

Health Stewardship:

The Responsible Path to a Healthier Nation



a publication of the
aspen health stewardship project
the aspen institute

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THE ASPEN INSTITUTE

Health, Biomedical Science and Society Program
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Washington, D.C.

2009

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Published in the United States of America in 2009
By The Aspen Institute

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ISBN: 0-89843-499-8
Inventory Number: 09-001

TABLE *of* CONTENTS

FOREWORD	iv
INTRODUCTION	11
STEWARDSHIP: A UNIQUE PERSPECTIVE ON HEALTH REFORM	15
AMERICAN ATTITUDES ON HEALTH STEWARDSHIP	21
THE LIMITS OF REFORM WITHOUT STEWARDSHIP	27
PURSuing VALUE THROUGH EARLY HEALTH MODELS	31
GOVERNMENT ROLES IN STEWARDSHIP	35
CONCLUSION	45
REFERENCES	49
APPENDICES	
The Aspen Health Stewardship Project Advisory Board.....	50
The Aspen Health Stewardship Project Questionnaire	52
The Aspen Health Stewardship Coalition	71
ABOUT THE HEALTH BIOMEDICAL SCIENCE AND SOCIETY PROGRAM	72

In recent years, growing numbers of Americans have come to understand that our nation's approach to health care requires fundamental changes. Sadly, many people have learned this the hard way. More and more Americans have become sick over the past decade as the rates of obesity and related chronic illnesses have risen. Meanwhile, equally troubling, nearly 50 million Americans don't have health insurance while millions more do but can't get the care they need. With health care costs rising, our economy faltering and the health of the American people declining, many policymakers and government leaders have concluded that what is unfolding is nothing less than a catastrophe, albeit slow moving.

Recognizing the problem — and an opportunity to make progress against it with the prospect of a new U.S. president and federal administration — the Aspen Institute established the Aspen Health Stewardship Project in October 2007. Consistent with the Institute's history and ideals, the project convened a bipartisan group of thought leaders to help concentrate the national conversation on the root problems of the country's health care system and on making related improvements that would be both smart and sustainable. Specifically, the group was charged to craft bipartisan principles that could inform the development of any health reform proposal. The members also were called upon to promote the principles and encourage their adoption in the policymaking process.

The project has been chaired by Mark Ganz, president and CEO of Regence BlueCross BlueShield; Joe Hogan, former president and CEO of GE Healthcare (now CEO of ABB); Elizabeth Olmsted Teisberg, tenured professor at the University of Virginia Darden School of Business and co-author of the book *Redefining Health Care*; and Christine Todd Whitman, former governor of New Jersey and founder of the Whitman Strategy Group.

After formulating the Aspen Health Stewardship Principles, the group released them at an event held at the National Press Club in Washington, D.C., on February 13, 2008. In addition to the principles, the project issued a series of backgrounders to support them along with a questionnaire on health care reform that had been provided to the presidential candidates. In the months that followed, Senators Barack Obama, Hillary Rodham Clinton and John McCain all completed the questionnaire and returned it to the Institute. The project then commissioned Zogby International, one of the nation's leading public opinion research firms, to conduct a national poll on health stewardship and health care reform to compare the presidential candidates' questionnaire responses to the attitudes and concerns of the American people. On May 14, 2008, the project held a public briefing at the Russell Senate Office Building, where the candidates' responses were released, along with the poll findings, which showed that the American people strongly agreed with the Aspen Health Stewardship Principles.

This report builds on the Aspen Health Stewardship Principles and other insights from the meetings of the project advisory board. It seeks to suffuse health care reform with a long-term perspective while calling for governmental leadership, individual initiative and immediate, sustained action and coordination among providers, employers, health plans and communities. In short, it urges all stakeholders to play a role in helping to bring about a healthier America.

Acknowledgments

As we end the first phase of the Aspen Health Stewardship Project and transition to new objectives, I would like to express my deepest gratitude to those who helped lay its foundation and carry out its work over the past 18 months. On behalf of the Aspen Institute, I am pleased to acknowledge the contributions of several people as follows:

The co-chairs of our project were instrumental to its success. Mark Ganz provided the initial vision and critical, indispensable guidance on numerous occasions, especially during the project's formative stages.

He has been a tireless advocate for the project from the outset. Gov. Whitman offered crucial insights on how to navigate the political realities associated with major reform, and on approaches for making state-level improvements. Joe Hogan and Dr. Robert Honigberg of GE Healthcare made countless valuable observations pertaining to the role of medical technology and innovation. Robert also generously shared his perspective as a physician many times and to the project's great benefit. Professor Elizabeth Olmsted Teisberg provided essential insights on health care value and quality, themes at the very heart of the project.

Elizabeth Teisberg and Scott Wallace, former president and CEO of the National Alliance for Health Information Technology, drafted the initial versions of this report and helped us expand our discussion of the stewardship principles. This report draws on Professor Teisberg's pathbreaking work with Michael Porter, namely their seminal book *Redefining Health Care*. Many others have contributed to the report, including Noah Bartolucci and Franmarie Kennedy of the Aspen Institute. In addition, the project advisory board members have been tremendously generous in their time and contributions.

With regard to the advisory board, the project itself would not have been possible without the time, attention and overall support of the board members. I thank each of them for the countless hours they have poured into our shared endeavor. The full listing of board members is provided at the end of the report. Special thanks go to board member Craig Fuller who helped guide the project at pivotal moments, shared his experiences with the political process and made sure we included thoughts on how new interventions get to patients.

Of course, the project also would not have been possible were it not for the generous support of the Oregon Community Foundation. The foundation took an early interest in the project and encouraged our work throughout. We also received support for our second-phase launch event from the Eli Lilly and Company Foundation and the Pharmaceutical Research and Manufacturers of America, to whom we also are grateful.

At every stage of the project we have been fortunate to receive assistance from dedicated supporters. I cannot adequately thank Kerry Barnett,

Jason Daughn and the rest of the Regence BlueCross BlueShield team for their considerable help and great ideas as we carried out our work. I also am happy to thank Christina Lisi and Nell McGarity of the Glover Park Group for providing their assistance with our events at the Senate and National Press Club. Thanks also to Seppideh Sami and Lee Repasch, who provided research support for the project; to Sharon Newsom and her colleagues at i3 graphic design for the report production; to John Zogby and his team at Zogby International for conducting the poll that plays a key role in our findings; to the George Washington University health policy research team led by Christine Ferguson for their help in drafting the backgrounders to the stewardship principles; and to Helen Benet-Goodman, Elizabeth, Jason and Robert for their further research on and editing of several of the backgrounders. Among many other resources, we have drawn on the backgrounders in preparing this report.

Finally, I thank my staff and colleagues at the Aspen Institute for their many contributions to the project. Noah Bartolucci, Alison Drone, Ty Harris, Franmarie Kennedy, and Eleanor “Teddy” Weiss of my staff supported the project — in ways too numerous to mention — with great devotion, demonstrated teamwork and innovative spirit. I also am pleased to thank the Institute’s communications department, led by Jim Spiegelman, for increasing the visibility of our work. In a related expression of thanks, I am grateful to Jean Morra and Alexa Law for their assistance with our Web presence. I also would like to thank Elliot Gerson and Peter Reiling for their leadership of the policy programs at the Institute, and ours, in particular. Last, I thank Walter Isaacson for leading the Institute and for giving our project not only his guidance but also his staunch and loyal backing.

Michelle McMurry, M.D., Ph.D.

Director

Aspen Health Stewardship Project

Health, Biomedical Science and Society Program

Washington, D.C.

March 2009

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I. Introduction

The time has come for America to realize that health is a national resource to foster and grow, or squander and lose. Stewardship, the careful and responsible management of resources, can protect and preserve the collective well-being of the American people. Every person, organization and community has a role to play. We must become better stewards of our health and take bold steps to safeguard this vital resource, which, across our nation, is becoming increasingly scarce. At this critical juncture, with the health status of the American people faltering and our national economy likewise growing anemic, there could be no more crucial moment to implement health stewardship. We must work on many fronts to improve our system of care and what it returns to us. We must become a healthier nation.¹

Improving the health of all Americans is nothing less than an economic priority. Our country must have a healthy workforce to enable productivity and maintain its standing in the world. Health care spending has a dramatic impact on every sector of the economy, and in a service-based economy like ours, the consequences of misuse can be especially pronounced. In these precarious times, a dollar spent inefficiently in health care is not just a missed opportunity for better health. It is also a dollar denied to other critical national goals.

But our challenge is much broader than wise use of money. Health is inextricably linked to our quality of life and overall stability. It undergirds the energy and richness of our everyday experiences. To be sure, it is a precious resource for individuals, families, communities, and the nation. Yet, despite its importance, the health of the American people is declining.² We must respond with vigilance to the gradual depletion of this resource, our efforts rooted in a clear understanding of what causes it.

Sadly, many Americans do not have the opportunity or information to take charge of their own health, diminishing their quality of life and producing a ripple effect throughout society.³ Behavioral choices are but one of the social determinants of individual health. Other strong influences include education, housing, and income level.⁴

But behavioral choices cannot be ignored, especially in view of the fact that even small ones can have a powerful effect on personal and population health. Everyone can do better, whether doing better means exercising more frequently, eating a healthier diet, reading the labels on one's medications or asking one's doctors questions about the treatments they prescribe. As a country, we should do more to empower individuals and provide meaningful choices. In the pursuit of health, each of us must realize we are our own best advocate.

Our health care system, too, is broken in fundamental ways, notwithstanding the fact that it employs the best technology in modern medicine and has the treasure of a dedicated workforce. Among the problems: its errors are untenable, its uneven quality intolerable, its inefficiency inexcusable, and its cost increases unsustainable. Astoundingly, our system works against itself by focusing on acute treatment rather than on prevention and wellness. Routine and acute care, as well as chronic disease management, are inaccessible not only to the nearly 50 million Americans without insurance but also to millions with it.^{5,6} Health insurance no longer ensures access to needed care. The care delivered lacks coordination and varies wildly in quality.^{7,8} Hindered by outdated management and information systems — and overwhelmed by patient load and red tape — health care providers assume the care they render is good enough, and yet they at times lack access to or ignore lessons from clinical evidence, scientific innovation and quality improvement.

For their part, business and government leaders too often ignore the health consequences of their decisions, exacerbating health challenges confronting the country. For instance, when deciding whether to serve processed foods or more nutritious school lunches that may require slightly higher labor costs to prepare,⁹ or whether to sell a parcel of land for retail development or to build a park, decision makers frequently fail to consider whether their choices will foster or harm health. Such decisions can be difficult, but we should bear in mind that every choice we make brings us closer to, or moves us further from, our long-term health goals.

The reform of our health care system is an urgent national priority. Implementation of rapid and meaningful change requires a reliable compass for widespread action, cooperative effort and shared benefit. Despite obvious failures, the discussion of health challenges rarely focuses on how to improve health or change the systems of care delivery. Instead, the national debate centers on how to expand coverage in our overburdened system, on which groups should effect the change, and who should bear the costs.

Access for all is necessary but is not enough to fix today's problems, nor is it affordable under our current system. Simply put, the current debate fails to acknowledge that health is a national resource and its stewardship a shared responsibility. The existing preoccupations with who is responsible to bring about the needed changes, and who should pay for them, are distractions. They ignore the unique role of health in society and mask the system's fundamental shortcomings, such as its lack of support for preventive and early stage treatment of disease, its reliance on expensive care in emergency rooms, and its endless battle to treat late-stage illnesses without effective coordination or realistic strategies.

Better stewardship can empower Americans and improve health. The stewardship perspective clarifies that good health, and not maintaining the status quo with cost reductions, is the primary goal of reform. Cost reduction as the ultimate goal would imply that pain killers and compassion could solve the health care challenge. They will not. Moreover, cost reduction as a singular goal assumes that today's health outcomes are good enough, if only they were achieved at lower costs. But today's health care is not good enough because it fails to achieve good health overall and yields highly variable results among patients with similar medical conditions.¹⁰ The American people are among the world's fattest.¹¹ The United States lags behind other developed nations in rates of infant mortality and overall life expectancy, among other measures.^{12, 13} And disparities in outcomes among clinical facilities, geographic locations, ethnicities, and gender of patients point to an urgent need for improvement.

While cost reductions won't fix the system, neither will cost increases without fundamental improvements in health care. As stewards, we must demand greater value for our health care dollar — better health for what we spend. We can achieve this goal through improvements in the organization, delivery and quality of care. A highly effective system of care is coherent, compassionate, collaborative and centered on patients, and results in a high-quality product. We deserve nothing less. And, no matter who pays for health care, when value and delivery

of care improve, the nation can afford better quality health care for more people. Such goals are intrinsic to health stewardship.

“PROTECTING AND PROMOTING HEALTH AND WELLNESS IN THIS NATION IS A SHARED RESPONSIBILITY AMONG INDIVIDUALS AND FAMILIES, SCHOOL SYSTEMS, EMPLOYERS, THE MEDICAL AND PUBLIC HEALTH WORKFORCE, AND FEDERAL AND STATE AND LOCAL GOVERNMENTS.”
-PRESIDENT OBAMA*

Alas, resources are not unlimited, which makes the objective of achieving greater value a fulcrum as we seek to leverage improvements to the health care system. Having limited resources also means that the various stakeholders must be willing not only to assume responsibility but also to sacrifice on behalf of the greater good.

Our nation can do better, and it must. But doing better — reforming the health care system through implementing health stewardship — will not be achieved by mandating responsibility to one group or another. Similarly, playing the blame game and ignoring our obligations won't remedy our present situation. Americans take great pride in the fact that we like to solve problems that other nations walk away from; indeed, it is a part of our national identity. Rising to the challenge to improve America's health, everyone must own the solution. Individuals, families, schools and communities, doctors and other care givers, health plans, suppliers, employers, and government organizations all have a role to play. With collaborative effort, high resolve, and a focus on stewardship, we can become a vastly healthier nation.

* All raised quotes in this report can be read in context in Appendix II.

II. Stewardship: A Unique Perspective On Health Reform

Stewardship is a fundamentally different approach to health reform. Borrowed from the environmental movement, the concept calls for Americans to value and manage our nation's shared health resources in the same sense that we seek to be good stewards of the environment. It is an ethic that embodies shared responsibility, individual initiative, and cooperative planning and management by providers, businesses, communities and government, among other stakeholders. Founded upon bipartisan principles, the stewardship approach concentrates on bringing about enduring solutions, addressing not just the symptoms but the root causes of our nation's broken system of care.

Recognizing the need for bipartisan principles — and seeking ultimately to help build a healthier nation — the Aspen Institute established the Aspen Health Stewardship Project in the fall of 2007. Consistent with the Institute's history and ideals, the project convened a bipartisan group of thought leaders and asked them to develop a set of core principles that, transcending political biases, could help guide any health care reform proposal. As a secondary charge, the group was called upon to help reframe and broaden the national conversation on health care reform leading up to and following the 2008 presidential election.

To be clear, the project's goal was never to develop a new health care plan, but rather to suffuse reform efforts with bipartisan principles to facilitate smart, sustainable improvements to the U.S. health care system.

The project advisory board has been led by Mark Ganz, president and CEO of Regence BlueCross BlueShield; Joe Hogan, former president and CEO of GE Healthcare; Elizabeth Olmsted Teisberg, tenured professor at the University of Virginia Darden School of Business and co-author of the book *Redefining Health Care*; and Christine

Todd Whitman, former governor of New Jersey and founder of the Whitman Strategy Group. Together with the project's 10 board members, these leaders developed the Aspen Health Stewardship Principles, which are as follows:

ACCESS IS NOT ENOUGH. Health insurance must be accessible and affordable for all Americans not only because it is socially just but also because it will help our country achieve a system that is effective and efficient. Insurance for all is essential so that more care is provided at earlier stages, when it is most effective and least costly. But we can't stop there. Access alone will not drive the improvements needed to increase safety, reduce waste, enable coordination and promote quality. Consider, too, that in recent years, nearly 40 percent of insured Americans reported having trouble getting the care they needed. Providing access to all without a greater focus on prevention and significant improvements in the delivery and value of care is neither affordable nor sustainable.

I AM IN CHARGE OF MY HEALTH. Health is not just an issue of access to care. It is also an issue of access to information and to the ability and resources needed to act upon it. Individually and collectively, we are the stewards of our own health. Reclaiming this power is essential. All Americans should know that, ultimately, they are their own best health care providers. Going forward, we cannot ignore the personal and political health choices we make. If we, as individuals, made healthier choices and our leaders enacted policies that supported the promotion of health and the prevention of disease, we could reduce our current rate of illness and disability by as much as 40 percent.¹⁴ As a nation, we should treat our health and health care dollars like gold, conserving and protecting them. We should each have more control over our own health care and more rewards for being good stewards of our health.

VALUE AND QUALITY IN CARE ARE PARAMOUNT. For any solution to have a lasting impact, it must drive dramatic improvements in health care and health outcomes while increasing efficiency. The point is not to reduce costs at the expense of health. We need to enable innovations that drive up value to have the best health outcomes for

our investment, and that should be our primary measure of value. We must reduce overuse and inappropriate care and deepen investments that truly make a difference to health. The United States already spends more per capita than any other nation¹⁵ — more than we need to — on health care. With proper redesign, we can have better individual health, better health for the population as a whole and improved efficiency at the same time. Fundamental improvements in value will be accelerated when doctors, nurses, insurers, researchers, communities and individuals — in a word, everyone — works toward these aims. The goal of improving value aligns everyone's interests.

“ONE-QUARTER OF ALL MEDICAL SPENDING GOES TO ADMINISTRATIVE AND OVERHEAD COSTS AND RELIANCE ON ANTIQUATED PAPER-BASED RECORD AND INFORMATION SYSTEMS NEEDLESSLY INCREASES THESE COSTS”
-PRESIDENT OBAMA

FOCUS ON CULTURAL CHANGE. We haven't paid enough attention to cultural barriers within the health care system to achieving our health care goals. Meaningful reform must address more than the symptoms of a broken system. We must surmount the culture of the current health system that protects the status quo and empower all quarters of our community to produce real change. Health care delivery must be reorganized to suit patients, not the industry. Care should be well coordinated and easy to navigate. Health insurance plans must be refocused on enabling health rather than limiting care. Employers, communities and governments must redirect their efforts toward supporting health. These changes are essential to enable health stewardship and needed improvements in health and health care.

HEALTH SPAN, NOT LIFE SPAN. Life span is how long we live. Health span is how long we live with the best possible health. Our goal is better health, not more treatment. That said, health care should focus more on early health and less on late disease. To achieve that goal, we will need a much greater focus on prevention, and this must be brought to bear everywhere: at work, at school and at home. Incentives must be changed to support and encourage people to stay healthy. We must move to a system that prevents illness and protects health for as long as possible and for as many as possible. This should be accomplished through better coordination of care so even individuals with chronic

illnesses stay healthier longer and have fewer complications. This alone should decrease health care spending while providing a national health benefit in the form of increased productivity.

TURN INFORMATION INTO INSIGHT. Information technology and biomedical research form the backbone of our health care system. We must minimize barriers to innovation and use information more effectively to better understand disease and therefore better treat it. The time has come to use information technology across the entire health care spectrum and to introduce tools that will protect privacy while fostering efficiency and improving health. If we want better health, we must define it. To define it, we must gain insight by measuring outcomes and identifying what works. And once better health is measured, we should reward those who achieve it best. Better information will help us meet our objectives.

AN EFFECTIVE HEALTH CARE SYSTEM IS A TRANSPARENT ONE. Stewardship and individual health empowerment require the right information and tools. Health information should be timely, accessible and user-friendly, particularly to individuals. It must be available to us at the right place and at the right time to make the right decisions for our health. This information must enable individuals and clinicians to consider and compare the full spectrum of care, not just isolated procedures. Individuals must have the right to any data on their health that exist electronically at no charge or nominal cost. Such transparency needs to extend to health costs and quality as well. Insurers, hospitals, doctors—all health care stakeholders—should share their performance and health outcome information so that they can improve and individuals can make well-informed decisions regarding their health care choices, especially when it comes to early health, wellness and prevention.

EQUITY IN HEALTH, NOT JUST IN HEALTH INSURANCE. From heart disease and diabetes to cancer and childhood diseases, Americans face crippling disparities in both the occurrence of disease and their successful recovery from it.¹⁶ Better stewardship should include pathways to reducing these financially unsustainable health

differences based on ethnicity, gender, income, region and language. Transparency is critical. When outcomes are measured and discussed, disparities in care will be unmasked and intolerable.

WE SHOULDN'T HAVE TO TELL OUR CHILDREN THAT THEY WON'T LIVE AS LONG AS WE WILL. It is almost unfathomable that with our nation's wealth and technological prowess, our children face shorter life spans than we do. But that is what current trends predict.¹⁷ Rising rates of obesity and diabetes are just part of the brick wall being placed in the path of longevity for future generations of Americans. We must reverse this trend. Our policies must take into account the overall health of populations as well as the health of each individual.

HEALTH IN ALL POLICIES. Health is fundamental to every sector of our economy. Recent research has shown that many factors outside of health care have a huge impact on health.¹⁸ From agricultural policy that influences the food on our dinner table to environmental decisions that put us at risk for disease, every choice we make brings us closer to, or moves us further from, our national health goals. Therefore, every policy, large and small, and every decision, personal and political, should take into consideration its impact on health. No compromise should be reached without analyzing what we have termed its "health footprint."

For more information on any of the Aspen Health Stewardship Project principles, visit the project website, where a series of backgrounders with accompanying references is posted.^{*}

^{*}www.AspenHealthStewardship.org. See "Principles." Used with permission.

III. American Attitudes on Health Stewardship

Across the nation, from Anchorage, Alaska, to Zion Hill, Texas, Americans agree that fundamental health care reform is needed in the United States. And, not surprisingly, they have some ideas on what it should incorporate.

In May of 2008, the Aspen Health Stewardship Project commissioned Zogby International, one of the nation's leading public opinion research firms, to conduct a national poll to gauge American attitudes on health stewardship and the types of reform that people deemed necessary.⁷ The poll findings revealed that Americans overwhelmingly agreed with the stewardship principles.

Not all of the principles could be directly translated into poll questions, but the survey nonetheless incorporated the themes underlying the principles, presenting questions designed to shed as much light as possible on American attitudes about related issues and congruent subject matter.

The vast majority of those surveyed called for major reform of the U.S. health care system. To a great extent, when Americans report that they want fundamental reform, they align themselves with the very foundations of the stewardship project. (See Table 1.)

* The online survey of 8,218 people was conducted May 1-5, 2008. A sampling of the adult population of the United States was invited to participate. Slight weights were added for region, age, race, gender, religion and political party affiliation to more accurately reflect the population. The margin of error was 1.1 percent. To download a free copy of the poll report, titled "Transforming Health Care: American Attitudes on Shared Stewardship," visit www.AspenHealthStewardship.org.

TABLE 1: Agreement with the Stewardship Principles

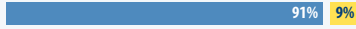
To what extent would you agree or disagree with the following statements:

AGREE **DISAGREE**

I am in charge of my health...I determine my health and well-being more than anybody else.



How long I live a healthy life is more important than longevity.



We must strive for equity in health.



We should not have to tell our children that they won't live as long as we will.







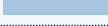



SOURCE: Aspen Health Stewardship Project/Zogby International Survey, May 2008

For instance, with regard to the principle “I am in charge of my health,” 93 percent of those polled said they either strongly agreed or somewhat agreed with the assertion that “by making healthy choices, by reading the labels on my medicines and by asking my doctors questions about the treatments they prescribe, I determine my health and well-being more than anybody else.” Similarly, clear majorities agreed with the health stewardship principles relating to equity, health span, and children’s health. The opinions expressed were largely consistent across racial and ethnic groups, age categories, geographic locations, and other demographics.

While not all Americans are steeped in the workings of the health care system, they nonetheless grasp its key failings, the survey showed. Many of the poll findings demonstrated a broad understanding of the need to place greater emphasis on prevention and the failure of insurance alone to provide health security, threads that run through all of the principles.

Asked how they would measure success in reforming the health care system, those polled indicated the desire for much more than acute treatment and chronic disease management. Primarily, they wanted increased preventive health care and access to more affordable health insurance. (See Table 2.)

TABLE 2: Defining Success in Health Care Reform

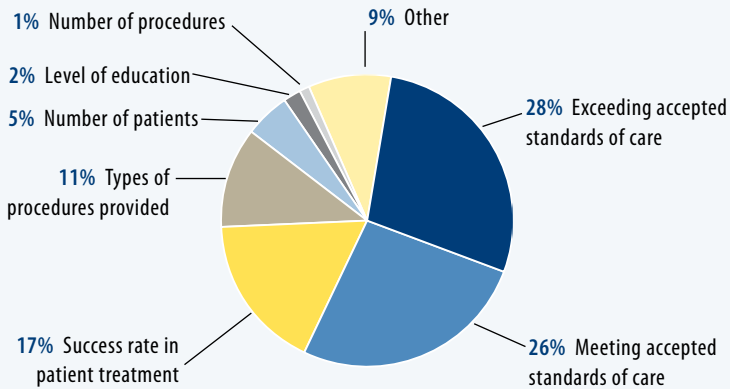
PRIORITIES	%	
Providing preventative health care to all Americans	48	
Having access to more affordable health insurance	47	
Protecting Americans from cost of catastrophic illness	38	
Keeping as many Americans as healthy as possible	29	
Having access to better quality health care	28	
Having health insurance	22	
Other	12	
No reform is needed	9	

SOURCE: Aspen Health Stewardship Project/Zogby International Survey, May 2008

Of course, Americans have long viewed the quality of health care in the United States as among the best the world has to offer. Of those polled, the majority (69 percent) rated the quality of health care in our country as excellent or good. But nearly half of all respondents (48 percent) also said they had suffered or knew someone who had suffered an illness, injury or death that they believed could have been prevented by better health care.

Americans want high quality health care but also better value. And many want payment to be linked to quality of care. Interestingly, strikingly few polled said doctors should be paid in the way that they are currently compensated, namely by the number of patients they see, the types of procedures they provide, and/or the number of procedures they carry out. By comparison, far more people expressed the opinion that provider compensation should be based on meeting or exceeding accepted standards of care. (See Table 3.)

TABLE 3: Basis for Physician Pay



SOURCE: Aspen Health Stewardship Project/Zogby International Survey, May 2008

The American people favor increased transparency in the U.S. health care system. Seventy-nine percent of those polled thought that hospitals should be required to publicly report the success rates of treatments given to patients, and 73 percent indicated they believed that doctors should be subject to the same public reporting requirements. Such reporting would encourage improvements to the U.S. health care system by enabling providers to benchmark their performance against others and by giving patients the information they need to make informed choices.

And, when it comes to choices, Americans believe that people should be given incentives to make the right ones for the sake of good health. The opposite, however, is not true. Most of those surveyed indicated that they did not believe that people should suffer any financial penalty for making unhealthy choices or for otherwise being unhealthy. (See Table 4.)

TABLE 4:

Personal Responsibility, Accountability in Health Care

To what extent would you agree or disagree with the following statements:

■ AGREE ■ DISAGREE

Americans who make poor health choices should be held responsible for them.

78% 22%

We should establish financial incentives such as lower health insurance premiums, deductibles, or co-pays to help people adopt healthier lifestyles.

80% 20%

We should assess financial penalties for Americans who fail to improve their health.

29% 71%

If unhealthy behavior is fined, exceptions should be made for family predisposition.

64% 36%

Americans with unhealthy lifestyles should pay more for health care.

58% 42%

We should restrict foods sold in schools to healthy options.

80% 21%

Employers should be able to base hiring decisions on applicant's health.

29% 71%

SOURCE: Aspen Health Stewardship Project/Zogby International Survey, May 2008

Taken together, the findings in Tables 3 and 4 suggest not only that Americans are dissatisfied with the way they pay for health care but also that they don't want to subsidize their neighbors for living less healthy lifestyles. All Americans have a financial stake in their neighbors eating healthy and exercising regularly, whether they realize it or not. If such a perspective is widely adopted, it could facilitate a cultural change in the same way that secondhand smoke prompted people to realize that they had a stake in their neighbors' smoking behavior.

The poll was commissioned with the intention that its results could inform the national dialogue on health care reform and help policymakers seeking to chart the wisest course in improving our nation's system of care. It makes clear that Americans realize the distinction between providing more medicine and achieving better health. Furthermore, it suggests that many people are prepared to act as stewards — to make the personal and financial hard choices needed to reach our health goals.

iv. The Limits of Reform without Stewardship

Prior reform efforts have held great promise, some among them inspiring hope on the part of families struggling to afford health insurance and business owners pressed to control costs. Even so, the clear majority of all efforts have failed to win approval or fallen short of expectations. Critical shortcomings have precipitated these failures.

Among the biggest problems of past reform efforts has been the tendency to place the burden of change primarily on the shoulders of just one of the players, whether it be health care providers, health insurers, pharmaceutical companies, government or consumers. Unfortunately, these efforts typically imposed new obstacles to good health care and additional costs without providing corresponding benefits.

For example, managed care, emboldened by the enactment of the Health Maintenance Organization Act of 1973,¹⁹ gave health insurers the authority to set the nation's health care priorities but failed to offer incentives to patients or physicians.²⁰ The approach rewarded health insurers for creating administrative structures that presided over treatment decisions and focused on cost containment — but not on health. In theory, managed care made primary caregivers the gatekeepers of treatment, but these caregivers were not consistently supported. It soon became apparent to patients and physicians that health insurers were the ultimate decision makers, and resistance to the authoritarian role of insurers was swift and intense. Physicians and patients quickly recognized that managed care was a system in which some types of care were readily available while others were hard to come by or non-existent. Despite its shortcomings, managed care has yielded progress in important respects, such as the introduction of predetermined co-payments so people know ahead of time how much they must pay out-of-pocket for services. Ultimately, though, managed care, by itself, is not an adequate solution for the very reason that it exerts downward pressure on the quality of care.²¹

More recent initiatives, centering on evidence-based medicine and “pay-for-performance,” have also propagated the culture of control through administrative management of health processes and delivery. The idea of basing health care on the evidence of what works best is eminently logical and needed. But the further that evidence-based medicine moved toward mandating administrative routines versus promoting quality health care, the more it repeated the mistakes of managed care. Pay-for-performance has become pay-for-participation in process. It focuses only indirectly on improving health and fails to reward innovations that actually reduce the need for care or improve long-term outcomes. Our nation will not attain the health improvements we seek through administrative control of physicians locked into the current organizational structures and mindsets. In like manner, we will not fully achieve the needed improvements by moving the locus of control from the health insurer to the employer or the government. Shifting power, rather than sharing it, is a fundamentally flawed approach.

Other reform proposals have targeted administrative simplicity through proposing a government-sponsored single-payer system. Such a change could streamline the way providers interact with insurers. Even so, the inefficiency of the web of Medicare intermediaries

would soon overwhelm any modest gains.²² As the only payer, the government would have more bargaining power than health insurers or employers have now. However, this increase in power and responsibility similarly would increase the temptation to pursue rationing and managed care. Proponents of a single-payer system assume that the government, as a good steward, will resist this temptation and work to improve care. But the debate about whether replacing the current patchwork of plans with a new government bureaucracy would increase or decrease managed care and rationing fails to address the heart of the matter: namely, who will ensure the good health status of the population.

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-PRESIDENT OBAMA

The critical question of how to improve health and the health care system is not addressed by changing who pays. In short, a single payer would be a change, but it is not a solution. Even with a single payer, the nation would need health stewardship by providers of care, the government, individuals, and all other actors in the system if it is to produce change that improves the nation's health, rather than just contain short-term costs.

Alternatively, calls for consumer-directed care place much of the onus of reform on patients and families. Such initiatives assume that consumers take action on an informed basis and that engaged patients can directly change the health care system.²³ The logic underlying this type of reform is that, with appropriate and sufficient information on clinical results and the price of care, consumers will use market power to reward the best clinicians and punish the worst. To proponents, enhancing individual responsibility is the ultimate health stewardship solution. And yet, individual responsibility alone will not lead to a comprehensive solution. Consumers must take charge of their own health, but they cannot bring about many of the needed changes absent other forces, such as the restructuring of the payment and care delivery systems. Currently, they simply lack the leverage.

A common denominator of many past reforms is that they failed to address and ultimately perpetuated the culture of control in the health care system, which includes efforts to govern referrals, medications, frequency of use of medical services, and physician and patient choice. Even so, efforts at control have been largely ineffective. Those who enact or reinforce controls have not only failed to contain costs, but also, in many cases, eroded the trust of the very people they think they are serving. To regain that trust, the various stakeholders must broaden the reform discussion and embrace the concept of health stewardship.

Prior reform initiatives have not transformed our health care system, but they have shed light on what doesn't work and imparted insights on what our present circumstances require. It is incumbent upon us to learn from those efforts and take the next step.

v. Pursuing Value Through Early Health

Sustaining health calls for more than treatment. It also requires a strong focus on prevention, early and accurate diagnosis, early-stage treatment and interventions to arrest the progression of chronic disease. Our nation cannot treat its way out of poor health. Late-stage interventions are far more expensive than prevention, and often they yield lesser results.

Treatment associated with seven chronic conditions (cancers, diabetes, heart disease, hypertension, stroke, mental disorders and pulmonary conditions) cost the United States \$277 billion in 2003.²⁴ That same year, those seven conditions also exacted a price in lost productivity that exceeded three times their treatment costs, according to research on absenteeism and diminished work capacity.²⁵

Many chronic disease conditions are preventable and can be managed effectively at modest expense. Identifying the early onset of disease and taking action to mitigate risk factors and symptoms are critical strategies for effecting favorable patient outcomes. A recent study of patients from 18 to 30 years of age demonstrated that those with borderline high blood pressure were already developing symptoms of heart disease and were at significantly greater risk of heart attacks and strokes later in life.²⁶ The answer for such patients is not better treatment after strokes or heart attacks, nor is it medication. Not surprisingly, the best solutions are lifestyle modifications, including diet, exercise and smoking cessation, numerous studies make clear.^{27, 28, 29}

Obesity, too, is largely preventable. One of the biggest threats to public health in the United States, obesity remains a failure of health stewardship at the family and societal levels. Among minority populations in this country, the numbers of children suffering from obesity are especially alarming. In 2006, the Centers for Disease Control and Prevention reported that 22.9 percent of non-Hispanic black boys from 12 to 19 years of age were obese, as were 21.1 percent of

Mexican-American boys in the same age category. The CDC data also showed that 27.7 percent of non-Hispanic black girls and 19.9 percent of Mexican-American girls of the same ages were obese.³⁰ Obesity affects children's quality of life, limiting them on the playground, impeding their school functioning and undermining their self-esteem. Among overweight children ages 5 to 17, an astounding 60 percent have one or more risk factors for heart disease, such as high cholesterol, high blood pressure or abnormal glucose tolerance.³¹ The cost of inaction is high. Between 1979 and 1999, hospital costs related to obesity increased almost four-fold (from \$44 million to \$160 million in 2006 dollars) for children ages 6 to 17.³² And, being overweight as a child dramatically increases the likelihood of poor health in adulthood.³³ Recent estimates predict that the growth in childhood obesity will cause more than 100,000 additional cases of heart disease per year in the United States by 2035.^{34,35} These concerns also extend to adult obesity. As adults continue to gain weight over the course of their lives, they increase the risk of progressing to each next chronic disease (i.e., from obesity to diabetes, to heart disease, to cancer). American adults on average gain one to two pounds each year. The link between obesity and chronic disease has two big implications. First, obesity rates are a good marker of the nation's health. And second, by addressing the root causes of obesity, namely lifestyle, our nation could impact most chronic diseases.³⁶ No generation wants to be the first to tell its children that they will have shorter and less healthy lives than their parents. The mandate for viewing health differently is clear, and its urgency becomes magnified when looking to the future of children.

Health stewardship suggests a fundamental change in thinking about health, away from a single-minded focus on treatment to a much more comprehensive view of healthy living, including the concept of health span. Increasing life spans over the last century have masked the

**"I WILL WORK WITH SCHOOLS TO CREATE MORE HEALTHFUL ENVIRONMENTS FOR CHILDREN. I WILL WORK TO GET JUNK FOOD OUT OF VENDING MACHINES IN SCHOOLS AND IMPROVE NUTRITIONAL CONTENT OF LUNCHESES THROUGH FINANCIAL INCENTIVES, INCREASE GRANT SUPPORT FOR PHYSICAL EDUCATION, EXPAND FEDERAL REIMBURSEMENT FOR SCHOOL-BASED HEALTH SERVICES, AND PROVIDE GRANTS FOR HEALTH EDUCATIONAL PROGRAMS FOR STUDENTS."
-PRESIDENT OBAMA**

reality that people are not necessarily living well. The length of time a person may anticipate living in good health, their health span, has been subsumed by the quest for a longer life span.

Emblematic of the country's treatment-oriented culture is the fact that 12 percent of all U.S. health care spending and 27 percent of all Medicare spending is incurred for the treatment of people in their last year of life.³⁷ Additionally, while pain management and other treatments ease suffering and help people die with dignity, it has been shown that as much as 30 percent of Medicare spending for people during their last two years of life is largely inefficient and does nothing to improve patient health.³⁸ Our nation must not cease trying to provide the best possible care for the poorest and sickest among us. And yet the focus on and resources devoted to end-of-life care — among all other types — must be considered in light of our need to emphasize prevention and effective disease management.

One can see compelling evidence of the effectiveness of health stewardship when examining the differences in end-of-life care between those who enter later life healthy and those who do not. Studies show that people who die older and who were healthy as older adults spend less on end-of-life care than those who die following prolonged illness or after battling multiple chronic conditions.³⁹ In large measure, people who lived in good health into their later years, the healthy aged, die having endured fewer chronic diseases. They suffer from fewer health complications, and they and their families tend to be more accepting of death and seek fewer expensive, life-prolonging treatments that would have been futile. Health stewardship and good health are less costly than poor health.

Early detection, accurate diagnosis and rapid treatment of disease dramatically improve health and create value, but the transition to their increased use is fraught with challenges. Unfortunately, the current health care system typically delivers only episodic, not comprehensive, care. Early detection requires more preventive care and screening, which is generally underemphasized and without economic incentives in the current health care system, even for people with insurance coverage. And, when diagnoses are inaccurate, they render

the care on which they are based ineffective and risky for the patient, while wasting precious resources. Additionally, lack of coordination among clinical teams often imposes on patients and their families the responsibility to navigate the system of care, coordinate tests and align the efforts of disparate medical specialists. It's a lot to ask of people.

The change in perspective that stewardship entails invites innovation across the health care spectrum. For example, improvements in prevention, diagnosis, and early stage treatment could result from innovation in medical science, in the reorganization of health care delivery, or in technological modernization, particularly in the form of health information technology. As clinicians and suppliers turn their efforts to becoming stewards, they will encounter the necessity to improve information systems that will foster learning and, ultimately, facilitate care.

Everyone benefits from a system that emphasizes early detection, accurate diagnosis and rapid treatment of disease by clinical teams coordinated over the full cycle of care. Patients realize better health, better quality of life and less time lost to illness and injury. Physicians benefit because better health and care outcomes mean that they more efficiently and effectively achieve their mission of healing the sick and injured. Businesses benefit because a healthier workforce is more productive and less expensive to insure. There is wide agreement on the latent power of prevention and early health models to improve health and increase value for patients, families, employers and society, and yet our nation has made only modest advances in this direction. In striving to make such inroads, government can — and should — play a leadership role.

VI. Government Roles in Stewardship

Elevating health stewardship to the level of national priority and facilitating its introduction into the health care system are fitting roles for government — and roles that it alone can play. Individuals cannot realize many of the needed changes unaccompanied by structural improvements to the system. Neither can they meaningfully take charge of their own health without coverage and the information one would need to make the best choices. Similarly, businesses and providers seeking to become better stewards of health often find themselves swimming up financial and regulatory streams. Government, though, has both the ability and authority to make systemic changes. Working together, federal and state governments can facilitate stewardship by making, at a minimum, four critical improvements:

- Ensuring access to affordable care
- Enhancing health infrastructure, including health IT infrastructure
- Combating institutional barriers to reducing health disparities
- Examining the health impact of all policies, not just health policies

Ensuring access to affordable care

Ensuring that every American has access to affordable health insurance must be regarded as one of government's essential responsibilities. The lack of affordable insurance precludes effective health stewardship for tens of millions of Americans and needlessly increases health care costs.^{40,41} Replete with coverage gaps, the nation's existing health insurance system imposes financial strains on physicians and health care providers that promote inefficiency and trigger illogical cost reallocations. Federal and state governments will need to collaborate to ensure that all Americans are able to access the health care system and that the care they receive is not only comprehensive but adequately compensated.

The fact that nearly 50 million Americans, or 16 percent, lack health insurance is an oft-cited statistic,^{42, 43} but less well known are the consequences of these people not receiving preventive and early stage care. Typically, the uninsured wait to seek care until they have succumbed to an advanced stage of illness, meaning it is both more acute and expensive to treat. Their recoveries are prolonged, their productivity compromised and their quality of life diminished. Uninsured patients are also more likely to seek care in expensive health care facilities such as emergency rooms, compounding the costs of treating their conditions and exacerbating the problems associated with poorly coordinated care. Many providers that care for the uninsured are not able to collect payment for their services and are not able to absorb the cost of uncompensated care. They often attempt to transfer the cost elsewhere.

The nascent statewide effort in Massachusetts, based on the health care reform law enacted in the Commonwealth in 2006,⁴⁴ demonstrates that universal access is politically feasible. Universal access addresses the major problems that undermine the current system of care. It promotes effective stewardship by enabling everyone to take part in prevention, diagnosis and early treatment programs, as well as chronic disease management and long-term care that reduce the economic consequences of disease. Access also provides payment for every patient's care, thus reducing provider cost-shifting and other economic distortions. But to make certain that no state carries an inequitable burden in ensuring care, nothing short of federal government support for universal access is required.

Enhancing health infrastructure, including health IT infrastructure

Health stewardship depends on good information. Knowing what works and what doesn't, what needs to improve, where value is created and where it is squandered are all prerequisites to effective health stewardship. Such information must be accessible to health care providers, consumers, suppliers, payers and government. The Agency for Health Research and Quality (AHRQ) and the Institute of Medicine (IOM), working on parallel tracks, have carried out

pioneering work to improve the quality, effectiveness and safety of health care and, more broadly, to bolster the health of the American people. The federal government can encourage further progress by expanding the work of AHRQ and IOM to provide clinicians access to information about what treatments and processes are most effective and which provider teams are achieving excellent results.

Measuring health outcomes sheds light on what needs to improve and how to improve it. Such measurement is a vital component of transparency, giving clinical teams the ability to understand when and how they best facilitate good health outcomes, and when and how they may inadvertently cause medical errors. Historically, government mandates and private-sector initiatives have fostered the measurement of health outcomes, with the resulting information often put to good use. For example, such measurements have helped providers gain insight into, and improve the treatment of, patients with cystic fibrosis, infertility, some types of heart disease, pediatric cancers, diabetes, and certain conditions requiring organ transplants.

Government efforts to measure health outcomes spur the private sector to expand the scope and increase the sophistication of the measurements themselves. To satisfy a legal mandate, health care providers in New York and Pennsylvania began publishing mortality data on heart surgery. Recognizing that multi-faceted outcome measures were significant, while simple measures of mortality were misleading, the Society of Thoracic Surgeons committed to developing more robust, multi-dimensional measures of heart surgery.⁴⁵ Those efforts have continued to expand and are leading to measures of a broader scope of care for cardiac medical conditions involving cardiology and surgical teams. Large patient registries and databases have become a powerful method to understand dissemination of technology and appropriateness of care across geographical regions as well as a repository for new biomedical markers that can help better define disease both within individuals and across populations.

Similar evolutions from minimal outcome measures mandated by government to more comprehensive and sophisticated private sector measures have occurred in the areas of transplant medicine, in vitro

fertilization and dialysis. The lesson to be learned is that the reliance on outcome measures fosters improvement of patients' health, as well as of the measures themselves, presuming that what is learned is applied. Outcome measures are not merely report cards for physicians and hospitals. They hold great potential to catalyze innovation and health stewardship.

Electronic medical records are another opportunity lying in wait. Recognizing the promise that such records hold to increase safety and reduce costs over the long term, President Barack Obama included \$19 billion in his financial stimulus package, which Congress passed in February. The measure comes not a moment too soon. It is clear that our nation has reached a point where the lack of electronic medical records hurts every aspect of our health care system. It means that doctors and nurses cannot easily track the progress of their patients, cannot readily recall which medicines have worked for them, cannot automatically ensure that they don't prescribe medicines contra-indicated for their patients, cannot follow their patients' test results electronically regardless of where and when they were captured, cannot get help in making sure that they are following the most up to date protocols for their patients and, most importantly, cannot collaborate with their patients online in a way that is integrated with the patient-controlled personal health record.

It also means that we, as a nation, cannot learn in aggregate what is working for whom and what are the most cost-effective strategies for optimal outcomes, let alone push this learning back into the system as it is acquired.

To address the shortcomings, the federal government must take the lead in developing a mutual incentive system in which health care providers are rewarded for using electronic medical records on behalf of their patients and patients are rewarded for acting as stewards of their health by working collaboratively with their health care providers. Such a system should reward both parties more for good outcomes than bad or

"I WILL ALSO PHASE IN REQUIREMENTS FOR FULL IMPLEMENTATION OF HEALTH IT AND COMMIT THE NECESSARY FEDERAL RESOURCES TO MAKE IT HAPPEN — INCLUDING INCENTIVES FOR PROVIDERS TO FULLY SHARE THIS INFORMATION IN A SECURE MANNER... I WILL ENSURE THAT PATIENTS' PRIVACY IS PROTECTED."

-PRESIDENT OBAMA

neutral ones. It also should insist that only electronic medical records that support online data sharing with patient-controlled personal health records and online communication/collaboration with patients are the ones that receive the incentives. That way, both parties have an incentive to use electronic medical records integrated with personal health records and thus share the inducement to improve patients' overall health.

Concerns have been raised about security and privacy. The apprehensions are best addressed by adhering to a simple rule: Let patients control what data they choose to share with whom and mandate that personal health records that integrate online with electronic medical records comply accordingly. Furthermore, electronic medical records and personal health records both should be required to be stored with all data encrypted.

Combating institutional barriers to reducing health disparities

There is a crying need in the United States to strive for equity, not just in health insurance coverage, but also in health status. Studies by AHRQ,⁴⁶ IOM,⁴⁷ the Commonwealth Fund⁴⁸ and the Henry J. Kaiser Family Foundation,^{49,50} among other organizations, have demonstrated that the disparities plaguing the U.S. health care system are broad and pervasive. In a 2003 report on disparities, the IOM observed that the majority of health inequality studies found that racial and ethnic health disparities persisted even after adjusting for access to care and socioeconomic differences.⁵¹ Health stewardship calls for a focus on eliminating health disparities, which increased outcome measurements can help facilitate. As disparities become increasingly transparent among those directly impacted and the public at large, social and political pressures will compel clinical teams and communities to work to correct these inequities.

Health disparities among racial and ethnic groups are especially marked when it comes to chronic diseases. Hispanics in the United States are one and a half times more likely to have diabetes than are whites.⁵² Similarly, African-Americans are at higher risk for diabetes, hypertension⁵³ and asthma⁵⁴ than whites or Hispanics. And, in 2005,

heart disease accounted for 23 percent more deaths among African-American adults than white adults.⁵⁵

Disparities arise in connection with treatment, health and disease screening and other interactions with the health care system. According to a study of Medicare managed care enrollees commissioned by The Commonwealth Fund, significant racial disparities were found in rates of eye exams for diabetic patients, beta blocker use among cardiac patients and mental illness follow-up.⁵⁶ The results were largely unchanged even after adjusting for the age, gender, income, education, place of residence (rural vs. urban), Medicaid insurance status and type of health plan of the patients.

Heart disease is a locus of health disparities, and it finds expression within gender and race. Women are less likely than men to receive diagnostic or invasive cardiac procedures and experience worse outcomes following a cardiac artery bypass graft or a percutaneous coronary intervention (formerly called angioplasty). Furthermore, women's health, on average, is allowed to decline to a greater extent than men's before they receive revascularization procedures, such as those to restore blood flow to blocked arteries.⁵⁷ Across both genders, African-Americans are much less likely than white Americans to receive cardiac care to preserve brain function after a stroke as well as diagnostic and revascularization procedures to detect or repair damage from coronary artery disease.⁵⁸ These gender and racial disparities contribute to the growing incidence of heart disease.

Disparities also exist among populations of women with regard to testing and treatment. Against a backdrop of 20 years of modest overall improvements in breast cancer survival rates for women diagnosed with advanced-stage disease, the disparity in survival rates between white and African-American women continues to increase, despite a small improvement in the survival rate for African-American women.⁵⁹

In addition to gender, race and ethnicity, language plays a significant role in health disparities. Medicare beneficiaries with limited English proficiency have reduced access to traditional sources of care and are

less likely to receive preventive cancer screenings.⁶⁰ Because Medicare beneficiaries generally have similar health care plans and economic backgrounds, this difference is particularly striking. Language facility can dramatically impact people's ability to be effective stewards of their health by limiting their knowledge about access to care, their ability to communicate with health care providers and their ability to follow through on treatments. Health agencies and clinics can do their part to combat disparities attributable to language by hiring bilingual doctors and nurses or professional interpreters.

Despite initiatives to increase the use of telecommunications in medicine, called telehealth initiatives, and an array of private-sector initiatives to improve care in rural areas, Americans in rural settings suffer a variety of health outcome disparities.⁶¹ Small, critical-access hospitals in remote or rural areas typically lack many of the resources, technology and care available in urban, academic medical centers.⁶²

Disparities exist within the lack of shared information on health care. A frequently overlooked benefit of comprehensive outcomes measurements is that they reveal these disparities. Physicians and other health care providers, when made aware of specific outcome disparities among their patients, are empowered to address the causes of those disparities and to reduce their frequency.

Similarly, patients who become aware of disparities are empowered to address them rather than simply be silent and unknowing victims.

While all of the system's actors must do their part, government has the most critical role in the reduction of health disparities. In addition to facilitating outcome measurements, government must bear the responsibility to ensure that no groups encounter undue barriers when trying to get the care they need, and that all patients receive the same high quality of care delivery.

**"MY PLAN WILL REQUIRE HOSPITALS, HEALTH CARE PROVIDERS AND INSURERS TO REPORT QUALITY OUTCOMES TO THE GOVERNMENT AND THE PUBLIC SO THAT THE AMERICAN PEOPLE, HEALTH CARE PROFESSIONALS, CONGRESS AND THE WHITE HOUSE CAN MONITOR THE PROGRESS OF THE NATION'S HEALTH CARE SYSTEM IN DELIVERING HIGH-QUALITY CARE TO EVERY AMERICAN."
-PRESIDENT OBAMA**

Examining the health impact of all policies, not just health policies

Myriad factors affect health, including people's living and working conditions and the natural and built environments that surround them. That being the case, government must not limit its interventions to the health care system. Looking beyond the traditional boundaries of health care, federal and state governments should strive to suffuse all policies and programs with the principles and practical elements of health stewardship. Policymakers and business leaders must contemplate the health consequences of all decisions, both short and long term.

"I WILL TAKE STEPS TO ENSURE THAT MY NON-HEALTH POLICY DECISIONS ARE COMPATIBLE WITH MY GOAL OF IMPROVING THE HEALTH OUTCOMES OF ALL AMERICANS."
-PRESIDENT OBAMA

Environmental policies that promote health are an obvious first step. Environmental policy, for example, affects health in ways that are well documented, such as the demonstrated relationship between outdoor air pollutants and asthma. Oil refineries, power and chemical plants, and diesel engines all emit particulates that, together with certain pesticides, are known to trigger asthma. Interventions such as reducing downtown traffic congestion in Atlanta during the 1996 Olympic Games decreased traffic density and reduced ozone pollution in the metropolitan region, temporarily lowering instances of childhood asthma there during the period of the Games.⁶³

The United States spends roughly \$55 billion each year to treat children with diseases attributable to environmental factors.⁶⁴ A stunning \$43.4 billion in such expenditures result from lead poisoning.⁶⁵ Food, marketing, housing and environmental policy can reduce the threat to children posed by high levels of this metal. Building on prior government efforts, the Department of Health and Human Services has called for the total elimination of elevated blood lead in children by 2010.⁶⁶ Strict enforcement of lead abatement statutes yields enormous dividends from both health and financial standpoints. While the costs of abatement may seem high, the costs society would bear without intervention may be far higher.⁶⁷

Sensible agricultural, food and nutrition-related policies can have a positive impact on people's diets and, as a consequence, on their health. Conversely, a lack of access to affordable, healthy food choices in neighborhood food markets can have a negative effect on diets. Each additional supermarket in a neighborhood, for example, can increase a person's intake of fruits and vegetables by 32 percent.⁶⁸ Access to a supermarket also reduces the fat intake of residents in a neighborhood relative to those in neighborhoods without such markets.⁶⁹ Restaurant labeling and food restriction legislation also can impact healthy food choices and portion sizes. For example, New York City recently banned all trans fats at restaurants and instituted food labeling guidelines. Efforts such as New York's serve as a learning laboratory and could provide essential information on the best ways to curb the obesity epidemic.⁷⁰

Community planning choices, too, have long-term effects on health. Sidewalks, jogging trails, safe bike paths and parks encourage physical activity. Higher rates of walking and cycling in European countries result in much lower rates of obesity, diabetes and hypertension compared to corresponding rates in the United States.⁷¹ And, in countries with significantly lower rates of obesity, the average healthy life expectancies are 2.5 to 4.4 years longer than in the United States, despite those countries spending only about half the amount of money on health per capita as the United States.⁷²

Finally, social policy has the potential to affect health. Behaviors such as smoking, which is widely known to diminish health, can be influenced by a variety of factors and policies, including tax, agriculture, clear labeling and marketing restrictions. In 2006, almost 21 percent of adults over the age of 18 smoked regularly.⁷³ That year alone, smoking-related illnesses imposed nearly \$90 billion in health costs on the country.⁷⁴ In May 2007, the Institute of Medicine made 15 recommendations to decrease tobacco use in the United States, including substantial increases in taxes on tobacco products, using the proceeds of the tobacco tax on health education and limiting tobacco advertising to text printed only in black and white.⁷⁵ Using these and other initiatives, consumer demand for cigarettes can be lowered while giving tobacco farmers incentives

to grow healthier crops or converting land to other uses.

In North Carolina, a growth in wineries has, in some cases, been attributed to an increasing number of tobacco farmers switching to grapes. With money from a tobacco buyout, farmers were paid to stop growing tobacco, and many turned their land to other purposes, including non-tobacco crops and livestock.⁷⁶

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THIS NATION.”
-PRESIDENT OBAMA

Health stewardship calls for government leaders to re-examine policies that harm the health of the American people. Effective health policy requires that health consequences be contemplated in all legislation, tax and fiscal policies, as well as in employment settings. Evaluating the impact on health, what we call a “health footprint,” can lead to safer and more healthful products as well as a cleaner, healthier environment, and can identify public policies and business practices that compromise health. Recognizing the effective application of environmental impact studies, we call on our nation’s leaders to make health impact studies a standard of the legislative and regulatory processes of government.

VII. Conclusion

Transforming health care in the United States is an urgent national priority, clearly recognized by President Barack Obama. It is important that reform be done right, but it should not be driven by fears that history will be repeated. The fact of the matter is that the nation has the capacity to make significant improvements relatively quickly and to make broad, systemic reforms over a longer time horizon. Ultimately, what matters most is that we, as a nation, effect improvements to the health care system that are smart and sustainable. Sustainability is the cornerstone of the stewardship approach.

Now is the ideal time to act. Meaningful economic stimulus will require not just rebuilding our national infrastructure, but making the sometimes painful investments to make American business more competitive. But any health care down payment will need to realign how each of us views our rights and responsibilities to make anything more than a dent in the coming wave associated with an aging population, the spread of chronic diseases into younger and younger Americans, and the rising cost of treatment. As the national dialogue continues and policy proposals are formulated, there remains the need for principles that encourage participation by everyone, principles that put the common interests ahead of the special interests. The bipartisan principles enunciated by the Aspen Health Stewardship Project address this need and speak to individuals, communities, providers, employers and health insurers. We urge policymakers to adopt these principles as their foundation and build upon them a healthier nation.

The stewardship perspective calls for all stakeholders to do their part to help bring about mutual benefit for all constituencies. Universal participation in this endeavor will result in the reaping of greater benefits. It is not within the scope of this paper to detail what the various constituencies can and must do to play their part. That being said, what follows offers a glimpse at the actions each party must undertake to create the momentum that none can achieve alone.

Individuals need to recognize that they have primary responsibility for their health and act upon the knowledge that they are their own best health care advocates. The individual's most vital role is to adopt a healthy lifestyle and to support others, particularly family members, to do the same. Across the nation, some Americans are hampered by genetics and others by socioeconomic challenges, and many by both. But this does not negate the fact that the vast majority of us can do a great deal more to improve our health.

Communities, including schools, local businesses, community organizations and municipal governments, can make immediate inroads by focusing on the relatively small changes that can significantly improve the health of their citizens. The public health community has been advocating many of these changes for years, including providing healthy cafeteria food, bike helmets and racks, sports programs and health education. Many organizations have already seen such small investments in fostering healthy lifestyles result in substantial savings through improved health, reduced incidence of disease, lowered worker absenteeism and heightened productivity. The next tier of improvements for communities includes such challenges as ensuring clean water, safe working environments, adequate public transportation, development that encourages people to walk or bike, and sufficient access to health services.

Providers have always thought of themselves as health stewards. But caring about patients and working long hours are not the full essence of stewardship. It also demands rigorous attention to health outcomes, preventing disease, improving communication and reducing poorly coordinated care. Additionally, it calls for innovation in the delivery of care, ensuring that practice is based on current evidence and not conventional wisdom, reducing errors and waste, and encouraging patient engagement and public health monitoring and interventions. Every provider can make adjustments or take additional steps to improve the health of patients.

Given that the pharmaceutical and medical devices and diagnostics industries account for 12.9 percent and 6 percent of U.S. health care costs, respectively, the manufacturers of these products must assume

their fair share of responsibility for the impact they have on health care.^{77,78} So in their role of driving biomedical research and innovation, as health stewards, manufacturers are obliged to take steps to measure and improve the value they create for patient health, particularly in slowing the progression and in fostering the prevention of disease over time. The stewardship perspective will also encourage health care innovation that will lead to more accurate and timely diagnoses, the appropriate utilization of services and patient selection to optimize outcomes, and the promotion of preventive and early stage treatments that allow less invasive treatments and fuller recovery with better quality of life.

Health insurers and employers can demonstrate stewardship by ensuring that medical benefits promote better health. The usual approach of managing a health insurance plan from a bottom-line perspective is shortsighted. By giving physicians more say in their patients' care and by promoting active patient involvement in their own health decisions, both providers and patients are empowered to work together to achieve the patient's optimal health. Ultimately, health insurance plans and employers must measure their success in this joint venture by the health status of the plan members.

The examples of health stewardship mentioned above are but a beginning. In the end, stewardship's self-reinforcing nature is its most important value. It enables ever-widening opportunities, with the actions of one constituent building upon those of others. Today, more than ever, we are faced with the reality that resources are in short supply. That being the case, stewardship also must involve not only a willingness to assume responsibility but also to sacrifice to achieve collective, national health goals. Addressing the nation during his inauguration speech, President Barack Obama framed the challenge by saying, "What is required of us now is a new era of responsibility — a recognition, on the part of every American, that we have duties to ourselves, our nation and the world, duties that we do not grudgingly accept but rather seize gladly, firm in the knowledge that there is nothing so satisfying to the spirit, so defining of our character than giving our all to a difficult task. This is the price and the promise of citizenship."

Health stewardship is achievable in our lifetime. There are many compelling reasons why we must make it an urgent and major priority, not the least of which is the economic urgency we now face. A bold turn towards stewardship will lead us to both better health for the American people and economic health for our nation. What is called for is nothing less than deep cultural change, which is never a sprint; rather, it is an evolution. This seismic shift will require a high level of commitment, unfailing courage, leadership, innovation and, most important, collaboration across ideological lines. The time to start is now.

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Appendices

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* Project Co-Chair

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THE ASPEN HEALTH STEWARDSHIP PROJECT QUESTIONNAIRE

Submitted to presidential candidate Barack Obama, February 2008

Responses obtained April, 2008

The Aspen Health Stewardship Project (AHSP) was established by the Aspen Institute in the fall of 2007, and as part of its charge, has created this questionnaire, which is intended for candidates to clearly explain their perspective on the American health care system, how they characterize its weaknesses, how they intend to reshape the system and how they plan to sustain their program.

Led by a diverse cross-section of national thought leaders, AHSP's work is an innovative, non-partisan effort to frame a more multi-dimensional health care dialogue by focusing on the long-term, fundamental issues that will need to be addressed in order to fix America's broken health care system. This effort seeks to educate voters about what it will take to achieve true reform. And, ultimately, it calls on the presidential candidates and policymakers to develop plans that will meaningfully address the barriers that are preventing the nation from successfully dealing with health care — our most pressing domestic problem.

A major premise of this project is that surmounting the many barriers will require changing a culture in health care that is designed to protect and perpetuate the status quo. The current system makes it difficult, if not impossible, for Americans to be thoughtful, active and responsible stewards of their overall health. Cultural change also will require a shift in the focus of the public dialogue. Only by reframing the health care debate from one focused on the symptoms of the country's broken system to one focused on causes, can the country have a more substantive discourse about the stewardship role each of us play in creating a healthier America.

Thank you for participating in this important process.

QUESTION 1

The United States spends more than any other nation on health care, both per capita and as a percentage of gross domestic product. Even so, in a recent study of 18 leading industrialized nations, the United States finished dead last for the number of deaths that could have been prevented through effective health care. **What three fundamental aspects of the country's health care financing and delivery model would you seek to change to create a more sustainable, just, and effective system?**

First, I believe that we need to ensure that all Americans have affordable and quality health insurance – 47 million Americans lack health insurance, and consequently the financial security they need to visit a primary care physician and proactively address improving their health. My plan will guarantee coverage for every American through partnerships among employers, private health plans, the federal government, and the states. My plan both builds on and improves our current insurance system, which most Americans continue to rely upon, and leaves Medicare intact for older and disabled Americans. Under my plan, Americans will be able to maintain their current coverage if they choose to, and will see the quality of their health care improve and their costs go down. My plan also addresses the large gaps in coverage that leave 47 million Americans uninsured. Specifically, my plan will: (1) establish a new public insurance program, available to Americans who neither qualify for Medicaid or SCHIP nor have access to insurance through their employers, as well as to small businesses that want to offer insurance to their employees; (2) create a National Health Insurance Exchange to help Americans and businesses that want to purchase private health insurance directly; (3) require all employers to contribute towards health coverage for their employees or towards the cost of the public plan; (4) mandate that all children have health care coverage; (5) expand eligibility for the Medicaid and SCHIP programs; and (6) allow flexibility for state health reform plans.

Second, I will work to improve the quality of health care by ensuring the health insurance plans cover essential services that improve health outcomes, including preventative care and chronic disease

management. Under my plan, the benefit package will be similar to that offered by the Federal Employees Health Benefit Program (FEHBP), the program through which Members of Congress get their own health care. The new public plan will include coverage of all essential medical services, including preventative, maternity and mental health care. Moreover, coverage will include disease management programs, self management training and care coordination for appropriate individuals.

Individuals will also be able to purchase separate private insurance as an alternative to, or as a supplement to, my plan's public component. There is no limit on what services these private plans will provide for, but the National Health Insurance Exchange will assure that every participating insurer provides a common baseline level of benefits that equals those provided by my new public plan.

Third, I will go after the runaway costs in the health care system. My universal health care plan will reduce medical expenditures by up to \$2,500 per family by not only providing universal health insurance coverage and increasing the quality of health insurance coverage, but also by making strategic investments to modernize our health care delivery system. My plan will invest \$10 billion per year for 5 years into deploying health care information technology, which will reduce unnecessary spending in the health care system that results from preventable errors and inefficient paper billing systems; increase insurance industry competition and reducing underwriting costs and profits, which will reduce insurance overhead; and provide reinsurance for catastrophic coverage, which will reduce insurance premiums.

QUESTION 2

Overall do you feel that the United States spends too much or too little on health care and why?

I feel the U.S. spends too much money inefficiently in our health care system, and it's necessary for the country to reform the health care system so we can ensure that all health care spending is spent to better the health outcomes of the American people. Today, about 100,000 Americans die from medical errors in hospitals every year. Prescription drug errors alone cost the nation more than \$100 billion every year. And

one-quarter of all medical spending goes to administrative and overhead costs, and reliance on antiquated paper-based record and information systems needlessly increases these costs.

QUESTION 3

When people talk about the need for health insurance, they often neglect to identify the real problem: improving the health of Americans. And health insurance rates alone do not tell us much about insurance type, affordability or quality of care. **Beyond the number of people with health insurance, how will you define and measure the success of your health proposals and their impact on health outcomes?**

My plan will require hospitals, health care providers and insurers to report quality outcomes to the government and the public so that the American people, health care professionals, Congress and the White House can monitor the progress of the nation's health care system in delivering high-quality care to every American. By establishing and monitoring a comprehensive "report card" for the various parts of our health care system, our nation will be able to identify and address flaws in the health care delivery system in a much more transparent and meaningful manner than exists in today's health care system.

QUESTION 4

While the country has a clear interest in improving the health of its citizens, the incentives built into the system do not seem to promote that desired outcome. For instance, physicians are sometimes reimbursed in a manner that rewards the volume of care delivered without regard for quality. **How would your proposals realign incentives to change how insurers, providers and patients view their respective rights and accountabilities for health?**

Unfortunately, in today's health care system, both public and private insurers tend to pay providers based on the volume of services provided, rather than the quality or effectiveness of care. I will accelerate efforts to develop and disseminate best practices, and align reimbursement with provision of high quality health care. Providers who see patients enrolled in the new public plan, the National Health Insurance Exchange, Medicare and FEHB will be rewarded for achieving performance thresholds on physician- validated outcome measures. Insurers will

be required to spend a reasonable share of money on health care, not outrageous administrative fees. And Americans will be asked to take personal responsibility for their health and make the right decisions in their own lives – if they eat the right foods, stay active, and stop smoking.

QUESTION 5

Creating value in health care is of paramount importance, however, in our current system misaligned economic incentives thwart efforts to achieve this end. **Please discuss how your plan will create and measure value to ensure it is a vital component in America's health care system. Be certain to include specific metrics and case examples.**

My plan will create a value-based approach within our current health care system based on proven health outcomes for various treatments and processes. One of the keys to eliminating waste and missed opportunities is to increase our investment in comparative effectiveness reviews and research. Comparative effectiveness studies provide crucial information about which drugs, devices and procedures are the best diagnostic and treatment options for individual patients. This information is developed by reviewing existing literature, analyzing electronic health care data, and conducting simple, real world studies of new technologies. I will establish an independent institute to guide reviews and research on comparative effectiveness, so that Americans and their doctors will have accurate and objective information to make the best decisions for their health and well-being, and the health care system can start to prioritize health care treatments in a meaningful way.

QUESTION 6

It is thought that as much as 40 percent of health care costs are related to behavior, such as smoking, eating an unhealthy diet, lack of exercise and alcohol consumption. At the same time, public health experts have shown that these choices are influenced by policy, the accessibility of healthy options, and corporate and social marketing. **How will you encourage healthy choices? How will you shape policy and incentives to encourage businesses to make choices that emphasize early health, wellness and prevention among their employees and customers?**

I believe that protecting and promoting health and wellness in this nation is a shared responsibility among individuals and families, school systems, employers, the medical and public health workforce, and federal and state and local governments. Each must do their part, as well as collaborate with one another, to create the conditions and opportunities that will allow and encourage Americans to adopt healthy lifestyles.

(1) EMPLOYERS An increasing number of employers are offering worksite health promotion programs and many employers choose insurance plans that cover preventive services for their employees. I believe that worksite interventions hold tremendous potential to influence health and will expand and reward these efforts.

(2) SCHOOL SYSTEMS I will work with schools to create more healthful environments for children. I will work to get junk food out of vending machines in schools and improve nutritional content of lunches through financial incentives, increase grant support for physical education, expand federal reimbursement for school-based health services, and provide grants for health educational programs for students.

(3) WORKFORCE I will expand funding – including loan repayment, adequate reimbursement, grants for training curricula, and infrastructure support to improve working conditions – to ensure a strong workforce that will champion prevention and public health activities.

(4) INDIVIDUALS AND FAMILIES The way Americans live, eat, work and play have real implications for their health and wellness. My plan will require coverage of essential clinical preventive services such as cancer screenings and smoking cessation programs in all federally supported health plans, including Medicare, Medicaid, SCHIP and the new public plan. In addition, I will increase funding to expand community based preventive interventions to help Americans make better choices that can help ward off chronic and preventable diseases and improve their health.

(5) FEDERAL, STATE, AND LOCAL GOVERNMENTS The federal government and state and local governments play critical roles in disease prevention and health promotion activities. First, working together, governments at all levels should develop a national and regional strategy for public health that includes funding mechanisms for implementation.

Second, the field of public health would benefit from greater research to optimize organization of the 3,000 health departments in this nation, collaborative arrangements between levels of government and its private partners, performance and accountability indicators, integrated and interoperable communication networks, and disaster preparedness and response. Third, the government must invest in workforce recruitment as well as modernizing our physical structures. And finally, the government must examine its own policies, including agricultural, educational, environmental and health policies, to assess and improve their effect on public health in this nation. As president, I will prioritize all of these activities to strengthen prevention and public health.

QUESTION 7

Simply having access to health care is not enough to achieve equity in health outcomes. Income level, race, gender and location are just a few of the factors that contribute to the health of Americans. For example, women are less likely to receive the cardiac care that they need and on average have outcomes worse than men. **How would your health care system promote greater equity of health outcomes among men and women of different races, income levels and geographic locales including, but not limited to, access to traditional insurance?**

I will tackle the root causes of health disparities by addressing differences in access to health coverage and promoting prevention and public health, both of which play a major role in addressing disparities. I will also challenge the medical system to eliminate inequities in health care by requiring hospitals and health plans to collect, analyze and report health care quality for disparity populations and holding them accountable for any differences found; diversifying the workforce to ensure culturally effective care; implementing and funding evidence-based interventions, such as patient navigator programs; and supporting and expanding the capacity of safety-net institutions, which provide a disproportionate amount of care for underserved populations with inadequate funding and technical resources.

QUESTION 8

With the right information at their disposal, consumers could take greater charge of their health, wellbeing, and illness. **To that end, what will you do to ensure that health information is readily accessible, meaningful, and accurate so that it helps people make decisions and take action?**

My plan will require hospitals, health care providers and insurers to report quality outcomes to the government and the public so that the American people, health care professionals, Congress and the White House can monitor the progress of the nation's health care system in delivering high-quality care to every American. By establishing and monitoring a comprehensive "report card" for the various parts of our health care system, American citizens will be able to identify and address flaws in the health care delivery system in a much more transparent and meaningful manner than exists in today's health care system.

QUESTION 9

For years, health care technology has been developed for use by doctors and other health care providers. Still, we lack wide scale use of electronic prescribing, electronic medical records and other important health information technology tools. **What specific incentives would you favor to enhance the adoption of health information technology? What will you do to encourage free and secure data sharing among providers for the benefit of patients?**

I will invest \$10 billion a year over the next five years to move the U.S. health care system to broad adoption of standards-based electronic health information systems, including electronic health records. I will also phase in requirements for full implementation of health IT and commit the necessary federal resources to make it happen – including incentives for providers to fully share this information in a secure manner. I will ensure that these systems are developed in coordination with providers and frontline workers, including those in rural and underserved areas. I will ensure that patients' privacy is protected.

QUESTION 10

Given the rapid changes in how technology is used to deliver care and how biomedical breakthroughs are used to treat and predict disease, health care will need to be provided in innovative ways. **What will you do to encourage innovation in biomedical research, the science of prevention and the delivery of care? How will you promote the use of these advanced technologies to improve health?**

As a result of biomedical research the prevention, early detection and treatment of diseases such as cancer and heart disease [are] better today than any other time in history. I have consistently supported funding for the National Institutes of Health and the National Science Foundation. I strongly support investments in biomedical research, as well as medical education and training in health-related fields, because it provides the foundation for new therapies and diagnostics. I have been a champion of research in cancer, mental health, health disparities, global health, women's and children's health, and veterans' health. As president, I will strengthen funding for biomedical research, and better improve the efficiency of that research by improving coordination both within government and across government/private/non-profit partnerships. My administration will ensure that we translate scientific progress into improved approaches to disease prevention, early detection and therapy that is available for all Americans.

QUESTION 11

The range of health professionals needed is changing. Some groups have projected shortages in essential health providers ranging from nurses and primary care physicians to allied health professionals. **What would you do to encourage entry into and retention within these essential health fields?**

Primary care providers and public health practitioners have and will continue to lead efforts to protect and promote the nation's health. Yet, the numbers of both are dwindling, and the existing workforce is further challenged by inadequate training about new health threats such as bioterrorism and avian flu, antiquated funding and reimbursement mechanisms, and limited access to real-time information and technical support. I will expand funding—including loan repayment, adequate

reimbursement, grants for training curricula, and infrastructure support to improve working conditions—to ensure a strong workforce that will champion prevention and public health activities.

QUESTION 12

Do you feel that portability of health insurance is an important part of **improving health? If so, how would you structure a portable health insurance system to make it affordable and effective?**

Yes. The public and private health insurance options offered in my health care reform plan will be fully portable.

QUESTION 13

There is a great deal of evidence that policy decisions in areas such as education, taxes, environment and labor can have as much of an impact on people's health as policy decisions that address health directly. **How will you measure the health impact of your non-health policy decisions?**

I will take steps to ensure that my non-health policy decisions are compatible with my goal of improving the health outcomes of all Americans. For example, I am committed to restoring scientific integrity to the White House so that decisions for environmental, consumer safety and research policies are made to benefit the overall welfare of the American people, not special interests. I will also build off of my work in the U.S. Senate in this area to ensure that federal policies assess their potential health impact. Among my legislation in this area is the Healthy Places Act, which I authored to help local governments assess the health impact of new policies and projects, like highways or shopping centers. Once the health impact is determined, the bill gives grant funding and technical assistance to help address potential health problems. I also introduced the Healthy Communities Act to expand research on toxins and provide the resources to clean up blighted communities.

ASPEN HEALTH STEWARDSHIP COALITION

AARP

Advocacy Alliance – Susan G. Komen for the Cure

American Lung Association

American Public Health Association

Cancer Action Network – American Cancer Society

Disruptive Women in Healthcare (Amplify Public Affairs)

GE Healthcare

KEAS

Eli Lilly and Company

National Association of Community Health Centers

National Medical Association

Partnership for Prevention

PhRMA

Regence BlueCross BlueShield

Susan G. Komen for the Cure

WomenHeart: The National Coalition for Women
with Heart Disease

PLEASE NOTE: The aforementioned lists the coalition members as of March 12, 2009. The coalition was established to encourage policymakers, physicians, health care businesses and nonprofits, communities and other stakeholders to embrace the Aspen Health Stewardship Principles as a roadmap to help ensure smart, sustainable improvements to the U.S. health care system.

About the Health, Biomedical Science and Society Program

www.aspeninstitute.org/health

The Health, Biomedical Science and Society Program is a venue for academic, government and industry leaders to explore critical issues in health care and health policy and how they may affect individual health and that of families, communities, nations and the world. By convening bipartisan, multi-disciplinary forums, the program facilitates the exchange of knowledge and insights among decision-makers and helps to forge networks and other collaborations with the ultimate goal of improving human health.

Through public programs and strategic dialogue, including roundtables, policy briefings, conferences and Internet discussion forums, the program seeks to help chart the way forward on issues relating to health and medical science by bringing together the foremost experts in many fields. The program's work routinely incorporates the views of leading scientists, economists, physicians, policymakers, historians, patients and other committed voices in health care and health policy. The program's projects include:

The Aspen Health Forum. Born of the recognition that there is exploding interest in the future of health care, the Aspen Health Forum brings cutting-edge medical science and health care discussions to the public square. It is the world's only public gathering that offers a lay audience the opportunity to exchange ideas with Nobel laureates, prominent officials from the National Institutes of Health, health care industry leaders and other top experts in health policy and biomedicine. The next forum will be held at the Aspen Institute campus in Aspen, Colorado, July 24-27, 2009.

The Aspen Health Stewardship Project. Drawing on the expertise of a diverse group of leaders in health care and health policy, this initiative seeks to inform the national conversation on health care reform and to suffuse related policymaking with non-partisan principles to help drive smart, sustainable improvements to the U.S. health care system.

The Aspen Task Force on Global Nutrition and Health. A high-level strategy group, the task force is slated to launch in July 2009 and will build on the work of the domestic Aspen Nutrition Initiative. This new effort seeks to focus the attention of world leaders and other influential persons on the root causes of excess calorie intake, inadequate physical activity and their adverse affects on health, economies and the environment. It also aims to highlight the benefits that developed and developing countries receive when they address social factors that impede health and educate and support their citizens to make healthy lifestyle choices.

The Future Medicine Project. Started in the fall of 2006, the project addresses critical roadblocks to the implementation and adoption of new health care technologies and aims to fundamentally change the way business leaders, policymakers and the public think about technological advancement in health care. The project formed and convened two strategy groups, one on personalized medicine and the other on pandemic influenza surveillance.

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