As a health care provider and consumer and as a place of medical research and scholarship, Emory University is uniquely positioned in the public discourse around health care reform in this country. In the national media and debates, informed voices from this institution have offered compelling perspectives on matters ranging from policy and implementation to constitutionality and ethics.

In this issue of the Academic Exchange, we aim to bring Emory’s substantial intellectual resources to bear on the issues surrounding the Patient Protection and Affordable Care Act (PPACA), voted into law on March 25, 2010. From the health sciences and social sciences to the humanities, business, and ethics, Emory scholars weigh in with their expertise on the ongoing conversations about health care reform in the U.S. and its implications for issues such as cost, quality, access, policy, and practice. Their writings deepen and expand our understanding of health and care in this society. For the individual patient and practitioner as well as the full population facing new and challenging epidemics, the notion of “well being” is in flux.

With those shifts in mind, in these pages, Kenneth Thorpe, Robert W. Woodruff Professor and Chair of the Department of Health Policy...
While the PPACA represents a major change in health care in our country, it certainly will not represent the last major change we make.
and Management, provides an overview of the new legislation and what it aims to do, and University Chancellor Michael M.E. Johns and John T. Engelen, Vice President for Governmental Affairs, offer their take on what the PPACA means for major academic health centers like Emory’s. And in a Q&A, Ruth Katz, Emory Board of Trustees member and chief public health counsel for the Committee on Energy and Commerce and Management, provides an overview of the new legislation and what it aims to do, and University Chancellor Michael M.E. Johns and John T. Engelen, Vice President for Governmental Affairs, offer their take on what the PPACA means for major academic health centers like Emory’s. And in a Q&A, Ruth Katz, Emory Board of Trustees member and chief public health counsel for the Committee on Energy and Commerce.

For the individual patient and practitioner alike, the notion of “well being” is in flux. The faculty writings in this issue of AE deepen and expand our understanding of health and care in this society.

in the U.S. House of Representatives, offers an intriguing Washington insider’s view of the legislative process. Then we broaden the lens. In a second Q&A, Sander Gilman, a prominent cultural, medical, and literary historian, questions some of the assumptions behind the reform bill’s economics and approaches to disease prevention. And anthropologist Michelle Lampl, also a leader in Emory’s Predictive Health Institute, presents a view of health care reform grounded in prevention rather than disease. Kathy Kinlaw, who directs the program in health sciences and ethics in Emory’s Center for Ethics, invites readers to consider the concepts of justice and liberty and their place in the national discussion of health care reform. And Andre Nahmias, emeritus professor of pediatrics, offers an insight drawn from the correspondence of Thomas Jefferson, eleven years prior to the penning of the Declaration of Independence, placing “health” among those values key to the pursuit of happiness.

Several of this issue’s contributors then take a look at specific provisions in the reform bill. David Howard, in the Department of Health Policy and Management, looks at some pragmatic and critical issues around health care spending and the bill’s measures in addressing a growing problem. Howard’s departmental colleague, Steven Culler, who also has an adjunct appointment in the Goizueta Business School, examines some new endeavors under the act to better coordinate patient care (and thus reduce inefficiencies) nationwide. Zohar Kapasi, associate professor and interim director of the Division of Physical Therapy, shares his predictions for the impact of the reform bill on his profession and his students, who are preparing for careers in a dramatically changing professional environment. And Deanne Dunbar and Howard Kushner bring their perspective as historians of medicine to addiction treatment over the past several decades in this country and how health policy may once again change prevailing practices.

As always, the Academic Exchange is a place for ongoing conversation. We invite feedback and comment, voices, and perspectives on this topic not heard in this particular issue. Please send your remarks to me at aadam2@emory.edu.

—Allison Adams, Editor

The Patient Protection and Affordable Care Act
Opportunity and uncertainty for academic health centers

On March 23 President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law, and on March 25 he signed the Reconciliation Act of 2010, which made additional changes. His signature capped a contentious yearlong legislative debate, which included bruising bare-knuckle politics and outpourings of intense emotions on both sides of the issue. While one cannot distill more than a thousand pages into a thousand words, this essay will address a few issues of great importance to academic health centers. Passage of the PPACA, elements of which will be phased in over four years, is only a first step with much heavy lifting to come as the Obama Administration struggles to commence the marathon effort necessary to convert a massive piece of legislation like PPACA into regulatory policy. While Emory supports comprehensive health care reform and hopes that the coverage expansions contained in the thousand-page legislation results in the increased availability of low-cost health insurance for more Americans, we believe that work still must be done to lower health care costs, foster innovation, and create access to health care for all.

For example, PPACA proponents predict that 32 million Americans who are currently uninsured will gain coverage starting in 2014. They expect that roughly half will enroll in Medicaid, and the remaining 16 million will purchase insurance through the new exchanges authorized by the legislation. If so, almost 20 million individuals will still not have health insurance, and the legislation expressly prohibits coverage for undocumented immigrants. It is crucial that a safety net be maintained to compensate health care providers who will continue to provide care for the uninsured. Currently, Medicare-funded Disproportionate Share Payments (DSH) are used to help compensate providers who see these patients. There is concern that the cuts to the DSH program after 2014 to help pay for PPACA provisions may create hardship for providers who will care for the remaining 20 million uninsured patients.

Then there is the question of the health care workforce. While PPACA will surely expand health insurance coverage, Emory believes the act does not do enough to ensure that the newly insured will have access to care by a physician or health professional. Today, long before PPACA coverage expansions go into effect, our nation faces a significant shortage of physicians. Before the PPACA passed, the Association of American Medical Colleges (AAMC) predicted that the U.S. faces a shortage of 125,000 new doctors by 2025. According to AAMC, the need for new primary care physicians is particularly acute. These shortages will surely be exacerbated as the newly insured look to find their medical home and seek health care in new ways starting in 2014.

As it takes up to seven years to fully train a generalist physician, Congress and President Obama must act now to address the workforce issue. Their first step should be to expand federally funded Graduate Medical Education residency positions. These spots, allocated by the federal government, have been frozen in place since the passage of the Balanced Budget Act of 1997.

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Academic Exchange: Describe the work you did on the health care act.

Ruth Katz: My primary responsibility was for the public health-related provisions in the bill. These sections didn’t receive nearly as much attention as those on health insurance, quality of care, Medicare, and Medicaid. More specifically, I focused on prevention and wellness initiatives designed to help us become a healthier nation.

AE: What impact could such initiatives have on the country?

RK: These initiatives could help transform our health care system from one that focuses almost exclusively on acute medical care to one that also emphasizes preventive care. Sooner or later everyone gets sick or has chronic disease. We must ensure that Americans have access to health care services when that happens. But we must also prevent and postpone illness as best we can for as long as possible. This will allow people to live longer, more productive lives and help reduce medical costs in the long term. In turn, we should improve our standing among the nations around the world in terms of various health and health care indicators. We are not where we should be in those rankings. This legislation will help us get there.

AE: What aspect of the national debate about health care did you find most intriguing?

RK: The legislative process itself. Health reform is an extremely difficult and complicated thing for any administration to achieve. The country

Sander Gilman
Distinguished Professor in the Liberal Arts and Sciences

Academic Exchange: What in the national debates about health care did you find most intriguing?

Sander Gilman: There are two general questions. Assuming that the present health care bill remains the same over the next few years as it comes into effect between now and 2015-16, one of the real questions has to do with whether the changes will reduce costs and thus enable more people to get better health care. That is, I think the relationship between access and costs was not completely convincingly thought through. The idea was—and this is classic Adam Smith economics—the more people you have in a pool, the fewer percentagewise are going to get ill at any given time, and therefore the general costs will go down. Meaning, if you have lots of healthy eighteen-year-olds in the pool, it’ll pay for older people with more health problems.

The assumption I’m not completely convinced of is that eighteen-year-olds are all that healthy and therefore will not use health care. For example, if the claims about increased obesity in children and teenagers are anywhere near accurate—and I’ve written now four books on the subject, and I think they are more accurate than not—then we’re going to have an enormous number of younger people who will have major illnesses early on, as well as the sequelae from those illnesses. If you become diabetic when you’re forty, you’ll have cardiovascular problems when you’re sixty. If you become diabetic when you’re ten, that means you’re going to be a sick and very expensive thirty-year-old. So that’s the first problem.

I’m a great believer that what medicine does best is to think about multiple causes for complex outcomes. And much of what I’ve heard over the last couple of years both in the medical science, sadly, and also in the political realm is exactly the opposite.”

The other problem is that while it’s not articulated in the politics, there’s been a set of claims within the realm of medicine that may be counterproductive—claims in predictive health, genetics, public health about being able to intervene with certain illnesses. On the contrary, what has happened is the expenditure of huge amounts of money with very little results. I’ll give you an example. There is an obsession in the United States with “precancer” in women. If you have the “genetic marker” for and a family history of breast or uterine cancer in the United States, advocacy groups and the medical profession advocate double mastectomy or hysterectomies in advance of the appearance of cancer. First of all, this is not effective. What we know is that if you have a breast cancer mutation, there’s a very good chance that if you develop cancer at all, you may develop another kind of cancer. Second of all, the interventions themselves are questionable. We don’t always get all the

Among the most immediate challenges we face... is our communication efforts with the American public: we need to keep everyone informed about what the new law does and doesn’t do, and how it will work for them.”
has been at it since the Truman administration. The process of trying to cobble together a piece of legislation that a minimum of 218 House members would support—especially in a very difficult political environment—was not only challenging but incredibly exciting and rewarding. It was literally a once-in-a-lifetime professional experience.

AE: How will the health care act change our understanding of disease and wellness?

RK: We know a lot about what we need to do to be and to remain healthy—ongoing exercise, good nutritional choices, not smoking, appropriate use of preventive health services such as vaccines and mammograms, etc. What we don’t understand as well is how to get people to actually do these things and then stick with them. We need more public health research so we can learn about what really works. Once we know that, once we have the evidence, we need to get that information out to communities and public health departments so they, in turn, can develop programs that are tailored to meet the needs of their own populations. The health reform law provides $15 billion over ten years for prevention and wellness activities that will help make all of that happen.

AE: What impact will the health care act will have on our medical culture?

RK: Hopefully, the implementation of health reform will help shift our medical culture towards a greater emphasis on not only prevention and wellness, but also quality of care. That concept means different things to different people, but it is definitely not code for health care rationing, as some people have suggested. Instead, it is all about trying to ensure that, based upon the evidence, patients get the best possible care they can.

AE: What are the greatest challenges to implementing various parts of the act?

RK: Incredible challenges lie ahead. This is a complicated law with lots of moving parts. We have hard deadlines to meet. Implementing rules and regulations must be developed. States, private insurance companies, academic health centers, and other health care providers need to get prepared. The list goes on and on. Among the most immediate challenges we face, however, is our communication efforts with the American public. We need to keep everyone informed about what the new law does and doesn’t do, and how it will work for them.

AE: What role can universities and scholars play in the discussion?

RK: Universities, especially those with academic health centers like Emory, can lead the way in embracing health reform and helping to make it a reality in all of its many parts—from the law’s numerous opportunities for research to its focus on quality of care. Down the road, they can also help evaluate the law’s effectiveness in achieving its many goals. And in between, universities and academics can help those responsible for implementing the law think through potential mid-course corrections. And those should be expected. Health reform is not a perfect law, but in my view it is a giant step forward in ensuring that all Americans have access to the quality health care they need and deserve.

AE: What are other ways the reform bill might intersect with your work?

SG: The childhood obesity question has been taken up by Michelle Obama as one of her primary interests. I’m a great advocate of this. I signed a public letter trying to say to her, You’re doing good stuff, but you also don’t want to stereotype all people who are obese as lazy and stupid and unable to deal with these questions. That is, you want to see this as a problem of health, not a problem of morals. The difficulty I’m seeing is that obesity has become a public health issue that has a pot of money available for it. Everybody is jockeying to get a part of that pie: the geneticists are making claims that it’s all a question of genetic inheritance; the endocrinologists are arguing that this is mainly a problem of metabolic change; the people interested in social medicine are saying if people only had access to “whole food” there wouldn’t be any problem with obesity—all of which, in bits and pieces, is true. But right now with health care I’m very anxious about who’s going to be heard. If Mrs. Obama is heard, it’s a little extreme. They also understand that it puts a real economic burden on the system with relatively few positive outcomes.

AE: What is the medical culture?
Ahead of the Curve
Challenging conventions with predictive health

The passage of the Patient Protection and Affordable Care Act (PPACA) and the heated debate it brought forth yield a powerful opportunity to challenge conventions and to reshape health care in ways that truly improve our national health by preempting the onset of chronic disease. Achieving a healthier population not only benefits the individual, but it is critical to solving the economic and political issues concomitant with our greater health care dilemma. Emory’s Predictive Health initiative is key to addressing this opportunity.

Predictive health seeks to discover what keeps people healthy. Developed in response to the national need for a transformation in health and health care, Emory’s Predictive Health initiative aims to support individuals in taking care of their health and forestall the decline in health that leads to the need for medical intervention. This is a significant ideological shift in focus from our present disease-based health care system.

Predictive health promises to be pivotal in resolving the greater health care issue of ever-increasing spending that delivers disappointing results. The U.S. spends an unprecedented amount on health care—in terms of nominal as well as real dollars. To put this in perspective, the U.S. invests roughly 16 percent of its GDP in health care (versus 8 percent to 11 percent for Japan, Germany, or France) and maintains a higher annual rate of cost increase. Life expectancy is shorter in the U.S., and the rate of increase in life expectancy is lower than other nations. The PPACA legislation aims to help by expanding health care access to a greater population. A central question is how that health care is delivered:

“I believe in the power of education to help people lead more productive and healthy lives. Emory's Predictive Health initiative is at the core of a broader perspective of identifying predictors of health and illness. By focusing on understanding the science behind health and illness, Emory is able to discover what keeps people healthy and what can lead to disease. This approach is transformative and will change the way we think about health care.”

Michelle Lamp, Dobbs Professor of Anthropology and Associate Director, Predictive Health Institute

By Andre J. Nahmias, Emeritus Professor of Pediatrics

Nearly a decade ago, in an essay in the February/March 2001 Academic Exchange, I wrote, “Would it not have been more humane for Americans of the past, present, and future, if the founding fathers had been more specific—Life, Health, Liberty, and the Pursuit of Happiness? Alas, there are apparently some who believe that most people can live happily without good health.”

Imagine my delight, then, to read recently about Thomas Jefferson’s views relating health to happiness in a review of his contributions to academic medicine. The essay noted a reference to a letter Jefferson wrote on July 6, 1787—eleven years before the Declaration of Independence—to his relative T.M. Randolph Jr.: “With your talents and industry, with science and the steadfast honesty, which eternally pursues right regardless of consequences, you may promise yourself everything—but health, without which there is no happiness. An attention to health, then, should take place of every other object.” (The original letter may be found in a volume of The Writings of Thomas Jefferson, edited by A.A. Lipscomb, 1904.)

Perhaps Jefferson’s increasing attention to the subject of health was the outcome of his personal experience with the long-term suffering of his wife Martha from a chronic illness (diabetes?) and her eventual death in 1782. One wonders whether a greater knowledge or acknowledgement of these reflections, by the main author of the inalienable rights for all Americans, would have had some impact on the dialogue about health and health care in the last century—and more particularly over the last two years. Could it do so now?

Coincidentally, in the Emory community, we have recently had several opportunities to consider these questions. In addition to this issue of the AE devoted to health care reform, Emory also hosted the J. Willis Hurst History of Medicine Symposium (September 25) and a series of three lectures on the “Pursuit of Happiness” in September, sponsored by the Center for the Study of Law and Religion. That same center also hosted an interfaith “summit” in October, at which happiness was discussed from several religious viewpoints.

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Broadening Our Lenses
Ethical reflections on health care reform

In August 2009 in a speech to religious leaders, President Obama called health care reform “a core ethical and moral obligation.” What ethical concepts are fundamental in the debate that make health care reform centrally an ethical issue, if not an obligation? What is really at stake? The values of justice and liberty are arguably two ethical concepts most central to the reform debate and engender much passion in public discussion.

That public discussion has been hampered by the “chaos despite good intent” that characterized the recent history of efforts at health care reform leading up to March 2010. The Clinton administration’s attempt in 1993/1994 garnered political resistance and defeat—perhaps due in part to the perceived lack of any true negotiation process in Congress. The current administration has similarly been criticized for lack of attention to a truly collaborative process across the aisles. An effective and fair process for reform efforts is an important component of procedural fairness and consensus building that may still be missing in health reform efforts.

Six months after enactment of the Patient Protection and Affordable Care Act (PPACA), there are still many misconceptions of what the health reform legislation will do and won’t do, and much controversy. The lack of clarity about the legislation’s impact makes it difficult for many Americans to feel fully informed and thus to render a thoughtful opinion about this complex legislation, with provisions that go into effect in different phases between 2010 and 2017. And most begin, not surprisingly, with one’s own positional perspective—how will reform affect me and my family? (If I am uninsured, perhaps I see a hope for coverage. If my child is a young adult, extending coverage to age twenty-six may be welcome. If I am fully insured already, I may be concerned that reform will restrict my current choices.) How do we broaden our lenses?

This question draws us back to the twin ethical concepts of justice and liberty and their place in our understanding of health care policy.

Justice
What health care services does a democratic society wish to afford its members—both to prevent illness and protect health as well as to provide care when threatened by illness or injury? And, if there are obligations to treat members of society fairly, what does fairness—or at least a fair opportunity for health—require? A recent Robert Wood Johnson Foundation report indicates that without health care reform, current estimates of uninsured Americans—about 49.4 million in 2010—are projected to increase to 59.7 million in 2015 and 67.6 million in 2020. Addressing the inequities in access to care is one of the primary declared goals of the PPACA in the wake of rejection of a single-payer system. The Congressional Budget Office projects that reform will increase the number of non-elderly covered by insurance by 12 million (and, amazingly, reduce the federal deficit). Already enacted “high-risk pool” state programs (which will become “health care exchanges” in 2014) make it possible for those with pre-existing conditions to receive coverage, if they can afford the premiums. And these state-run health insurance exchanges would provide some choice of plans with, presumably, a basic (minimum) level of health care coverage. A recent article by Eibner et al. in the September 1, 2010, issue of the New England Journal of Medicine estimates that the number of workers who will be offered employer-sponsored insurance will increase from 84.6 percent to 94.6 percent of U.S. workers with PPACA reform. While these projections for increased availability of insurance with at least a basic standard of care are promising, affordability of offered coverage continues to be an important question.

Liberty
A classic value discussion that contrasts public health ethics with clinical ethics (or health care ethics at the patient’s bedside) is how one balances obligations to the individual with responsibilities to the community or society as a whole. U.S. society has traditionally placed great value on individual liberty or autonomy, the ability of the individual to make his or her own choice in health care decisions. Many critics of health care reform raise concerns about the potential loss of choice—of doctor, health care facility, type of coverage, and so forth. And the current lawsuits brought by twenty states against the federal government and challenging the constitutionality of the legislation’s mandate to purchase coverage through the health insurance exchanges, are also centered around one’s “right” to choose. Can we require that individuals purchase health insurance to provide for their own and the general welfare?

There are already many ways in which each of us has accepted certain restraints on our liberty so that society as a whole can function (for example, speed limits while driving, pollution emission controls, school attendance). Indeed the exercise of our personal freedoms may only be truly possible in a strong society that agrees to both the rights and responsibilities of its members. So the ethical challenge here may not be freedom from constraints, but a balancing of the value of personal choice defined through specific commitments such as maintaining the ability to continue with one’s current provider or purchase private insurance outside of those plans offered through the exchanges—with supporting new pathways for accessing health care. Balancing these ethical interests is at the heart of successful reform.

The ethical challenge may not be freedom from constraints, but a balancing of personal choice with supporting new pathways for accessing care.

Choice in advanced illness and at the end of life
One particular area of the reform debate where the language of personal choice drew a great deal of attention was the discussion of “death panels.” As an ethicist who is close to patient care and involved with physicians-in-training, I was disappointed to see the incredibly important area of palliative and end-of-life care reinterpreted as imposing death and infringing on patients’ and families’ liberty. To claim that discussions about the difficult choices that face patients and families as illness advances would take away patient decision making was an insult to patients, families, and clinicians. We all need to be encouraged to have these conversations and express our choices.

Patients clearly have the right to make their own treatment decisions in consultation with their medical teams. And when patients are medically unable to make such choices, families are central to these discussions. Other assumptions are an abuse of all of the efforts that palliative and end-of-life care clinicians have spent their careers doing—supporting individuals in the ways that honor that individual’s values and beliefs as they deal with difficult decisions that sometimes are near the end of the patient’s life. This misappropriation and mislabeling of a powerful part of all of our lives provides a compelling example that language matters deeply as you construct public policy conversations.

Moving forward
Our current health care system is failing many Americans, and change seems essential. But the promise of health care reform is not yet reality. Implementation—and perhaps evolution—of the PPACA will raise new questions and leave others unanswered. Who will still lack coverage as we move to mandated insurance for most by 2014, and what are our obligations to those not covered? How do we answer the question of services for illegal immigrants? As the legislation is phased in, there is an opportunity for each of us to enter the conversation with constructive concern and to explicitly examine the underlying values.
Defusing a fiscal time bomb

Cost Control and Health Care Reform

Defense procurement budgets and food stamps would seem to have little to do with health policy, but as budgets become tighter, these issues are increasingly intertwined. Earlier this year Defense Secretary Robert Gates sounded the alarm on the Department’s growing health budget, noting that “health care costs are eating the Defense Department alive.” In August, the House of Representatives voted to increase aid to states for Medicaid with offsetting cuts to food stamps. One representative likened it to “Sophie’s Choice.”

An overstatement? Yes. But in the coming years politicians in all levels of government will be forced to make difficult tradeoffs between health care and other programs.

The problem with health care spending is not simply that it is increasing. We spend more money today on many goods and services—computers, for example—than we did in the past. Rising expenditures on information technology because we spend less on other goods, like typewriters, and because decades of productivity growth have resulted in per-capita income levels that are almost twice as high as they were in 1970. Eventually spending on computers will level off as the as-yet unexploited opportunities to improve our lives through information technology diminish. Because consumers and firms pay the costs of computers out of their own pockets, the process will be gradual and non-disruptive.

Health care is different. Medicare, Medicaid, and other public programs account for almost 50 percent of health spending. These programs pay for medical care, the cost of which is increasing by about 7 percent per year, using taxes on wages and income, which are growing but at much lower rates. This gap, combined with an aging population and a pay-as-you-go financing scheme, is a fiscal time bomb.

It is not as if the extra money we’ve spent on health care has been wasted. A number of studies show that new medical technologies, from anticlotting drugs and surgery for heart attack patients to intensive care for low birthweight infants, have been accompanied by large gains in health. The technologies are expensive but worth it.

I recently undertook a study with my Winship Cancer Institute colleagues Joseph Lipscomb and John Kauh to measure the value of new chemotherapeutics for patients with late stage colorectal cancer. Medicare and other insurers pay thousands or tens of thousands of dollars for every patient who receives one of these drugs. Using Medicare claims data, we found that, on net, these drugs cost about $100,000 for every additional “quality adjusted” life year gained. Most estimates of the willingness to pay for a life year are in excess of $100,000, and so even these drugs, which are often cited as prime examples of high cost/low value medical care, would pass a cost-benefit test.

Yet cost control will be a top priority in the coming decades, if for no other reason that the ability of the federal government to finance spending via borrowing is limited. The recently passed health reform act makes some tentative steps towards cost control, and perhaps some of the act’s pilot projects will pay off down the road, but most experts agree that the bill did not go far enough in terms of reining in spending.

In the absence of a debt crisis that forces severe and immediate budget cuts, Congress over the next decade or so will probably undertake a number of incremental steps to lower costs. Medicare and Medicaid will reduce reimbursement rates for drugs. Hospitals, physicians, and other providers, which have grown accustomed to near-automatic inflation adjustments, will face stagnant reimbursement rates.

Congress and the federal bureaucracy will gradually restrict coverage for costly new treatments. The process has already started. In 2009, the Center for Medicare & Medicaid Services (CMS) decided not to cover CT colonography, a non-invasive screening test for colorectal cancer. CT colonography costs about $500 and ought to be performed every five years, whereas colonoscopy, the main competitor, costs $650 but is recommended only once every ten years. CMS justified its decision on the basis of effectiveness, but the extra cost of CT colonography was clearly an important consideration.

Avastin is a chemotherapy drug that costs tens of thousands of dollars per year. The Food and Drug Administration (FDA) approved Avastin for treatment of colorectal cancer in 2004 and breast cancer in 2008. In July of this year, however, the FDA’s Oncology Drug Advisory Committee took the unusual step of recommending that the FDA revoke coverage for Avastin as a treatment for breast cancer. Officially, the decision was based on Avastin’s benefits and side effects. Like CMS, the FDA is not allowed to consider costs. It seems unlikely, however, that the drug would have received such careful scrutiny had it been less expensive. One panel member, Jean Grem, admitted as much: “We aren’t supposed to talk about cost, but that’s another issue.” A final decision by the FDA is forthcoming.

There is only so much agencies can do on their own. Earlier in the year, for example, the FDA approved a controversial therapy for advanced prostate cancer that extends life by four months but costs between $50,000 and $100,000. At some point, Congress will decide that we can no longer afford the luxury of carte blanche coverage policies and begin to chip away at the principle that approval and coverage depend on effectiveness, not costs. Drugs, devices, and procedures that do not pass a cost-benefit test will be subject to coverage restrictions or not covered at all.

An alternative to this piecemeal approach for controlling costs has been set forth in Congressman Paul Ryan’s (R-WI) Roadmap for America’s Future. The Roadmap plan would give each Medicare beneficiary a voucher with which to buy health insurance in the private market. The plan is a radical shift in the context of Medicare, but it is not so different from the scheme the federal government uses to provide insurance to its own employees. The key element of the plan is that over time the value of the voucher would rise by the inflation rate, but not the rate of growth of health care spending, which is much higher. With the stroke of a pen, the plan goes a long way towards putting the U.S. on a firmer fiscal footing. Of course private plans would have to restrict coverage of costly new technologies, but the mechanism for reaching these decisions—market competition—is very different from the centralized approach envisioned by many health reformers. Ryan’s plan has yet to attract many supporters, even from his own party, but it may look more attractive as pressure to cut costs intensifies.

David Howard
Associate Professor of Health Policy and Management
The Affordable Care Act
Will the bill improve coordination of care in the U.S.?

The Patient and Protection Affordable Care Act (PPACA) will change health care delivery for all citizens, regardless of age, current health insurance coverage, or personal health. One thing most experts agree on is the PPACA will increase access to health insurance. Current consensus is that approximately 94 percent of all Americans will have health insurance coverage once the insurance provisions are fully implemented. The PPACA also addresses the lack of coordination of care within the current system. The primary purpose of this essay is to examine how the PPACA proposes to improve coordination of care.

The PPACA mandates testing a number of independent pilot projects—each of which, if proven effective and viable, could improve the coordination of care. For the most part, the PPACA left the development and implementation of these projects to federal agencies or newly created advisory boards, so much about them remains unknown. This essay reviews three pilot projects aimed at care coordination. For each pilot, this essay highlights its rationale, potential opportunities, and challenges that will need to be overcome.

Pilot 1
The Establishment of Accountable Care Organizations (ACOs) by the end of 2012. ACOs are groups of primary and specialty care providers that will coordinate care for Medicare beneficiaries currently enrolled in fee-for-service plans. The pilot requires ACOs to have shared governance, include primary care providers, cover at least five thousand Medicare beneficiaries, be accountable for all physician care, define processes to promote evidence-based medicine, and report quality of care. ACOs that meet quality benchmarks will share in any cost savings to the Medicare program.

Rationale: Critics often cite the lack of coordination between physicians treating the same patients, duplication of ancillary tests and services, and the use of emergency departments for routine care as major sources of waste in the U.S. health care delivery system. These critics also claim that there are several existing ACO-like organizations, the Mayo Clinic being frequently cited, providing high-quality coordinated care at below average cost.

Opportunities: Because they are accountable for the overall care of patients, ACOs offer two possibilities for better care coordination. First, ACOs may be more effective at using primary care providers to manage the majority of routine care and effectively involve appropriate specialty physicians as needed. Second, ACOs have the potential to integrate a broad array of services, including preventive services, nutritional education, and lifestyle/behavioral change programs to maintain or improve health and potentially delay the onset of chronic diseases. Better coordination and integration of health care services could also improve quality of care provided and consumer satisfaction.

Challenges: One major challenge to the ACO model is that consumers may balk at attempts to limit choice of physicians, especially specialists. Individuals in the private insurance market have demonstrated that they are willing to pay higher deductibles and co-payments to have the right to use providers outside the insurer’s network. A second challenge to this pilot is the creation of regulatory procedures that are flexible enough to allow ACOs to take advantage of the strengths of the local health care delivery system to coordinate care, but detailed enough to assure that ACOs do not selectively enroll only healthy patients. ACOs are conceptually very similar to managed care organizations, which were unpopular with many providers and the general U.S. population. As a result, the federal agency developing the final rules and financial arrangements must assure that the managers of ACOs create financial incentives for primary care physicians to act as “care coordinators” and not as “gatekeepers.”

Pilot 2
Study of bundled payment for acute inpatient hospital services by January 1, 2013. This pilot program will define a bundle of services for an episode of care that begins three days prior to a hospitalization and ends thirty days following discharge. The bundle is expected to include acute inpatient hospital services, physician services, outpatient hospital services, and post-acute care services. The goal is to demonstrate that paying a single fee for a bundle of services will reduce total spending in the Medicare program but will not reduce the quality of care received.

Rationale: Most critics agree that bundling all hospital services into a single payment creates incentives for hospitals to improve the efficiency of care without reducing quality. Further, for selected acute inpatient hospital episodes, published clinical studies demonstrate that improving the coordination between hospital and post-acute care can reduce hospital readmission rates.

Opportunities: Theoretically, bundling payments for all hospital, physician, and post-acute care services into one payment creates the opportunity for all players involved to reduce the fragmentation of care and develop efficient treatment protocols across sites of care. Bundled payments also align the economic interests of hospital management and physicians to encourage the use of the most effective treatments (new or old) and to reduce hospital complications, improving quality of care, consumer satisfaction, and lowering health care costs.

Challenges: This pilot restructures the fundamental working relationships in the U.S. health care delivery system, in particular between physicians and hospitals. Additionally, this raises the question of who the patient advocate, or “team captain,” is once an episode of inpatient care begins. A second challenge will be the creation of regulatory procedures that define episodes of care, the services included in each episode, key quality measures, and the appropriate length of time for each acute episode, especially if a patient has more than one chronic condition. Consumer may also balk at the reduction in choice over consulting physicians, outpatient centers, and post-acute care services. For example, federal regulators will need to ensure that there are enough post-acute care sites so that patient travel costs do not reduce the likelihood that patients comply with recommended post-acute care. A final challenge for federal regulators is to assure that bundled payments for acute inpatient episodes, especially in single hospital communities, does not result in a single, vertically integrated health care organization with the market power to raise prices in the private health market.

Pilot 3
Independence at Home Demonstration Program by January 1, 2012. This program aims to provide high-need Medicare beneficiaries with primary care services in their home and to determine whether increasing access to primary care can reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes, improve the efficiency of care, reduce the cost of total health care utilization, and improve patient satisfaction.

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Fall 2010
The Academic Exchange
The new health reform law takes an aggressive approach to prevention. Seen as one of the key elements of reform, lawmakers hope that key investments in preventive services and delivery models will help lower overall health care spending and improve health indicators for more Americans. The American Physical Therapy Association estimates that over time these provisions will be positive for consumers and physical therapists. Physical therapists who focus on prevention and wellness promotion may experience new opportunities. Employer-based wellness programs are already catching on across the nation. The incentives provided in health reform will likely encourage further investment in this area.

Of the $2+ trillion dollars we spend on health care every year (6 percent of our GDP), 47 percent is government spending in programs like Medicare. Growth of the Medicare program is inevitable as the population of seniors continues to climb. To assist Congress with difficult decisions relating to spending in health care, the health care reform law authorizes an independent body called the independent payment advisory board (IPAB) to make policy recommendations that would limit spending within Medicare. This independent body will assist Medicare with its fiscal challenge of an aging population, a decline in the number of workers per beneficiary, and increasing life expectancy. The impact on physical therapy could be positive if the IPAB looks at the potential cost savings of physical therapy interventions compared to surgery or other more costly interventions. The impact could be negative if the IPAB simply focuses on increasing use of physical therapy services without looking at the larger cost savings that can result from physical therapy in lieu of more expensive interventions.

Over the past several years, studies by the Center for Medicare & Medicaid Services (CMS) have determined that higher hospital readmission rates are linked to higher costs, which in turn result in lower quality care to Medicare beneficiaries. Therefore, CMS has been actively exploring ways to improve the quality and efficiency of care by reducing readmissions within the Medicare program. In addition, CMS has actively pursued programs to reward providers with added incentives when adhering to evidenced-based practice and achieving better outcomes by the reduction of readmissions.

Another policy concept that has garnered much attention in recent years is “bundling,” or payment to hospitals or other entities in health care delivery that would cover episode costs—acute plus post-acute care costs over a defined period of time (30 or 60 days). The hospital or other entities would face the choice of either delivering post-acute care services (such as home health, skilled nursing, inpatient rehabilitation, or long-term care) itself or paying freestanding providers to deliver those services. The new health care reform law has identified two possible methods of reducing readmissions and achieving higher quality care by improving coordination of acute and post-acute care. First, the law mandates payment adjustments for excessive readmissions to the hospital. Second, it directs the Secretary of the Department of Health and Human Services to develop a national voluntary pilot program that requires hospitals, physicians, and post-acute care providers to improve patient care and derive Medicare savings through a bundled payment model.

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Health care reform and the limits of abstinence policies

Although methadone has been used to treat addiction since the 1940s, it was most widely deployed in the 1960s and 1970s in response to increased drug use among white, middle class youth. This new class of user appeared to challenge the historically embedded notion that addicts had irredeemable character defects, and it briefly enabled more permissive approaches to addiction. Methadone maintenance emerged with the free clinic movement and the idea that health care is an inalienable right, irrevocable despite drug use.

According to historian Carolyn Acker, however, such utopian notions would not persist in the following decades. Nancy Reagan’s Just Say No campaign would make a sharp distinction between abstinence and any use at all of illicit substances. A similar agenda was behind the “zero-tolerance” drug policy of the George H. W. Bush Administration. The Clinton Administration would also fail to fund syringe exchange.

Addiction policy decisions tend to reflect long-standing public attitudes about the identity of addicts. That is, most policy supports addiction management by the criminal justice system. While the promise of the new health care reform bill recalls the free clinic era as it aims to diminish inequities in health care access, the bill has not changed most of the assumptions about addicts and addiction. Despite overwhelming medical evidence that addiction is a disorder rather than a choice, addicts by and large are more likely to become stigmatized than treated.

These ongoing policies of criminalization have their roots in a history of attitudes and punitive practices. For instance, the earliest federal addiction intervention, the 1914 Harrison Narcotic Act, attempted to limit public access to narcotics by regulating the prescribing practices of physicians. Several historians date the Harrison Act as the beginning of attitudes and punitive practices. Despite overwhelming medical evidence that addiction is a disorder rather than a choice, addicts by and large are more likely to become stigmatized than treated.

The study of addiction in historical perspective uncovers the contingent nature of not only social policy, but also scientific research agendas aimed at elucidating the causes of addiction. Across time, various etiological hypotheses—psychopathology, degeneracy, addictive personality, altered brain chemistry—have held out little hope for a cure and have provided ammunition for those advocating a punitive policy response to addiction. More recently, however, a consensus has arisen among the claims popularized initially by Alan Leshner, director of the National Institute for Drug Abuse from 1994 to 2001, who argued in a 2001 publication titled Addiction is a Brain Disease that prolonged substance use turned on “a switch in the brain” that permanently transformed brain mechanisms. The result, Leshner argued, was to make interventions aimed at reversing addictions extremely difficult. According to the brain disease model, addicts require medical treatment rather than stigmatization and legal penalties, especially incarceration.

While also eschewing the criminalization of addiction, historians have attempted to place the brain disease paradigm in a wider context by providing evidence that calls into question the effectiveness of negative incentives and criminalization. They remind us that the science of each era has attempted to identify the mechanisms behind the observed behaviors of addiction. Not surprisingly, these attempts reflect the dominant scientific paradigm of each era. And there is plentiful evidence that organic triggers for and biological effects from substance dependence interact with cultural and social forces. Addiction historian and psychiatrist Griffith Edwards, former chairman of the UK’s National Addiction Center, offers a more useful definition of addiction arising from a broader look at centuries of observations: addictions are not “brain diseases,” he suggests, but are actually syndromes of dependence with multiple triggers and pathways, ranging from the cultural to the organic.

Edwards’ distinction between syndrome and disease has important implications for illicit substance use. Measles, polio, and Huntington’s are diseases—a tentative diagnosis based on signs and symptoms is confirmed or rejected through a laboratory test indicating a pathogen or genetic mutation. In contrast, the cause of a syndrome—such as schizophrenia, Tourette syndrome, or affective disorders (depressions)—remains unknown. The diagnosis of syndromes depends on possible combinations of signs and symptoms displayed by an individual within a certain time period. This list of signs and symptoms is tentative, and disagreement often surfaces over which signs and symptoms are crucial to authorize a diagnosis. As a result, identification of a syndrome often varies over time and by geographic location.

Recognizing the many and varied routes to substance dependence syndrome, researchers and clinicians have begun to craft a variety of interventions and policies that consider a spectrum of cultural and biological triggers. Further, there is growing evidence that substance dependence alters brain reward mechanisms, such as brain architecture and neurochemistry, sometimes permanently, as proposed by neuroscientists Nestler and Leshner.

FURTHER READING


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variation and asked the Institute of Medicine to convene two committees that
provided $400 million up front to address cost control. With training in the
emerging science of health, our students are looking forward to healthier lives
and are positioned to help to shape how our society creates the tools for a health-focused
care system. As well as society’s. They remark that “our health care system fails
to study the issue. Secretary of Health and Human Services Kathleen Sebelius
hosted a Geographic Variation Summit in September to discuss the
issue in more detail.

Unintended consequences
An additional issue of immediate concern is that the potential benefits of
PPACA could be greatly impacted by unrelated policy changes. During
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ated an agreement with President Obama and Congressional leaders
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congressional consideration of PPACA, the hospital community negoti-
ated an agreement with President Obama and Congressional leaders
to limit the negative financial impact on hospitals to $95 billion over
ten years. It was believed that such sacrifice was necessary to offset the
cost of significant coverage expansion. That agreement did not take into
account the imposition of significant financial burdens imposed on hos-
pitals at the state and federal levels.

For example, nearly every state is faced with severe budget shortfalls.
In Georgia, the state budget deficit exceeded $12 billion, with a shortfall
in its Medicaid budget of almost $600 million. In response, the state im-
posed a “provider tax” of 1.45 percent of gross revenue on not-for-profit
hospitals. Sapping resources in this way will make it harder for hospitals
to adapt in a timely manner to changes and opportunities.

The classic American academic health center integrates clinical
practice with research, teaching, and education. While we don’t know for
sure the exact impact of PPACA on academic health centers, it is fair to
say that the cross integration characteristic of an academic health center
may position us to create the innovation and new thinking that will be
necessary to make PPACA a success.

For providers, there are always four key areas on which to focus:
managing costs, managing care, aligning an integrated care delivery
network, and managing the health needs of patients in an accountable
care network. We must find ways to deliver care in more efficient and ef-
fective ways. While this, of course, is an important focus with or without
health reform, appropriate follow-up action by Congress and the Obama
Administration will help us move forward.

Lampi
have considered the question of health care in terms of their own futures
as well as society’s. They remark that “our health care system fails to
recognize that proactive means are essential for health care to be less
costly” and comment that “individual preventive measures will have the
greatest impact on my (personal) health future.” Our students recognize,
and are almost amazed to realize, that much of their health is in their
control. With training in the emerging science of health, our students
are looking forward to healthier lives and are positioned to help to shape
how our society creates the tools for a health-focused care system.

We live in a time of both unprecedented knowledge expansion
regarding functionality of the human body and dynamic change in
how knowledge is afforded to the greater population. Technologi-
cal advances ranging from bioinformatics to molecular imaging are
enabling us to forecast the future and see where individuals stand in the
trajectory of health to disease. This raises the possibility for intervention
in the health continuum very early, before disease is manifest. Instead of
health care revolving around doctors reacting to the presence and dam-
age of disease, we are entering a time when health prediction is possible,
and promoting health can preempt a considerable amount of breakdown
and malfunction. Achieving this will require a fundamentally different
approach, new health personnel, and changes in access, screening, and
reimbursement strategies. The role of Predictive Health in this endeavor
is far-reaching, and Emory is presently ahead of the curve.

Johns and Engelen
Budget Act of 1997. This problem is particularly keen for Sun Belt states
like Georgia, which has seen its population increase by nearly two mil-
lion since 1997, leaving us with one of the lowest medical resident-per-
capita ratios in the nation.

Medicare and geographic variations
One debate that continues to rage on in Congress and the Obama Ad-
mistration is what geographic variation in Medicare means in terms of
efficiency and quality of patient care. On one side, proponents who sup-
port the creation of new regulation and funding incentives to reward low
cost providers rely on research conducted by Dartmouth University. This
research, compiled and published as the Dartmouth Atlas of Health Care,
looks at the amount hospitals bill to Medicare for patients with a chronic
disease who were in their last six months or two years of life. The Dart-
mouth researchers found wide variation, and some use it to conclude that
providers in the Upper Midwest and rural areas provide care more cost-
effectively than those in large urban centers and the South. During debate
on PPACA, it was suggested that using the Dartmouth Atlas as a basis for
regulation could net as much as $700 billion a year in cost savings.

Others, like Emory, who oppose a new regulatory scheme based
on the findings in the Dartmouth Atlas, argue that while the research
does identify variation, such differences are not so easily explained. For
example, we believe that wage and income status, not used as a factor in
the Atlas, has an impact on cost of care. Further, it does not adjust for the
recognized costs and additional payments to teaching hospitals for edu-
cation residents through Direct Medical Education and Indirect Medical
Education payments. We also suggest that the Atlas does not adequately
account for severity of illness or the higher costs associated with caring
for the poor who have had years of deferred health care or other social
and behavioral disadvantages leading to poor health. Academic health
centers routinely see more difficult, and therefore more costly, cases.

In order to pass the PPACA legislation, Congressional leaders negoti-
ad an agreement that provided $400 million up front to address cost
variation and asked the Institute of Medicine to convene two committees
includes two new benefits. The first is a new health risk appraisal to ac-
company the “welcome to Medicare” physical exam. The risk assessment
is designed to provide the foundation for the second addition, a person-
alyzed care plan. These new benefits are an important, if modest, start
-toward a new focus on preventing disease and mitigating the adverse
health consequences associated with unmanaged chronic illnesses.

The PPACA includes several key changes in our health care insurance,
wellness, and delivery system. The move toward compulsory insurance is
well known and has been hotly debated. The PPACA includes, however, a
broader range of changes less understood and potentially as important as
the changes in insurance coverage. While the PPACA represents a major
change in health care in our country, it certainly will not represent the
last major change we make.

Medicare policy changes
Finally, the PPACA includes several improvements in the Medicare
program. The most notable is the reduced out-of-pocket spending by
Medicare beneficiaries for prescription drugs. Today, the standard drug
benefit requires beneficiaries to pay the first $50, then 25 percent of the
next $2,520 in drug spending. Once total drug spending hits $2,830, ben-
eficiaries are responsible for 100 percent of the costs for the next $3,610 in
spending (the so-called “doughnut hole”). This year, beneficiaries hitting the
doughnut hole received a $250 rebate. By 2020, Medicare beneficia-
ries will pay 25 percent of the costs of drugs in the doughnut hole rather
than 100 percent.

In addition to eliminating cost sharing on preventive services,
Medicare added a new personalized prevention and care plan that

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last major change we make.
Culler
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Rationale: This program attempts to coordinate care for a specific subset of the Medicare population with special needs. A number of studies have documented the high cost of preventable hospitalizations among vulnerable elderly patients with special issues accessing primary care services.

Opportunities: A dedicated home-based primary care team should be able to improve the timing and coordination of primary care, leading to better health outcomes and satisfaction for vulnerable elderly patients. This pilot could also improve access to primary care and preventive services by broadly defining the types of health care professionals that can be part of home-based primary care teams. Elderly patients may also be better able to understand and comply with treatment protocols when they interact regularly with a familiar professional.

Challenges: In the short run, increasing access to primary care services for this vulnerable patient population is likely to increase the use of ancillary tests and other outpatient services. Similar to other pilots, this project will require regulators to define the professional make-up of care teams, which patients are high-need, the scope of primary care services supported, quality benchmarks, and ongoing monitoring to ensure that patients are receiving appropriate and necessary care. Home health agencies have found that some patients are hesitant to open their homes to health care providers, and home-based teams may face the same challenge.

Dunbar and Kushner
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Malenka in 2004. This alteration seems to occur even when the addiction, such as gambling, is not attached to a substance—thus raising a question about the labeling of certain non-substance behaviors as addictions.

Addiction involves attempts to alter consciousness—a fact of human life, historians have shown, since time immemorial. As Edwards reminds us in his 2004 book, Matters of Substance: Drugs and Why Everyone’s a User, for much of human history, including our own era, most mind-altering substances initially have been consumed to self-medicate for a variety of ills, including major and minor psychiatric disorders. That self-medication plays an important role in persistent substance use and abuse, despite awareness of potential harm, provides further support for questioning the effectiveness of abstinence policies. Neuroscience has shown that what we label “addiction” might be understood as a possible consequence of an attempted biological adaptation to social factors. Thus, all addictions are syndromes of dependence, informed and “enabled” by an interaction of culture and biology.

Kapasi
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As these provisions are implemented, physical therapists will play an integral role across the spectrum of care. As the federal government moves forward with developing a bundling payment model, physical therapists will provide value and critical decision-making on the best setting for care after the patient’s acute care hospital stay. In addition, physical therapists will play an essential role in ensuring reduction of hospital admissions because physical therapists assess the overall picture of the patient with their physical performance. Of critical importance will be the participation of physical therapists on technical expert panels and other advisory groups as assessment tools and quality measures are being developed. As this new legislation goes into effect, my message to my students will be this: how this legislation and its impact on our profession unfold may not be in our full control, but we can, by our knowledge and advocacy, influence the legislative process to positively influence our profession. We might advocate for a patient’s right to directly access the services of a physical therapist without needing the referral of a physician, and we might prevent self-referral by physicians to physician-owned physical therapy practices. Finally, as a profession, what we can control most is showing our patients the value we offer. Value is a ratio of benefits over costs. As long as we achieve comparable or better outcomes for our patients at lower costs compared to surgery and other more costly interventions, there will be a market for our services and patients willing to pay for them.

Summary
A review of these three pilot programs finds several common themes. First, while there will likely be significant modifications to the pilot projects when the final rules are released, all three of these programs will require new administrative rules and regulatory procedures to define stakeholders, describe covered services, monitor progress, and critically evaluate success over time. Second, each of these pilot programs will require changing long-standing working relationships and financial incentives in the U.S. health care delivery system. This suggests that the ultimate success of any of these programs will depend on stakeholders’ willingness to engage in change and how financial risks and rewards are divided among provider stakeholders. Finally, these pilot programs all require some level of restriction on consumer choice during an episode of care. Government restrictions on patient choice of provider have never been politically popular in the U.S.

Will the PPACA improve coordination of care in the US? The PPACA by itself most likely will not significantly improve the coordination of care in the current delivery system. However, the mere act of implementing, testing and evaluating the set of pilot projects contained in the bill will significantly increase all stakeholders’ attention and interest in improving the coordination of care. The long-term benefits of this increased focus alone would appear to be worth the effort.
Endnotes

Superhero physics

James Kakalios
Professor of Physics and Astronomy, University of Minnesota, from his talk “The Uncanny Physics of Superhero Comic Books,” September 24, 2010, sponsored by the Physics Department

I don’t see my job as just being Dr. No, Professor of Wrong, saying, Well, this could never happen, and this is impossible, and what’s the deal with the Hulk’s pants, anyway? What’d rather do is grant each character a miracle exemption from the laws of nature and say, If you were super strong, or could stretch like a rubber band, or run at super speed like The Flash, could you cross the ocean, or up the side of a building? Could you drag people behind you in your wake—all things these characters are shown doing, all things that are correct from a physics point of view once you make that suspension of disbelief? . . . Electro is a Spiderman villain who was up on a high tension line when he was struck by lightning and thus gained the ability to store electric charge and discharge it at will in the form of lightning bolts. Obviously. as a kid I could probably be forgiven for thinking that getting hit by lightning was one of the greatest things that could ever happen to me, second only to wallowing in radioactive waste. Personally—and this is just me, and you may have a different opinion on this—but if I gained mastery over one of the fundamental forces of nature, I don’t know if those are the clothes I’d wear in public.

Writing disaster in Haiti

Deborah Jenson
Professor of French studies at Duke University, from her talk “New Directions in Afro-Diasporan Studies via Haiti,” September 17, 2010, sponsored by Emory’s Department of French and Italian

Disaster and catastrophe were in fact among the most common terms found in titles of pamphlets and memoirs by former colonists of Saint-Domingue in the course of the Haitian Revolution. The emergence of a free black state in the Americas was openly qualified as “catastrophe.” Colonists, including planters, who were free persons of color, wrote to the National Convention to denounce the disaster’s causes, authors, and narratives, often citing a terrible analogy between the destabilizations of the French Revolution and the disasters in Saint-Domingue. . . . In the first decade of the new millennium, a period marked by the bicentennial of Haiti’s independence in 2004, discourses of disaster again rose prominently to the researcher’s eye in texts about Haiti. The expressions “ecological disaster,” “humanitarian disaster,” “disaster management,” “disaster capitalism” have all proliferated around Haiti, well prior to the recent 2010 disaster that has reset the bar on the meaning of disaster. Among this proliferation of discourses about Haiti’s vulnerability one can find references to the Haitian disaster as a kind of metonymy for the Haitian state and its history. These crop up particularly frequently in assessments of corruption in Haiti’s political economy, an approach which I find very worrisome, as it unintentionally closes the loop with that earlier tradition regarding the advent of a black state as disaster, and replaces a whole national tradition with a kind of apocalyptic signifier, as if nothing were there but what might replace it.

Gender in the legal workplace

Gloria Santona
Executive Vice President and General Counsel at McDonald’s Corp., from her talk about diversity in the workplace, September 9, 2010, sponsored by Emory’s Law’s Latin American Students Association

We’re all familiar with the stereotypes of women lawyers. We’ve all heard it said that women are better negotiators than men because they’re more comfortable with collaboration and conflict avoidance. Others have claimed that women are better at recognizing interdependencies and establishing relationships. In 1991, even Sandra Day O’Connor discussed the differences that women brought to the bench in an essay about women judges speaking in a different voice. Just last year the “wise Latina” commentary by Supreme Court Justice nominee Sonia Sotomayor sparked national debate on the impact one’s gender and experience would or should have on judicial decisions. While there seems to be a lot of anecdotal evidence supporting claims that women lawyers have different skills than men, I don’t know that there’s any scientific evidence to that effect. . . . You can ask whether the skills that made me succeed and thrive in cross-cultural negotiations grew out of nature or nurture. Was it my nature as a woman to be a good negotiator and mediator, or did my ability to deal successfully with other cultures emanate from the fact that I grew up in a multicultural environment? I really don’t know the answer, and moreover I’m not sure that it matters. What was infinitely more important was that these were the skills that I brought to McDonald’s because of my unique background, and that [the company] found these skills to be of value and rewarded me for using them in the workplace.