

**Diagnosing Health Care:  
A White Paper discussing Maryland's  
health care challenges and solutions regarding  
increased costs, workforce shortages and an  
overhaul of America's health care system**

Presented by  
The Fort Meade Alliance



Compiled and Written by  
Linda Strowbridge

Produced by  
The O'Ferrall Group

August 2009

## Table of Contents

Executive Summary.....	2
Introduction.....	5
I. The Rising Cost of Health Care.....	6
A. Medicine by the numbers.....	6
B. Preventive health care.....	7
C. New medical delivery systems.....	8
D. Streamlining hospital operations.....	9
E. Cost-effective health care.....	10
II. Building a Health Care Workforce.....	10
A. Medicine’s growing labor shortage.....	10
B. Incentives for clinical physicians.....	11
C. Tapping new sources of medical professionals.....	12
D. Reforming medical education.....	12
III. Reforming America’s Health Care System.....	14
A. Expanding health IT.....	14
B. Hard choices about health care services.....	14
Conclusion.....	15
Appendix I: Diagnosing Health Care — Participants.....	17

## **Executive Summary**

The formidable and still-growing challenges facing America's health care system keep surfacing in newspaper headlines, political debates, expert studies and the narrow bottom line of many hospitals.

Across America, the cost of health care is growing at a striking rate. Health care expenditures which amounted to less than 10 percent of the country's Gross Domestic Product (GDP) in 1980, now account for 18 percent of the GDP and are projected to consume 34 percent of the GDP by 2040. Those increases have driven the average family's annual medical insurance premiums up from \$6,462 in 1996 to \$11,941 in 2006, and analysts predict those premiums could exceed \$45,000 by 2040 unless dramatic action is taken to contain medical costs.

In Maryland, the statistics are even worse. From 2003 to 2007, health care expenditures in the state grew on average 7 percent per year – a full percentage point higher than the national average. The Dartmouth Atlas of Health Care identified Maryland as the site of some of the most expensive health care in the country.

Meanwhile, hospitals, physicians' practices and other health agencies across the country are struggling with a shortage of doctors and other expert medical staff.

The Maryland Hospital Association has described this state's physician shortage as “a silent crisis that grows in intensity every day.” Maryland's supply of clinical practice physicians falls 16 percent below the national average with the most serious shortages in primary care, emergency medicine, hematology/oncology, thoracic and vascular surgery, psychiatry, dermatology and anesthesiology. To compound the problem, nearly one-third of all Maryland physicians are expected to retire by 2015.

The Maryland Hospital Association has reported the state is already grappling with growing shortages of many types of medical professionals, including nurses, laboratory technicians, respiratory therapists and dieticians.

### **“Diagnosing Health Care”**

In light of those challenges and the current political debate over reforming America's health care system, the Fort Meade Alliance brought together varied medical experts from across Central Maryland on May 12, 2009 for “*Diagnosing Health Care: Identifying Challenges and Building Solutions.*”

Speakers ranged from U.S. Congressman John P. Sarbanes (a long-time health care attorney) to Shock Trauma Physician-in-Chief Dr. Thomas M. Scalea to hospital presidents, practicing physicians, medical school professors, international health experts and human resources leaders in the health care sector. Those experts offered numerous propositions for containing rising health care costs and strengthening the medical workforce, plus examples of some successful efforts in other countries.

## **Containing health care costs**

The United States currently posts the highest rates of chronic disease of any developed country. More than 133 million Americans – nearly half the country’s population – live with one or more chronic conditions, according to the Centers for Disease Control and Prevention (CDC). The CDC reports that chronic diseases, such as cardiovascular disease and diabetes, rank among the most prevalent, costly and preventable health problems in America. Chronic conditions account for 75 percent of the nation’s \$2 trillion in medical expenditures each year.

Consequently, many conference participants stressed improvements in primary care, preventive care and disease management as key ways to contain America’s health care costs and improve Americans’ health.

Many European health authorities, speakers explained, have generated cost savings and health benefits by doing things like partnering with local gymnasiums to provide fitness classes tailored to stroke victims and osteoporosis patients or establishing treatment protocols that reward primary care physicians for delivering regular preventive services to patients with diabetes, arthritis and other chronic conditions.

Speakers also suggested that local health authorities could deliver better primary and preventive health care to more people at less cost by using alternative delivery vehicles, such as wellness clinics in seniors centers, public schools and workplaces.

## **Building a medical workforce**

Speakers warned that an “age tsunami” could sweep a large percentage of Central Maryland’s doctors, nurses and other medical workers into retirement within the next decade, exacerbating existing labor shortages.

They proposed multiple measures to offset that shortage, including:

- Expanding loan-forgiveness programs to encourage medical students to enter high-demand specialties and to encourage graduating students to establish their practices in Maryland.
- Financial incentive programs to boost the pay of badly needed primary care doctors. The incentives could be tied to the quality of primary and preventive care doctors provide to their patients, especially chronic disease sufferers.
- New licensing systems to enable military medical workers to quickly get Maryland medical licenses once they return to civilian life.
- Revised standards for professors in nursing and other medical programs, which would enable more trained professionals to qualify as instructors and enable nursing/medical schools to accept more students.

## Conclusion

The challenges of the American health care system obviously cannot be resolved in a single day of discussion regardless of how much expertise, insight and vision flow through the room.

However, the discussions at “*Diagnosing Health Care: Identifying Challenges and Building Solutions*” emphasized several key priorities in the efforts to improve America’s health care system.

1. America urgently needs to find new ways to contain its health care costs. If current growth rates continue, the price of medical care could significantly harm America’s financial health in the foreseeable future. It would also leave a large percentage of Americans unable to afford any medical coverage.
2. America’s health care system needs to focus more on promoting wellness, rather than solely treating sickness. Preventive care is the key to reducing the largest cost burden on the health system, namely chronic diseases.
3. Health educators and authorities must begin preparing for what could be an abrupt drop in practicing physicians, nurses and other medical professionals in the next decade.

Finally, several conference participants voiced one other concern. Physicians, nurses, hospital administrators and other practicing medical experts have found little real voice or real influence in the current political debate over reforming America’s health care system. Their input will be needed to generate real solutions for the health care system.

## INTRODUCTION

On May 12, 2009, health care leaders from Central Maryland gathered to discuss the greatest challenges facing their industry and share their insights on how to contain escalating medical costs, offset shortages of health care professionals and influence the current political debate over health care reform. The Fort Meade Alliance organized “*Diagnosing Health Care: Identifying Challenges and Building Solutions*” in the belief that a high-quality and affordable health care system is essential to the success of Fort George G. Meade and the communities and companies that support the base.

This white paper was created to record and share the expert insights voiced during panel discussions at “*Diagnosing Health Care.*” Speakers who addressed the conference, included:

- **U.S. Congressman John P. Sarbanes**, Maryland’s 3<sup>rd</sup> Congressional District
- **Secretary John M. Colmers**, Maryland Department of Health and Mental Hygiene
- **Delegate Ron George**, Maryland House of Delegates, District 30
- **Pegeen Townsend**, Senior Vice President for Legislative Policy, Maryland Hospital Association
- **Martin Doordan**, President and CEO, Anne Arundel Health Systems
- **David Grosso**, Vice President Public Policy, CareFirst BlueCross BlueShield
- **LTC Richard Lindsay**, Deputy Commander for Administration, Kimbrough Ambulatory Care Center
- **Bonnie L. Phipps**, President & CEO, Saint Agnes Healthcare, Ministry Market Leader, Ascension Health
- **Karen Olscamp**, President and CEO, Baltimore Washington Medical Center
- **Dr. Renee Fox**, Associate Professor, Department of Pediatrics, University of Maryland School of Medicine
- **LTC George Kyle**, Deputy Commander for Clinical Services, Kimbrough Ambulatory Care Center
- **Dr. Lawrence Linder**, Senior Vice President and Chief Medical Officer, Baltimore Washington Medical Center
- **Pamela Paulk**, Vice President of Human Resources, Johns Hopkins Hospital and Johns Hopkins Health System
- **Dr. Mary Stuart**, Professor and Director of Health Administration and Policy Program, University of Maryland Baltimore County
- **Dr. Thomas M. Scalea**, Physician-in-Chief, University of Maryland R Adams Cowley Shock Trauma Center

Physicians, nurses, educators, hospital administrators, economists, health care contractors, insurance company executives and other experts in the health care field contributed to the in-depth and enlightening discussion of the formidable challenges facing one of Maryland’s most important sectors.

## **I. The rising cost of health care**

### **A. Medicine by the numbers**

Health care expenditures, which comprised less than 10 percent of America's Gross Domestic Product (GDP) in 1980, now account for 18 percent of the GDP.<sup>1</sup> In response, medical insurance premiums for family coverage jumped 85 percent in 10 years, from \$6,462 annually in 1996 to \$11,941 in 2006.<sup>2</sup>

In Maryland, health care expenditures have grown at a higher rate than in the country as a whole, according to the Maryland Health Care Commission. From 2003 to 2007, health care spending in the state rose on average 7 percent per year – one percent higher than the national average. The difference was caused, in part, by heightened spending on hospital care. Per capita spending for hospital care in Maryland rose 9 percent annually from 2003 to 2007, compared to 6 percent nationally.<sup>3</sup>

“The Economic Case for Health Care Reform” – a June report from the Executive Office of the President of the United States – predicted national health care costs could reach 34 percent of the GDP by 2040. That escalation could drive an American family's health insurance premiums above \$45,000 by 2040, the report warns.

Those rising costs likely would also drive up the number of Americans without health insurance. Analysts predict the number of uninsured will grow from 46 million currently to 72 million by 2040 as medical insurance becomes more expensive and unaffordable for increasing numbers of companies and individuals.<sup>4</sup>

Maryland hospitals are already feeling the effects of serving large numbers of patients who don't have health insurance and don't have financial means to pay cash for medical care.

In its last fiscal year, Saint Agnes Hospital performed \$15 million in charity care and incurred another \$15 million in bad debt, said Bonnie L. Phipps, President and CEO of Saint Agnes Healthcare and Ministry Market Leader of Ascension Health. “Hospitals in Maryland run on a 1-2 percent margin so there is not a lot of leeway” to cover such costs.

At “*Diagnosing Health Care: Identifying Challenges and Building Solutions*,” discussions revolved heavily around the burden of rising medical costs and options for stemming the increases.

---

<sup>1</sup> U.S. Department of Health and Human Services, National Health Expenditure Accounts

<sup>2</sup> U.S. Department of Health and Human Services, Medical Expenditure Panel Survey – Insurance Component (2006)

<sup>3</sup> Maryland Health Care Commission, State Health Care Expenditures (2007)

<sup>4</sup> Executive Office of the President of the United States, “The Economic Case for Health Care Reform” (2009)

## B. Preventive health care

One cause of the rise in health care costs is that “for far too long we had a system that was focused on sick care rather than on keeping people healthy,” said Congressman John P. Sarbanes. The former chair of the health care practice at Venable LLP, Sarbanes currently is a member of the Health Subcommittee of the House of Representatives’ Energy and Commerce Committee.

The United States has the highest number of chronic disease cases per capita of any developed country, Sarbanes said.

More than 133 million Americans have one or more chronic conditions, according to the Centers for Disease Control and Prevention (CDC). The CDC describes chronic diseases, such as cardiovascular disease and diabetes, as some of the most prevalent, costly and preventable health problems in America. Chronic diseases account for 70 percent of all deaths in the United States. Treatment of chronic conditions accounts for more than 75 percent of the \$2 trillion that America spends on medical care each year.<sup>5</sup>

To a large extent, the cause of high chronic disease rates in America “can be traced back to the fact that we don’t have early intervention or the emphasis on fitness and prevention,” Sarbanes said.

### Preventive Care’s Payback

Medical studies have determined how preventive medicine and health-maintenance efforts can dramatically reduce medical problems and save money. Researchers have measured these results in studies on the prevention and treatment of diabetes.

Exercise program and 7 percent weight loss in pre-diabetics:  
reduces onset of Type 2 Diabetes by 58 percent

Maintaining healthy blood sugar level:  
reduces risk of eye, kidney and nerve diseases by 40 percent

Maintaining healthy blood pressure:  
reduces risk of heart disease and stroke 33 to 50 percent

Comprehensive footcare program:  
reduces amputation rate 45 to 85 percent

*Source: The Centers for Disease Control and Prevention*

---

<sup>5</sup> U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Chronic Disease Overview

“If you look at the U.S. compared to other developed countries, we are the most expensive in terms of per capita expenditures and percentage of GDP spent on health care, but the World Health Organization ranks us 32<sup>nd</sup> in our overall health performance,” said Dr. Mary Stuart, Professor and Director of Health Administration and Policy Program at University of Maryland, Baltimore County.

Stuart explained that many European countries have cut their medical costs and improved citizens’ health by pioneering preventive medicine programs. For nearly four years, Stuart has participated in a pilot program in Italy, designed to improve the health of stroke victims and individuals suffering from Parkinson’s Disease, osteoporosis and chronic back pain. Physicians, she explained, can recommend patients for entry into the program, which is administered by local health authorities. Then three times a week, patients go to a local, private gymnasium to participate in low-cost fitness classes that are designed to address their medical issues.

“This program has been a runaway success,” said Stuart, noting that it has grown to 35 classes with more than 1,500 participants. In addition to improving participants’ physical health, the program has also helped many individuals forge social connections and reduce incidents of depression (a common condition among stroke victims and patients with chronic, degenerative ailments).

Stuart is now piloting the program in Maryland, working in conjunction with the Howard County Department of Aging and Howard County Community College.

### **C. New medical delivery systems**

U.S. health authorities could more readily, effectively and cheaply provide preventive care and primary care to individuals by adopting a system of “place-based health care,” Sarbanes told conference participants. Offering health services through more school clinics, seniors centers and workplaces, he suggested, could greatly increase the level of preventive care in America, give Americans better access to primary health care and reduce service demands on hospitals.

Karen Olscamp, President and CEO of the Baltimore Washington Medical Center, suggested that community-based mental health services could help trim overall health spending while improving care. Many patients, who are admitted to the psychiatric unit at Baltimore Washington Medical Center, don’t actually need inpatient care, Olscamp said. Those patients, however, cannot be safely discharged unless they can access outside mental health services. And nearly half of the hospital’s psychiatric patients don’t have medical insurance, so many can’t get psychiatric care outside of a hospital setting.

Pamela Paulk, Vice President of Human Resources for Johns Hopkins Hospital and Johns Hopkins Health System, said her hospital system started accruing financial and health benefits surprisingly quickly after it implemented a workplace wellness program.

The program which enables employees to see an onsite nurse for a wellness checkup, “is having remarkable effects,” especially among employees with chronic conditions, Paulk said. Medical expenses for many employees began to fall just two years after the wellness program began – much sooner than some hospital executives had expected.

#### **D. Streamlining hospital operations**

Dr. Thomas M. Scalea, Physician-in-Chief at the University of Maryland R Adams Cowley Shock Trauma Center, described how his facility realized striking efficiency gains through a simple act of communication.

The discovery happened on a Sunday afternoon eight years ago. Shock Trauma staff were using their 10 trauma beds to care for 18 people so the facility had closed to new traumas – a regular occurrence at the time.

“I was sitting in my office popping Roloids, trying to figure out what we were going to do about it and a light bulb went on,” Scalea said.

He declared an internal emergency, summoning all staff back to work. Together, they walked from bed to bed, discussing the condition of each patient, the status of their treatment and when the patient might be ready for discharge. They discovered that many patients were ready to be moved out of the trauma center, but poor communication among different specialists and outdated information on medical charts had previously led staff to conclude those patients were still waiting for treatment.

“We sent 15 people out of the hospital that day. We cut length of stay 15 percent in 24 hours ... We have maintained that drop in length of stay for eight years. Our unexpected readmission rate is still under 1 percent,” he said.

Shock Trauma formalized the information sharing by instituting daily “discharge rounds” which involve the entire medical team – physicians, nurses and therapists.

“It’s a slow-moving herd that goes down the hall,” Scalea said.

However, the medical team has streamlined the consultation on each patient to 45 seconds, Scalea said. “In 45 seconds, I can collect every bit of information I need to know in order to determine what we need to do to move the process forward with that patient.”

Shock Trauma, he noted, was built in 1989 to serve a maximum of 3,500 patients a year. “Last year, we admitted 7,700 patients in the same number of beds and with fewer doctors and fewer nurses than existed in 1989.”

The facility, he said, operates at 110 percent of capacity 365 days a year. “We believe that we have this mission and we believe the mission is to never say no. And we haven’t said no in eight years. We find a way.”

## **E. Cost-effective health care**

Several speakers at “*Diagnosing Health Care*” argued that health care authorities could offset rising costs by conducting a rigorous study of what constitutes the most effective treatment for individual medical conditions.

For example, does a patient diagnosed with high blood pressure need the newest anti-hypertension drug on the market, asked Dr. Renee Fox, Associate Professor with the Department of Pediatrics, University of Maryland School of Medicine. “Data shows that cheaper, generic drugs are as good or better.”

Other countries, such as Great Britain, have analyzed clinical trials and other quality research to determine the “comparative effectiveness” of alternate treatments for individual diseases, Fox said. That process has produced high-quality standards of care for medical conditions. It has also contained health care costs by avoiding expensive but less effective treatments.

Fox pointed to the Dartmouth Atlas of Health Care – a study produced by the Dartmouth Institute for Health Policy and Clinical Practice in New Hampshire – as evidence that treatment protocols and costs vary widely within the United States. The atlas identifies the Baltimore region as one of the most expensive areas in the country for health care.<sup>6</sup>

The cost of health care, for example, “in the last six months of life in the elderly and Medicare populations is double here than in Rochester, Minnesota,” Fox said. “I had the opportunity last year to work with the Congressional Budget Office under Peter Orszag and one of his comments was, ‘How can the best medical care in the world cost twice as much as the best medical care in the world?’”

## **II. Building a health care workforce**

### **A. Medicine’s growing labor shortage**

The Maryland Hospital Association describes the state’s physician shortage as “a silent crisis that grows in intensity every day.” A 2008 study by association and MedChi, the Maryland State Medical Society, concluded that Maryland’s supply of clinical practice physicians falls 16 percent below the national average.<sup>7</sup>

Central Maryland is better staffed than any other region of the state. However, it is currently experiencing physician shortages in emergency medicine, thoracic surgery,

---

<sup>6</sup> Dartmouth Institute for Health Policy and Clinical Practice, “Dartmouth Atlas of Health Care: Regional Disparity in Medicare Spending” (2006)

<sup>7</sup> Maryland Hospital Association and The Maryland State Medical Society, “Maryland Physician Workforce Study” (2008)

pathology, dermatology and hematology/oncology. And study authors warn of “alarming” indications that shortages could worsen by 2015.

A large percentage of Maryland’s doctors are nearing retirement. Nearly 10 percent of all clinical physicians are 65 or older and 33 percent are 55 or older. The largest concentration of older physicians occurs in Montgomery and Prince George’s counties. Nearly one-third of all Maryland physicians are expected to retire by 2015.

“I, for one, believe the age tsunami is very, very real and we have not yet seen the worst of it. In fact, it is just beginning,” Johns Hopkins’ Pamela Paulk told conference participants. “I really do lay awake at nights, worrying about how we are going to staff the hospital five or 10 years from now.”

Hospital administrators also face looming shortages in other medical professions. The latest Hospital Personnel Survey by the Maryland Hospital Association catalogued growing shortages of laboratory technicians, respiratory therapists, nurse midwives, nurse practitioners, dieticians and registered medical record administrators.<sup>8</sup>

### **Maryland’s Physician Shortage**

No. of clinical physicians working in the United States:  
212 per 100,000 residents

No. of clinical physicians working in Maryland:  
178 per 100,000 residents

No. of clinical specialists working in Maryland in 2007:  
40 per 100,000 residents

No. of clinical specialists expected to work in Maryland in 2015:  
37 per 100,000 residents

No. of Maryland physicians who are 55 or older:  
33.4 percent

*Source: “Maryland Physician Workforce Study,” prepared by Boucher & Associates for the Maryland Hospital Association and MedChi, 2008*

## **B. Incentives for clinical physicians**

John M. Colmers, Secretary of the Maryland Department of Health and Mental Hygiene, told conference participants that state officials and industry leaders need to initiate a variety of measures to ameliorate current and growing labor shortages in the medical care.

---

<sup>8</sup> Maryland Hospital Association, “Hospital Personnel Survey, Calendar Year 2007”

Colmers argued that the federal loan-forgiveness program for physicians-in-training cannot entice sufficient doctors to work in Maryland nor entice sufficient medical students to enter high-need specialties.

“It is astounding to me that the federal government with its loan-forgiveness program spends a grand total of \$250,000 a year on loan forgiveness for physicians in this state,” Colmers said. “Maryland matches that money, so it totals about \$500,000. Think about that. The average debt a physician has when they leave their training is about \$160,000, so we can barely cover three full physicians per year. It is absurd.”

Maryland’s General Assembly this spring passed legislation to create a state-run, loan-forgiveness program for physicians, Colmers said. The new program will spend \$8 million to \$11 million a year paying down physicians’ student loans and enable state officials to target medical students who are considering specialties that are experiencing the most severe labor shortages.

Dr. Renee Fox has studied the medical systems of many other countries, proposed the United States could ease its growing shortage in one field – general practice medicine – by emulating one component of the British health care system. British officials pay bonuses to general practice physicians who ensure their patients participate in health-maintenance activities. For example, a general practitioner would receive a bonus if his or her diabetic patients received annual foot examinations. (Diabetics face a high risk of suffering tissue death in their feet, which triggers gangrene and can ultimately lead to amputations.) The bonus program, Fox said, can enable general practitioners to earn as much as medical specialists and consequently entice more medical students to go into general practice. The program delivers the added benefit of reducing the need for medical specialists and critical care.

### **C. Tapping new sources of medical professionals**

Colmers and other speakers agreed that Maryland needs to make efforts to fast track other skilled, medical professionals into the state’s workforce.

The BRAC (Base Realignment and Closure) Subcabinet, headed by Lt. Gov. Anthony Brown, has already initiated programs to help spouses of BRAC workers quickly convert their out-of-state nursing, lab tech or other medical licenses to Maryland licenses once their families arrive here.

State and federal officials, Colmers and Sarbanes said, are also investigating options to help military medical staff get civilian licenses after they leave the armed services.

### **D. Reforming medical education**

Speakers at the “*Diagnosing Health Care*” conference also stressed the need to reform the medical education system to accommodate more students.

“The supply of candidates for nursing school is larger than ever. The problem is not that we don’t have enough people who are interested in going into the profession,” Colmers said.

The problem is a shortage of instructors.

Colmers and other conference participants suggested that Maryland needs to explore alternative training models for medical education. The state, for example, needs to decide if a Ph.D. nurse is needed to teach bachelor’s level courses, or whether that instruction could be handled by a different medical professional.

Some educational institutions in Central Maryland are already experimenting with creative ways to train and retain instructors. Towson University reduced its shortage of nursing instructors by half by offering free tuition to nurses who wanted to pursue a master’s degree. In return, the nurses had to agree to work as part-time faculty teaching clinical courses for at least three years. Meanwhile, some community colleges have developed partnerships with local hospitals. Under those agreements, nurses continue to collect full salary from the hospital yet spend part of their workweek serving as part-time college instructors.

“It is a particular crime when you have nursing candidates who really want to do this training and they can’t get [it],” Sarbanes said. “We’ve got to address that and we have to do it with a tremendous sense of urgency.”

Martin Doordan, President and CEO of Anne Arundel Health Systems, warned that simple demographics would exacerbate the shortage of medical professionals in the very near future.

“The next 20 years will produce the highest demand for health care this country has ever seen” as America’s generation of baby boomers turns into a record-high population of senior citizens, Doordan said.

Sarbanes suggested the current debate over health care reform and the efforts to provide coverage to uninsured Americans could sharply increase the shortages of medical professionals.

“I think the fact that 50 million people don’t have insurance in this country has masked the provider shortage issue,” Sarbanes said. “It has deluded us into thinking the provider side is more robust than it is because it hasn’t formally had to be responsible for those 50 million people . . . If we propose to go and insure another 50 million people roughly and we don’t do something about the pipeline of providers – physicians, nurses and other caregivers – then we are headed for a huge train wreck. And frankly, it will feed into the criticism that you can’t reform the system without leading to severe health care rationing.”

### **III. Reforming America's Health Care System**

*"Diagnosing Health Care: Identifying Challenges and Building Solutions"* occurred amid the mounting political debate about reforming America's health insurance system. The outcome of that debate likely won't be known for months or longer. However, speakers raised two early concerns about the challenges facing the reform efforts.

#### **A. Expanding health IT**

In early 2009, Congress passed a federal stimulus package that included \$17 billion to encourage hospitals and physicians to install certified health information technology systems to manage electronic health records. The Congressional Budget office projects the program, which will pay out Medicare and Medicaid incentives over the next 10 years to offset the cost of the new technology, will facilitate nationwide health information exchanges, improve the coordination of care among different providers and reduce medical errors and duplication of care.

"I think we have a huge amount to gain in the health care industry from better IT," said Dr. Lawrence Linder, Senior Vice President and Chief Medical Officer for the Baltimore Washington Medical Center. "Compared to a lot of other industries, I think we are probably still in the stone age of IT."

However, Linder warned that the health IT systems are still imperfect and highly expensive.

"To put it in perspective," Linder said, "in our hospital if we want to build a state-of-the-art OR, it is about \$1.5 million ... If we want to build a brand new hospital, like we just built, an eight-story new building, it is about \$118 million. When we went to look at a really good new IT system, it would be a couple hundred million dollars. That's how much money it costs us and the products are still not that great."

#### **B. Hard choices about health care services**

Several speakers suggested that Americans need to become more prudent consumers of health care services.

"In this country, the way health insurance has evolved is as a third-party payer so that the consumer has no idea how much care costs and as consumers we expect to get everything covered through our health insurance," said Dr. Renee Fox.

That habit, however, can stress health care facilities, generate unnecessary costs and push up medical insurance premiums.

"Consumers need to be more aware of what health care costs and more involved in decisions about care," Fox said.

State Del. Ron George suggested that legislators should consider allowing some flexibility in the roster of services that must be covered under health insurance plans. The state of Maryland currently requires insurance companies to provide a large list of mandated services, he said. However, if individuals could select what services they want covered by their health plan, insurance might become less expensive and more accessible for individuals and employers, George suggested.

Other speakers suggested that Americans should even expect to forego certain services as the country works to stem medical spending increases.

“On a bigger, more global issue, we as Americans need to decide a couple of questions,” Linder said. “We need to decide how much do we want to spend on health care ... and where do we want that money to go.”

In 1994, the Oregon Health Plan adopted a system of prioritizing health care services, realizing that the state’s health budget might not be able to cover low-priority services.

“It wasn’t very popular, but I think it got at the root of what we need to do,” Linder said. “I think as a country we need to make some of those hard decisions before we can fix our health care system. Until we make those choices, I think these other [reform] efforts will continue to fail.”

## **CONCLUSION**

The challenges of the American health care system obviously cannot be resolved in a single day of discussion regardless of how much expertise, insight and vision flow through the room.

However, the discussions at “*Diagnosing Health Care: Identifying Challenges and Building Solutions*” emphasized several key priorities in the efforts to improve America’s health care system.

1. America urgently needs to find new ways to contain its health care costs. If current growth rates continue, the price of medical care could significantly harm America’s financial health in the foreseeable future. It would also leave a large percentage of Americans unable to afford any medical coverage.

2. America’s health care system needs to focus more on promoting wellness, rather than solely treating sickness. Preventive care is the key to reducing the largest cost burden on the health system, namely chronic diseases.

3. Health educators and authorities must begin preparing for what could be an abrupt drop in practicing physicians, nurses and other medical professionals in the next decade.

Finally, several conference participants voiced one other concern. Physicians, nurses, hospital administrators and other practicing medical experts have found little real voice or real influence in the current political debate over reforming America's health care system. Their input will be needed to generate real solutions for the health care system.

## Appendix I: Diagnosing Health Care — Participants

*Keynote Speaker:* **U.S. Congressman John P. Sarbanes**

*Moderator:* **Tim O’Ferrall**, CEO of The O’Ferrall Group and Communications Chair of the Fort Meade Alliance

### *Legislative Panel*

- **U.S. Congressman John P. Sarbanes**, Maryland’s 3<sup>rd</sup> Congressional District
- **Secretary John M. Colmers**, Maryland Department of Health and Mental Hygiene
- **Delegate Ron George**, Maryland House of Delegates, District 30
- **Pegeen Townsend**, Senior Vice President for Legislative Policy, Maryland Hospital Association

### *Care Provider Panel*

- **Martin Doordan**, President and CEO, Anne Arundel Health Systems
- **David Grosso**, Vice President Public Policy, CareFirst BlueCross BlueShield
- **LTC Richard Lindsay**, Deputy Commander for Administration, Kimbrough Ambulatory Care Center
- **Bonnie L. Phipps**, President & CEO, Saint Agnes Healthcare, Ministry Market Leader, Ascension Health
- **Karen Olscamp**, President and CEO, Baltimore Washington Medical Center

### *Academia & Workforce Panel*

- **Dr. Renee Fox**, Associate Professor, Department of Pediatrics, University of Maryland School of Medicine
- **LTC George Kyle**, Deputy Commander for Clinical Services, Kimbrough Ambulatory Care Center
- **Dr. Lawrence Linder**, Senior Vice President and Chief Medical Officer, Baltimore Washington Medical Center
- **Pamela Paulk**, Vice President of Human Resources, Johns Hopkins Hospital and Johns Hopkins Health System
- **Dr. Mary Stuart**, Professor and Director of Health Administration and Policy Program, University of Maryland Baltimore County

*Keynote Speaker:* **Dr. Thomas M. Scalea**, Physician-in-Chief, University of Maryland R Adams Cowley Shock Trauma Center