

Chairs' Corner --September 2009
Health Care Reform

TO: UW Foundation, Deans, University Advancement Staff

FROM: Daniel J. Evans, Chair, UW Foundation
Lyn Grinstein, Vice Chair, UW Foundation
Orin C. Smith, Immediate Past Chair, UW Foundation

Dear Friends,

There is no shortage these days of commentary about health-care reform. Most of it comes from experts, pundits, journalists, and politicians in the big east-coast policy centers. But of course we have one of the nation's premier medical centers right here at the University of Washington. So we decided to talk to a couple of our own experts, to see how things look from here.

Dr. James Davis arrived last fall to chair the medical school's Department of Family Medicine. Formerly at the University of Wisconsin, Dr. Davis was headed for the other Washington on a prestigious Robert Wood Johnson Policy Fellowship when Dean Paul Ramsey persuaded him to come here instead. "He convinced me," says Dr. Davis, "that I could be more effective here, helping to meet the huge needs of this region."

Those needs center on a critical undersupply of primary-care doctors—the cause closest to Dr. Davis's heart and, as he sees it, the big missing piece of health-care reform. "Nothing in the current proposals," he says, "deals with expanding the number of primary-care doctors, which is essential to expanding people's access to affordable care." He cites the familiar statistics about medical students' increasing preference for specialized fields rather than primary care. Even at the UW, though it is still ranked number one for primary care, only about 13 percent of medical students now enter family medicine—and that's higher than average for U.S. medical schools. Even fewer prepare for family practice in rural or underserved areas.

The costs to the region—and, by extension, to the nation—are clear. "My ultimate constituency," says Dr. Davis, "is the communities in the five WWAMI states [see <http://UWmedicine.washington.edu/Education/WWAMI/>], and as I travel around those states, there is no place where there isn't a need for more primary-care physicians. I see crowded emergency rooms even in small communities."

But Dr. Davis also sees some promising developments. One, predating current reform efforts, is a federal grant called TRUST (Targeted Rural and Underserved Training), awarded last year to the Department of Family Medicine. The grant is meant to help the UW attract and retain students for primary-care disciplines, building on programs already in place.

“With TRUST,” says Dr. Davis, “we start by paying more attention to the admissions process. We look for attributes that predict, historically, which students are most likely to go into primary, rural, and underserved care.” TRUST-track students are then mentored, steered early into appropriate experiences, and finally sent off into TRUST-affiliated residencies in WWAMI communities. “The vast majority of doctors end up practicing within 30 to 60 miles of their residency sites,” says Dr. Davis, “so this is a way to start addressing regional needs.” Dr. Davis hopes to make the TRUST program a permanent part of the medical school—and possibly a national model—even after the grant runs out. (For a New York Times story about UW medical students out in the field, go to <http://www.nytimes.com/2009/09/09/health/policy/09medschool.html>.)

Another reason for optimism: despite the lack of explicit plans to expand the primary-care workforce, national reform proposals do include new payment models that could make primary care more attractive and rewarding.

Currently, says Dr. Davis, family doctors do a lot of time-consuming work for which they are not compensated, such as arranging referrals and generally coordinating their patients’ care. The most promising idea on the table now, he says, is payment reform to support the “medical home” concept: patient-centered, easily accessible primary care that helps patients better navigate the health-care system, with evidence-based quality measures built in. “We’re not talking about huge increases,” he says. “A reimbursement system that adds 10 percent to current primary-care fees could make a big difference.”

Two up-coming local events will address these issues: a two-day “learning session” for the Washington State Medical Home Collaborative (a two-year pilot project of the Washington State Department of Health and the Washington Academy of Family Physicians), for which Dr. Davis is a faculty member; and a Healthcare Payment Reform Summit sponsored by the Puget Sound Health Alliance, The Washington State Medical Association, and the Washington Academy of Family Physicians. So there are many local players in the health-care reform effort. Might states actually get there first?

Aaron Katz, Principal Lecturer in Health Services and Global Health, comes to this conversation after 30 years of studying health systems in the U.S. and around the world. For 15 years he directed the U.W. Health Policy Analysis Institute. (You might have seen him on The News Hour with Jim Lehrer on September 4.)

Professor Katz has a very careful formulation of what we should be trying to achieve with health-care reform: “We want to assure that people who need medical care get it, from the right caregiver at the right time, and that the care is of high quality and as efficient as possible.” You can reach those ends, he believes, with a variety of means, as different countries have.

“But around the world,” says Professor Katz, “there are two important characteristics that are necessary, though not sufficient, to achieve that goal. First is universal coverage. Everybody has to be in. That’s on the table in our current proposals. Second, you have to limit the amount of money in the system. That’s not being talked about.” Without

such limits, he says, the good ideas we're now considering—expanding Medicaid, subsidizing insurance for low-income people, banning exclusions for pre-existing conditions—will broaden coverage in the short term but will not be financially sustainable in the long run. “There is no evidence,” he says, “to support the notion that health-care costs would come down as a result of anything now being proposed.”

So who sets the limits? It depends on the system. “Germany is a good model for us,” says Professor Katz. It operates through private insurance, heavily regulated. Every year, a committee representing labor, employers, and government decides how much money the country can afford to put into health care. The German system also features “risk-adjusted premiums”: insurers who attract a sicker population get a larger share of the overall premium pool, which means that insurers compete on the basis of quality and efficiency, not risk avoidance.

Professor Katz believes the current political discussion needs stretching in directions like this. But he hasn't given up on reaching the health-care goal. “I'm hoping,” he says, “that this will be a multiple-session process—that this year is the first step in a larger game plan. If that's the case, winning expanded coverage and more-regulated insurance this year would constitute significant reform. It would be good incrementalism. But then we have to keep going.”

Will we get there? And where is “there”? Obviously, we have only scratched the surface here of an immensely complex subject. But these two UW experts, and many of their colleagues, are deeply involved in the national conversation, and we hope they have given you new things to think about.

Dan, Lyn, and Orin

Looking Back

- **Contributions July 1, 2009 through July 31, 2009 total \$33,859,631.**
- **The July Report of Contributions** is attached and contains fundraising details. There are some slight changes in the report, including additional information about UWAA's correlation to giving (page 7).
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Looking Ahead

- **Friday, January 29, 2010.** Foundation Board Meeting, 8:30 a.m. coffee; 9:00-11:00 a.m. meeting.
- **Friday, April 23, 2010.** Foundation Board Meeting, 8:30 a.m. coffee; 9:00-11:00 a.m. meeting.
- **Friday, September 10, 2010.** Foundation Board Meeting, 8:00 a.m. coffee; 8:30-11:30 a.m. meeting.