Tomorrow's Doctors, Tomorrow's Cures®

Principles for U.S. Health Care Reform: A Guide for Policy Makers

October 2008

Learn
Serve
Lead

Association of
American Medical Colleges

AAMC

Learn. Serve. Lead.

Principles for U.S. Health Care Reform

The United States health care system faces a crisis of access, cost, and quality that must be addressed now. The Association of American Medical Colleges (AAMC) and its members believe that ensuring access to safe, high-quality, appropriate and affordable patient-centered health care is, and should continue to be, the focal point of all health care reform discussions. Broadly defined, access is the timely, efficient, and effective provision of the most appropriate treatment for all in the most appropriate setting.

The U.S. health care system is recognized for discovering and providing life-saving treatments for many of the most difficult diseases and conditions and for educating a highly skilled health care workforce. Yet, at the same time, many believe that in its current form it is on an unsustainable course. The current system is costlier than other nations' health care delivery systems, does not provide insurance coverage for all, does not adequately emphasize preventive and primary care services, and is characterized by wide variation in utilization and the quality of care delivered. Because of these and other factors, our health outcomes lag behind those of many other nations.

In addition, many observers have concluded that our current health care system is poorly positioned to respond to the growing demographic and lifestyle issues that promise to exacerbate health care costs and create barriers to access in the future. These core issues mandate that the United States reexamine its health care system.

AAMC members, including 130 medical schools, nearly 400 of the nation's largest teaching hospitals, 100,000 teaching physicians, and more than 160,000 medical students and resident physicians, represent a significant presence in the U.S. health care system. AAMC members educate and train our future physicians and provide sites for the clinical education of other health care professionals. These institutions and individuals also care for large numbers of the uninsured and those in need of specialized services unavailable elsewhere in their communities. Their presence in the U.S. health care system is disproportionate; major teaching hospitals and their clinical

staff account for 6 percent of all acute care hospitals but provide 45 percent of all charity care and 25 percent of Medicaid inpatient care. The National Institutes of Health (NIH) also invests nearly half of its $29 billion budget in medical schools and teaching hospitals, recognizing their unique ability to advance scientific knowledge alongside education and clinical care.

In light of its significant role in the delivery of health care, the education of future practitioners, and the creation of new knowledge, the AAMC believes that the academic medical community must play an integral role in identifying and implementing health care reform. Such reform must include improving delivery systems as well as financing health care while preserving the greatest strengths of the current health care system.

The AAMC has developed the following principles to help guide health care reform discussions. These principles will be used by the Association to evaluate reform proposals, but they are only a first step. The AAMC will subsequently provide a series of discussion and position papers that it hopes will provide a launching point to improve delivery of care, scientific discovery, and the education and training of the nation's health care professionals in our member institutions and the nation.

The AAMC and its members are committed to the following principles and believe that academic medicine must play a pivotal role in improving health and health care and in achieving positive changes in the health care system. We believe that, with a concerted national effort from both the private and public sectors, the goal of affordable, quality health care for all is achievable and sustainable within the next decade.

1 Covering America

Health care coverage that is affordable, transportable, and continuous, and that combines the best of public and private systems, should be available to all.

All individuals must have health care coverage to benefit from an improved delivery system. "Coverage" refers to insurance or equivalent mechanisms that help to assure the delivery of necessary preventive, acute, and chronic care required by an individual and—ultimately—the overall population. Lack of health insurance coverage is the single most common barrier to access in the current health care system.

Individuals who do not have adequate coverage for significant periods of time are less likely to receive preventive care and more likely to have serious health problems diagnosed at a later stage. Without adequate health care coverage, an improved delivery system will still be plagued by the unnecessary loss of healthy and productive years of life for the population and inefficient use of resources for society. Even the vast majority of Americans who have private or publicly funded health insurance are vulnerable to lapses in coverage due to changes in employment or other factors that affect insurance status. Viable mechanisms to maintain coverage must be available for individuals who change jobs, or if their eligibility for insurance changes for other reasons, to ensure continuous coverage.

Reform initiatives should analyze and preserve the best elements of both public and private systems. As we deliberate how best to achieve coverage for all, innovation will be required. State and local delivery systems have long been an incubator for change, and they should have the freedom to continue to innovate and test new approaches. The correct balance between federal and state control and the role of the private sector will need to be determined as part of this process.

Rethinking Delivery

2 The health care delivery system must be restructured to facilitate health promotion and disease prevention while providing high-quality, cost-effective diagnosis and treatment of illness as well as palliative care.

The current delivery system is disjointed and lacks the necessary infrastructure and processes to achieve optimal results. An improved delivery system should help enable professionals to provide coordinated patient-centered care—including medical homes—by improving communication among providers and patients.

Policies aimed at improving coordination and integration of care must be strengthened to enable providers to function more efficiently and effectively. An electronic health record, that ultimately is interoperable, is a critical component of the changes necessary to correct these flaws and must be available for everyone as soon as possible to facilitate effective and efficient health care. The health care delivery system should also be better coordinated with the nation's public health systems to optimize opportunities for improving individual and community health.

All individuals should have options available regarding health plans and providers, and meaningful support in decision making also should be available to diverse consumers. This support should empower providers and patients to help reduce the nation's health disparities and encourage value in spending while not discouraging patients from obtaining necessary, valuable services because of cost-sharing disincentives. Care should be centered on patients' needs and preferences, with shared responsibility among patients, providers, and payors. The health care system should also be easily navigable to allow patients to actively participate in their own care.

3 Financing

Health care financing mechanisms should be sustainable, equitable, explicit, accountable, and promote efficiency and quality.

The health care delivery system, and health care itself, are influenced by incentives embedded in the health care financing system. The health care financing system and payment policies should be designed to promote the delivery of efficient, high-quality patient and family-centered care that is affordable to the individual, the family, and the nation. To the extent possible, payment policy decisions should be premised on evidenced-based guidelines.

The United States currently has a pluralistic system of financing health care that includes employer tax incentives and employer-sponsored insurance, public insurance for the poor and the elderly, cost shifting between insured and uninsured sources, and individual payment for insurance and health care services. The current system makes efficient delivery of care difficult because of factors such as the number and complexity of insurers, providers, and funding mechanisms. This complicated financing system significantly increases administrative expenses and other costs of health care and, therefore, should be simplified.

Ultimately, no nation can provide all possible care to everyone who wishes it. If the nation believes that a finite set of resources (whether defined as absolute dollars or as a percentage of the nation's gross domestic product) should be devoted to health care, the pursuit of unlimited and potentially unnecessary services for some individuals may create ever-widening inequities and cost escalation and restrictions on basic services for others. A core level of services could be available to all, while a broader set of services could be available to those who choose to allocate additional resources for these additional services.

Some key drivers of escalating health care costs are an expanding and aging population (including a doubling of the population aged 65 and older), overuse of some diagnostic and interventional treatments, and administrative inefficiencies. Costs also are increased by redundancies, inconsistencies, and inappropriate variations in care. These multiple drivers are not amenable to any single strategy for cost reduction, and a variety of approaches will likely be necessary. If done appropriately, cost-reduction strategies can lower cost growth without reducing essential commitments to quality, access, and value.

Preserving The Safety Net

4 Existing programs that serve defined populations should be maintained until superior alternatives can fully replace them.

The AAMC recognizes and supports the need for change in the overall health care financing and delivery structure. We also recognize that implementing new programs and structures will take time. Consequently, we believe that current programs should be supported until we are sure the replacements, as determined by a variety of criteria, are better and more rational than the systems they would be replacing.

This is particularly true for the quilt work of current mechanisms that finance care for the poor. "New" plans should not be financed prematurely by reducing or eliminating current mechanisms that include public payment systems and special payments to safety net providers, such as community health centers, state and county hospitals, and academic health centers. We must avoid the lure of terminating existing programs before new ones are proven and established. Not doing so would jeopardize the care provided to millions of vulnerable patients.

Developing The Workforce

5 **The supply of health care practitioners must be adequate and reflect the population and its health care needs.**

Even if efficiency is improved and unnecessary care is eliminated, access to appropriate health care services will not be possible unless the nation expands its health professional workforce, an effort that will require a substantial investment. The predicted future shortage of physicians, as well as nursing, pharmacy, dental, and other medical professionals, has been well documented. Without a workforce expansion, access problems for all—but especially for those in underserved communities—will be exacerbated.

Serious efforts must be made to expand the number of health professionals educated to care for a population that continues to grow and whose aging will place unprecedented demands upon the health care system. The costs of educating and training physicians, in particular, are exceptionally high compared to the costs of other professions because of the extensive duration of physician education and the need for education in a clinical environment.

And just as the health care delivery and financing systems must identify ways to improve efficiency and quality, academic medicine must also assess the educational process to determine whether it can become more efficient, while maintaining and improving the goals of achieving a high-quality physician workforce that both reflects the population and meets its health care needs. Changes in the delivery system will affect how clinical education is conducted, and the education process must reflect this.

The costs of physician education and training have traditionally been borne by a complex variety of sources, particularly the trainees, the medical schools and teaching hospitals that train them, and the government. As the system istransformed, these costs will continue and may even rise as adjustments are made to the content of the education, sites of education, number of students, and the expanding scope of knowledge. Given the

impending physician shortages, it will be important to identify stable funding sources that will expand and build upon existing mechanisms.

We must also address the geographic disparity of providers. Health care professionals are virtually absent in some communities; nearly 30 million people live in federally designated underserved communities. While improved access may be facilitated by coverage for all, coverage alone will not ensure access. The nation must work to develop policies that create appropriate, effective incentives for health providers—whether nurses or generalist or specialist physicians—to locate in communities of need supported by services such as telemedicine, regional health networks, and other innovations.

Finally, the health care workforce should reflect the underlying diversity of the nation and support continued improvement in health status across diverse communities. This will require attention not only to geographic disparities but also to ethnic disparities, the needed mix and location of primary and specialty providers, and to the relationships between providers and the patients and communities they serve.

Advancing Discovery and Innovation

6 **Any reconfiguration of the health care system should recognize and provide stable support for the costs inherent in health research, technology development, and the provision of necessary specialized services to the broader society.**

Research, and the development of medical and health systems knowledge, is the keystone to a vibrant "learning" health care system. These efforts have inherent costs largely borne by the government, academic medical community, and device and pharmaceutical companies. This work will become increasingly important as we strive to enhance the evidence base for care processes and evaluate their relative effectiveness.

Medical education is enhanced when it occurs in a setting where research is conducted, so that future physicians and other professionals learn not only current knowledge, but also are exposed to the intellectual aspects of discovery and areas for exploration inside the professional context of continuous learning and inquiry. Research, education, and patient care should not be isolated from each other. This collaboration can only be accomplished with recognition and understanding of the full costs of these interrelated activities and if adequate, stable support is available. Any changes to the delivery system should strive to allow this synergy among the closely interrelated missions of academic medicine—education, patient care, and research—to continue.

**Association of
American Medical Colleges**

2450 N Street, N.W., Washington, D.C. 20037-1127
T 202 828 0400 **F** 202 828 1125
www.aamc.org

A PDF version of this publication is available for download at
www.aamc.org/publications