Head and Neck Surgery, and the American Broncho-Esophagological Association.

Dr. Cantrell has published numerous articles and delivered lectures nationally and internationally.

Don E. Detmer, M.D.
University Professor
University of Virginia
Co-Director
The Virginia Health Policy Center

Dr. Detmer is the Louise Nerancy Professor of Health Sciences Policy at the University of Virginia.

Nationally, he chairs the Board on Health Care Services of the Institute of Medicine, National Academy of Sciences, and the Secretary's National Committee on Vital and Health Statistics, Department of Health and Human Services. He is a board member of the China Medical Board of New York and a fellow of the American Association for the Advancement of Science, the American College of Surgeons, the American College of Sports Medicine, the American Medical Informatics Association, and the Association for Health Services Research.

He has authored more than 150 articles, monographs, and book chapters. Dr. Detmer earned his medical degree at the University of Kansas after undergraduate studies there and at Durham University of England.
Michael A. Geheb, M.D.
Director and Chief Executive Officer
University of Alabama at Birmingham Health System
Professor of Medicine
University of Alabama School of Medicine
Dr. Geheb is the director and chief executive officer for the University of Alabama at Birmingham Health System. Dr. Geheb has also served as professor of Medicine, associate dean for Clinical Affairs, and director of Clinical Services at the State University of New York at Stony Brook University Medical Center.

Dr. Geheb's professional associations include the American Federation for Clinical Research; the Board of Directors of the University Hospital Consortium; and the American Board of Internal Medicine's Board of Directors.

Dr. Geheb is co-editor of the textbook *Principles and Practice of Medical Intensive Care* and co-editor for the Critical Care Clinics series. He also speaks frequently to national audiences on health care policy issues related to academic productivity and financial models for academic clinical enterprises.

Jeff C. Goldsmith, Ph.D.
President
Health Futures, Inc.
Dr. Goldsmith is a lecturer in the Department of Medicine of the Pritzker School of Medicine at the University of Chicago. A former lecturer in the Graduate School of Business at the University of Chicago on health services management and policy, he also lectured on these topics at the Harvard Business School, the Wharton School of Finance, Johns Hopkins, Washington University, and the University of California at Berkeley.

Dr. Goldsmith has served as national advisor for health care for Ernst & Young LLP and was director of Planning and Government Affairs at the University of Chicago Medical Center and special assistant to the Dean of the Pritzker School of Medicine.

Dr. Goldsmith has written for the *Harvard Business Review* and has been a source for articles on medical technology and health services for *The Wall Street Journal*, *The New York Times*, *Business Week*, *Time* and other publications.

Michael M.E. Johns, M.D.
Executive Vice President for Health Affairs
Emory University
Director
The Robert W Woodruff Health Sciences Center
Chairman of the Board and Chief Executive Officer
Emory Health Care
Dr. Johns is a professor in the Department of Surgery at Emory University School of Medicine. He is the former dean of the Johns Hopkins School of Medicine. He has held numerous positions, including assistant chief of the Otolaryngology Service at Walter Reed Army Medical Center, and professor and chair of the Department of Otolaryngology-Head and Neck surgery at Johns Hopkins.

Dr. Johns is also a member of the Institute of Medicine, a fellow of the American Association for the Advancement of Science and the Executive Council of the Association of American Medical Colleges.

Dr. Johns received his bachelor's degree and continued with graduate studies in biology at Wayne State University in Detroit. He earned his M.D. at the University of Michigan School of Medicine.
Peter O. Kohler, M.D.
President
Oregon Health Sciences University

Dr. Kohler is president of Oregon Health Sciences University. After holding positions at the National Institutes of Health (NIH), he became professor of medicine and chief of the Endocrinology Division at Baylor College of Medicine. Later he served as chairman of the Department of Medicine at the University of Arkansas and then dean of the Medical School at the University of Texas Health Science Center in San Antonio.

Dr. Kohler has served on several boards. He has been chairman of the NIH Endocrinology Study Section and chairman of the Board of Scientific Counselors for the National Institute of Child Health and Human Development. Currently, he is chairman of the Institute of Medicine Task Force on Quality in Long-term Care and chair of the Board of Directors of the Association of Academic Health Centers.

Dr. Kohler received his B.A. from the University of Virginia and earned his M.D. at Duke Medical School.

Edward D. Miller, Jr., M.D.
Dean and Chief Executive Officer
Johns Hopkins Medicine

Dr. Miller is chief executive officer of Johns Hopkins Medicine. His former posts include chairman of the Department of Anesthesiology and Critical Care Medicine; interim dean of the School of Medicine; professor of anesthesiology and surgery and medical director of the Surgical Intensive Care Unit at the University of Virginia; E.M. Papper Professor at Columbia University; and chairman of the Department of Anesthesiology in the College of Physicians and Surgeons.

Dr. Miller has authored and co-authored more than 150 scientific abstracts and book chapters. He received his A.B. from Ohio Wesleyan University and his M.D. from the University of Rochester School of Medicine and Dentistry.

John G. Nackel, Ph.D.
National Director
Health Market Unit
Ernst & Young LLP

Dr. Nackel is the national director of Health Market Unit with Ernst & Young LLP. While with Ernst & Young he has worked in various positions and directed numerous projects in the United States and internationally. These include strategy for the development of an integrated delivery system; post merger integration; design, development, and implementation of continuous quality improvement and clinical performance improvement systems for hospitals; facilitation of organizational alignment and organizational change management; and design, development, and implementation of performance improvement systems for hospitals. He has served the pharmaceutical and life sciences, managed care, and provider segments of the health care industry.

Dr. Nackel has presented papers and keynote addresses at more than 200 professional society and health care trade association meetings. He has published more than 30 articles on applications of cost and quality improvement, information systems and health systems engineering; and is the co-author of the award-winning book Cost Management for Hospitals. He was co-editor of the Society for Health Systems' special issue focused on patient care.

Dr. Nackel received a B.S. from Tufts University and masters degrees in public health and industrial engineering from the
University of Missouri-Columbia. Also from the University of Missouri, he was awarded a Ph.D. in health care systems design from the Department of Industrial Engineering.

George F. Sheldon, M.D.
Chairman and Professor
Department of Surgery
University of North Carolina at Chapel Hill

Dr. Sheldon's background in graduate medical education spans four institutions: Kansas University, Mayo Clinic, University of California at San Francisco, and Harvard University. He is currently chairman and professor of the Department of Surgery at the University of North Carolina at Chapel Hill and was formerly professor of surgery in the Department of Surgery at the University of California-San Francisco.

He has held several national appointments including: president of the American Surgical Association; chairman of the American Board of Surgery; and Council on Graduate Medical Education. He is currently president-elect of the American College of Surgeons and chair-elect of the Council of Academic Societies of the Association of American Medical Colleges.

He has published 195 articles and book chapters and co-authored eight books.
About the Invited Participants

Ron J. Anderson, M.D.
President and Chief Executive Officer
Parkland Health & Hospital System

In addition to his executive roles at Parkland Health and Hospital System, Dr. Anderson also is an attending physician at Parkland Hospital and a professor of internal medicine at the University of Texas Southwestern Medical Center in Dallas. Dr. Anderson has been widely recognized for his vision of providing “community oriented primary care” (COPC) for medically underserved and uninsured residents of Dallas County by establishing a network of neighborhood clinics. As a nationally recognized speaker on current health care issues, Dr. Anderson also was instrumental in effecting legislative changes at both the state and national levels to prevent “patient dumping” of the uninsured.

He has authored and co-authored more than 200 articles and publications on medicine, ethics, and health policy issues. Dr. Anderson is the recipient of numerous awards and honors at the local, state, and national level, and has recently been elected to the Institute of Medicine of the National Academy of Sciences.

Dr. Anderson completed his B.S. (Pharmacy) in 1969 at Southwestern State University of Oklahoma, and received his M.D. in 1973 from the University of Oklahoma Health Science Center School of Medicine.

David J. Campbell, FACHE, M.H.A.
President and Chief Executive Officer
The Detroit Medical Center

Mr. Campbell has held positions at the Detroit Medical Center, Allegheny Health Services, Inc., Allegheny General Hospital, the Henry Ford Health System, and University of Michigan Hospitals. He has served in several capacities with the Michigan Health & Hospital Association (MHA). He is presently a member of the Finance Committee of Premier (formerly American Healthcare Systems). He also is a former member of the American Hospital Association’s House of Delegates. He currently serves on the boards of the Greater Detroit Area Health Council, New Detroit, and the Greater Detroit Chamber of Commerce Board.

Mr. Campbell is a fellow of the American College of Healthcare Executives. He received his Master of Hospital Administration from the University of Michigan, and his B.S. from Michigan State University. Mr. Campbell is a recipient of Crain’s Detroit Business “1995 Newsmaker of the Year” award. In 1994 he received the Lawrence A. Hill Memorial Award for Excellence from the University of Michigan Department of Health Services Management and Policy.
Michael J. Goran, M.D.
National Director Integrated Delivery Systems
Ernst & Young LLP

Dr. Goran is national director for Integrated Delivery Systems. His areas of expertise include: managed care strategy, strategic partnering, quality measurement and improvement, advanced care management, network development and management, capitation management and risk sharing, physician practice management including primary care, single specialty and multispecialty group practice, faculty practice plans, and academic medical centers.

With more than 30 years of experience, Dr. Goran has held a number of prominent positions, including president of a national utilization review company and director of a large third-party administrator and reinsurance company; national director of health care consulting for a large employer benefits consulting company; chief executive officer and medical director of several HMOs, national director of quality assurance and utilization review programs for the federal government, and clinical practice of psychiatry.

Dr. Goran earned his A.B. from the University of Chicago and his M.D. from the University of Illinois, College of Medicine.
Look for:

- The Blue Ridge Academic Health Group's next report on Knowledge Management, Fall 1999
- The Virginia Health Policy Center and Ernst & Young on the Internet

http://www.virginia.edu/~vhpc

http://www.ey.com/industry/health/ahcpage.asp
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