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DAILY BRIEFING • April 25, 2007

Provided below are takeaways from yesterday's keynotes, Executive Congress, and selected sessions at the WHCC.

Keynote: Consumerism

This panel, with leaders from the world of technology (Intel, Microsoft, and Google) and moderated by the CEO of Consumers Union (publisher of Consumer Reports), discussed the vision of consumerism and the obstacles faced.

- The panel agreed on a **vision** of equipping consumers with **timely, relevant, trustworthy, accessible, and actionable information** to empower them and help them make informed decisions.
- This information will provide consumers the **power** of: **discovery** (about their options), **transparency** (about such things as providers), **choice**, **control**, and ultimately power to **change** the entire health care system.
- The **barriers** to achieving this vision are **not technical**—the technology exists—they are psychological and legal. The psychological barrier is that consumers don't know they can ask for and providers don't realize they can provide to consumers the consumers' own data. The legal barrier is that **consumers are not granted access to the wealth of electronic data that already exists about them** in the health system.
- Craig Barrett of Intel believes that change requires the **major purchasers** (the federal government and major companies) to **demand change** (i.e. to get reimbursed, prescriptions must be electronic). Adam Bosworth from Google believes **consumer demand exists**; consumers just need access to their data. He believes **innovative providers will take the lead** in providing consumers with data, creating a cascading effect where others follow.

> *"The government needs to make it clear that data transfers to consumers are OK and are good, and needs to give consumers a right to the data that's already in the system."*
> —Adam Bosworth, VP, Google

- There was **optimism** that **change will occur rapidly** in the next few years.

Keynote: The Global Business Imperative: Sustainable Solutions for Prevention and Quality

Dow Chemical's CEO, Andrew Liveris, offered his comments on the changes needed in health care and described Dow's strategy. GE Healthcare's CEO, Joseph Hogan, and futurist Ian Morrison responded.

- **Fundamental change** of the US health care system is **required**. Mr. Morrison thinks the key is changing the reimbursement system; this will drive other changes.
- The high costs of health care are **hurting US businesses** and the overall economy. The situation is especially **difficult for small businesses**.
- The panelists agreed on the importance of **more emphasis on prevention**. Mr. Hogan divided health care into: prevent, diagnose, treat, and monitor; 75% to 80% of costs are on treating. Improving health and lowering costs requires "early health." Dow is very focused on prevention and quality. The company has strengthened its **preventive benefits** and is offering multiple **prevention programs**; 90% of employees have had **health risk assessments**, which is leading to decreases in risk.
- However, Mr. Morrison commented that the idea of prevention is good, but for individuals to **change behaviors** (i.e. diet, exercise, etc.) is very hard. Company **leaders** play a role in **setting a positive example**.
- The panel agreed on the **importance of transparency**, but Mr. Morrison believes the value will come not because data will be used by consumers, but because poor rankings **will drive providers to improve**.
- The panel agreed: **obesity is an epidemic** and **isn't getting enough attention**. A vast culture change is needed.

Keynote: Universal Access

Oregon Senator Ron Wyden summarized his proposed Healthy Americans Act.

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- This proposal provides **guaranteed, lifetime universal coverage**, which cannot be taken away, with health care provided through a **private delivery system**.

> *"This is universal coverage with a private delivery system."*
> —Senator Ron Wyden, Democrat, Oregon

- **Employers will administer** coverage for employees, **but will not pay for it**; **individuals** will choose their health plan and **will pay**.
- As the system **transitions** from employer to individual payment, employers will "cash out" employees by initially providing employees with increased wages for the amount that the company had paid for health insurance; over time, employers will make "**shared responsibility**" payments.
- Ultimately, health insurance will be a **consumer market** as insurers offer differing benefit plans to compete for consumers' business. Insurers will have to **guarantee coverage**, **can't cherry pick** who they cover, and will use community ratings.
- There will be **tax benefits** and **premium reductions**, assisting, for example, people who are unemployed.
- **Medicare** will be improved, but its structure will remain **largely the same**. Medicare Part D is helping people with low income and big bills; it needs to be simplified and improved.
- Proposal is estimated to **save $1.45 trillion** over 10 years.
- This proposal has **support** from several business and union leaders.
- The **conventional wisdom** is major health care change **won't happen until 2009**. Senator Wyden is **pushing for it in 2007**.

Keynote: Health Care in America

Wal-Mart CEO, Lee Scott, shared what Wal-Mart is doing to contribute to improved health care in the US.

- It is **time for real change** in the health system. Health care must be **affordable, accessible, and high quality**.

> *"It's time for real change…the question is how to get there…business can lead."*
> —Lee Scott, CEO, Wal-Mart

- Business needs to **empower consumers** to—in conjunction with their doctors—make better decisions. This involves transparency and better tools and information.
- Wal-Mart's **$4 generic prescriptions** are a way of empowering consumers and providing price transparency. To date this has generated **$290 million in savings** and 30% of prescriptions are being filled by those without insurance.
- The country needs to **invest in health information technology**. For Wal-Mart, IT has streamlined its operations and lowered costs. Wal-Mart has joined with companies such as Intel and Pitney Bowes to create a safe, up-to-date **personal health record** for employees. Other technologies applicable in health care include **bar coding** to improve safety and **RFID**.
- **Everyone needs health coverage**. 90% of Wal-Mart's employees have coverage, which has improved in recent years. Plans are more affordable (as low as $23 per month for employees), with shorter waiting periods, no lifetime max, and no requirements on hours worked to be covered.
- Wal-Mart's **in-store clinics** provide a new form of access to health care. The current experiment has been at 76 stores; it has shown a successful model for customers and communities. This **will grow to 400 stores** in the next year, and in 5-7 years **could be in 2,000 stores**. (There may be opportunities to partner with community hospitals in operating these clinics.) To date, 90% of customers are satisfied; 50% are uninsured; 15% would have gone to the ER; and 20% of patients seen were children.
- Steps employers can take include joining **Dossier** in creating an EHR for employees, and **participating in the Better Health Care Together coalition**.

Executive Seminar: Consumer-Centric Approaches to Engagement

Experts in engaging consumers shared approaches they are using and how they are working.

- Dr. E. Dale Collins from Dartmouth-Hitchcock Medical Center described a r**edesigned care process** for breast cancer treatment. It engages consumers by using **decision aids** (risk assessment, video with information and data, advice sessions, etc.) to help them **understand options** and data, and **make better decisions**.
- Dr. David Cochran described some of Harvard Pilgrim Health Care's efforts to engage its members in their own

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health care. Examples included **mailing wallet cards to diabetic patients** containing key questions for them to discuss with their physician, and an **automated, interactive phone system** that calls consumers and walks them through a series of questions. The specific example shared was an osteoporosis outreach program aimed at engaging a targeted group of women. This program reached 80% of the target; 87% continued with the call; 53% wanted health tips; and osteoporosis testing rates subsequently increased by 25%.

> *"Members, when educated about and armed with the right questions, will drive physician behavior."*
> —David Cochran, MD, SVP Strategic Development, Harvard Pilgrim Health Care

- Maryann Stump explained "**Health Facts**," a web-based program **modeled after nutrition labeling** that engages consumers by providing simple, useful, actionable, easy-to-understand information about providers that is actually supplied by providers. (Providers support this because it is done with them, not to them.) Efforts are under way to supplement the factual information with information about patients' experiences.

Track 1: Executive Congress

Physicians, quality care measurement experts, health plan officials, and employers met to discuss the need for chronic care management and universal health coverage.

- Helping diabetes patients manage their diseases is **a critical cost-containment responsibility**. It must be shared by providers, health plans, employers, and patients. Encouraging implementation of **evidence-based clinical guidelines** is a critical first step in that endeavor.
- Process and outcomes can and should be **measured** to ensure quality care. It is **impossible to control costs without measurement**.
- Preventive care is **a vital element of health care treatment**. Wellness programs sponsored by employers are **indispensable** for controlling health costs.

> *"Prevention is really the way we need to go. It is a crucial part of effective diabetes management."*
> —Richard Kahn, PhD, Chief Scientific and Medical Officer, American Diabetes Association

- Universal coverage, ensuring access to health treatment for everyone, is **an idea whose time has come**. A **collaborative effort** by federal/state governments, employers, health plans, and providers is required if universal coverage is to fulfill its promise of lowering costs.

Track 2: International Health Forum

In the Forum's final session experts on Asian health care discussed the increased globalization of health care.

- Curtis Schroeder, Group CEO of Bumrungrad International in Thailand, told why 60,000 Americans have traveled more than 10,000 miles and paid out of pocket to go to this hospital (and why hundreds of thousands more patients from the Middle East and Asia no longer flock to the US for care). It is because the **quality and service** are high and **cost is far lower**, often 10% to 20% of the cost in the US. This is **appealing to the US uninsured** (30% of whom make more than $75,000 per year) and is attractive to some with insurance that has limits, restrictions, and high deductibles.
- This type of global health care **has been B2C**, attracting consumers who pay out of pocket. Mr. Schroeder believes there will be an **evolution to "medical outsourcing"** which is **B2B** in that employers will use global health care to lower costs (as has occurred in other business tasks).

> *"Corporations are looking at international health care as a way to decrease cost."*
> —Curtis Schroeder, Group CEO, Bumrungrad Intl.

- Dr. Jason Yap, Director (Healthcare Services) of Singapore's Tourism Board, said that Singapore is **engaged not in medical tourism**, but in **medical travel** (the difference: this is not for vacation and is very high-quality care.) Singapore's approach is **not about competing** (its capacity is not sufficient to pose a competitive threat) but **collaborating.** Patients (often from other Asian countries) tend to be referred by their physicians because the care available is higher quality than available to patients elsewhere. Dr. Yap said Singapore is analogous to being an "out of network provider" which is just a bit further out of the network.

Track 6: Health Plan & Insurer CEO/CFO/CMO/CIO Summit

Speakers described lessons learned through corporate efforts to enhance consumerism to bring health care costs in

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line, and assessed how IT can encourage active consumer participation and ultimately improve care.

- Use **simple incentives** to motivate participants (cash works) and **be aware of employees' unique needs**, including logistic and psychological barriers to participation in programs such as disease management.
- **Integrate information and use it more broadly**. The PHR can identify gaps in care and stimulate online self-monitoring, with information flowing to case managers and health care providers for evaluation. Trained disease management staff can serve as trusted sources of information and advice on using health resources wisely.

> *"Health information technology can allow better communication among all providers—physicians, case managers, nurses, disease managers, health coaches—so they're all pulling in the same direction for the best outcomes for the patient."*
> —Charles Kennedy, MD, VP, Health Information Technology and Research, WellPoint

- **Use health information technology to facilitate more interaction and provide needed information.** For example, at the point where care decisions are being made, the physician and patient can use HIT to understand relevant health plan programs—e.g., formulary rules, disease management—instead of after the fact. Pilot programs are putting more clinical data on patients in the hands of physicians and nurses in emergency departments who are seeing those patients for the first time.

Track 7: Pharma & Biotech CEO/CFO Summit

Structures that have served the US pharma industry well for decades **will not fit** the changes on the horizon in how health care is assessed and delivered. Companies, regulators, and academia must find **new processes and priorities** as medical advances in the way diseases are diagnosed and treated make the current repayment methodologies outmoded. But no one has a handle yet on what the new models will, or should, look like. Among the most pressing issues the new design must deal with are:

- **Apportioning** between internal development, academic development, and use of outside contractors **new patient-tailored treatments** where there must be a biomarker aspect, a diagnostic aspect, and then a treatment aspect.
- Finding ways to **incentivize** health plan **enrollees to take the drugs** that are truly beneficial and forgo those that are of little use.
- Coping with **genomic testing** that is going to show a huge percentage of the population at risk for something, with little sense of the probabilities or treatment indications.
- Dealing with a serious **lack of understanding** by patients about the real impact of new medical breakthroughs and a growing shortage of specialists trained in helping them understand.
- The growing **overlap** between self-administered specialty pharmaceuticals and those delivered by home infusion firms, and the disparate ways the two delivery systems are regulated.
- Creating **appropriate payment formulae** for delivery of drugs with an essential service component, when the control approaches of drug coverage and major medical insurance have been traditionally quite different.

> *"What is the business model for personalized medicine? I don't know and I don't think my company knows. There are lots of questions here and no one knows the answers."*
> —Wayne A. Rosenkrans, Jr., PhD, Scientific & Medical Strategy Director, AstraZeneca Pharmaceuticals

Track 8: Health System and Hospital CEO/CFO/CMO/CIO Summit

This track's final session involved the CEO of a group of community hospitals and the CEO of National Surgical Hospitals sharing their differing perspectives on physician-owned specialty hospitals.

- James Hinton, CEO of Presbyterian Healthcare Services in New Mexico, argued that limited service specialty hospitals **don't improve health care**—they are **about the physician; not the patient**. These entities further fragment the delivery of care (versus improving coordination), cherry pick the most profitable cases, have processes structured around physician efficiency as opposed to being patient-centric, increase utilization, lack transparency, and at times are dangerous to patients.

> *"There is no evidence that fragmented, disconnected niche players improve quality or costs."*
> —James Hinton, President and CEO, Presbyterian Healthcare Services

- John Rex-Waller, Chairman and CEO of National Surgical Hospitals, offered a very different perspective. He argued that **specialization improves quality** and that **competition spurs all providers to improve the care delivered**. He stated that specialty hospitals desire to compete on quality, cost, and service—which benefits patients and the health care system. He argued that **physician ownership is more about autonomy, control, and efficiency** than finances, contending that the financial benefits of ownership are relatively small in relation to what such specialist physicians are earning anyway, in no way influencing medical decisions. In his view, the fact that specialty hospitals provide services in areas which have been profitable for community hospitals and which have cross-subsidized other areas of the hospital is a **reimbursement system problem that needs to be fixed**. He cited research that specialty hospitals had not hurt community hospitals. He also noted that while community hospitals are often perceived as saints, they are ferocious competitors.

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