The AMA and the Context of American Healthcare

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AMA Reach: The AMA Equation

House of Delegates + Members + Practice Tools + Research & Education + Advocacy = AMA

Voice of physician organizations

Direct personal engagement

Expertise in managing practice

Career, clinical, and practice enhancement

Authoritative advocate for physicians in Washington, in the courts, and to the public
The AMA Mission

To promote the art and science of medicine and the betterment of public health
Intersection of AMA Equation and Mission Statement

Initial focus of strategic planning:
Where our mission statement intersects with the AMA equation
AMA: Criteria for Focusing Impact

Within the frame of broad themes, AMA must make choices about how to focus resources for highest impact

- Alignment with the mission?
- Of urgent and critical importance to the future of health care?
- Alignment with broad base of physicians?
- Ability to make a significant, measurable, positive impact?
- AMA as the best, most likely leader?
- Credibility, competence, and resources to make a significant impact?
- Likelihood for AMA to be recognized and get credit for its role?
- Synergy with other aspects of strategy?
Strategic Review of AMA Mission Programs

Management Application of Board Criteria

Desirability (Mission, Urgency, Alignment, Credit)

Feasibility (Impact, Leader, Capacity)

- Core strengths to build upon
- Opportunities for reconfiguration
- Unlikely prospects; consider exit
AMA: The Path to Focus and Impact

*Internal and external reviewers applied Board-endorsed criteria to current AMA activities and identified three areas for strategic focus*
AMA: Five Year Rolling Strategic Plan
(Approved Feb, 2012)

Three Focus Areas (from >100)
- Improving Health Outcomes
- Reforming UME
- Enhancing Physician Satisfaction

Shifts:
- Process to outcomes
- Convening to Partnering/Doing
AMA FOCUS AREA  #1

Improving Health Outcomes

AMA History:
• Developing quality and performance measures

Future: move to focus on outcomes
• Develop AMA outcomes set
• Consolidate around outcomes set: research ethics, disparities, public health, etc.
AMA Focus Area #2

Reforming UME: AMA “Starting Hand”

- Governance relationship (AAMC/LCME)
- Agreement on need to reform
- Agreement on how to reform*
- No large federal $ restructuring
- Historical role of AMA in UME

*Competency based, sharing, clinical-basic science integration, simulation (e.g. i-Human), teams…
AMA Focus Area #3

Payment/Deliver and Physician Satisfaction

• Maintain “sculpting/improving” actions of AMA advocacy unit

• Develop a longer term view on payment and delivery
  – Define universe of models as those providing quality and value
  – Examine variant models through the lens of physician satisfaction
Where We Are, What To Do
The American Health System should function as an **IMPORTANT SYSTEM** in an **ADVANCED NATION**

- $2.6$ trillion system
- **BUT**
  - $39^{th}$ in infant mortality
  - $43^{rd}$ in female mortality
  - $42^{nd}$ for adult male morality
  - $36^{th}$ in life expectancy

*Caveats: access biased, population heterogeneity, 30/45/25 rule*
What Needs to be Fixed?

• “System” is a series of silos
• Incentivize what we want
• Stop incentivizing what we don’t want
• Diminish the national disease burden
• We instill in physicians the role as patient advocate, we instill less well the role of physician as steward of $2.6 trillion
• Need transparency
• Eliminate waste (estimated at $600 billion)
Silos: A Fragmented “System”

• 5000+ hospitals & hospital systems
• 100+ academic medical centers
• 900,000+ physicians
• Multiple payer systems

Contrasts with many other large scale enterprises, (auto, insurance, etc…..)
Incentivize What We Want*

- More systematic care
- More continuity
- Updated medical education
- Quality & safety
- Patient satisfaction (& physician)
- Telehealth
- Prevention
- In sum, tilt toward outcomes not processes

*But, delivery and payment reform must be linked
Stop the Incentives For What We Don’t Want

• Volume over outcome
• Treatment over prevention
• Valuing “new” with uncertain or marginal improvement over “old” with established effective track record
• Procedures over primary care
• Check-offs over outcomes
• Attention to acute over chronic
Diminish Disease Burden

• Enhance prevention
• Enhance wellness
• 45% of disease burden may derive from behaviors
  – 33% cancer deaths preventable by screening;
  33% of cancer deaths related to behavior, diet, obesity (ACS)
• Promote healthy lifestyles
  – 75% of spending related to chronic illness
Physicians as Stewards

• Need to understand and simultaneously hold two thoughts:
  – Patient advocate
    • Patient population defined as “my practice”
  – National steward
    • Patient population defined as 310 million

To do this, a research ethics base need be developed under this “question”
Eliminating Waste

Systemic waste across the board

<table>
<thead>
<tr>
<th>Excess Cost Estimates</th>
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<tbody>
<tr>
<td>Unnecessary Services</td>
<td>$210 B</td>
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<tr>
<td>Inefficiently Delivered Services</td>
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<tr>
<td>Excess Administrative Costs</td>
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<tr>
<td>Prices That Are Too High</td>
<td>$105 B</td>
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<tr>
<td>Missed Prevention Opportunities</td>
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<tr>
<td>Fraud</td>
<td>$75  B</td>
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**Total Excess Costs:** $765 B

The Healthcare Imperative, 2010. Lower bound totals of various estimates of excess healthcare expenditures, adjusted to 2009 total expenditure levels.

From: The Learning Health System, IOM, http://www.iom.edu/vsrt
Needed: Cost Transparency

For patients:
  How much does it cost?
For physicians:
  Who pays? How?
For US population:
  Why does it all cost so much?

“Nowhere else but healthcare are prices so arbitrary, so disconnected from value”

- Wall Street Journal 2/12/12
Cost Transparency: Early Signs

- Insurer prices online
- Consumer web platforms
  i.e. Health Bluebook
- State health insurance websites
- Development of real outcomes measures
  – And relating such to systems (and, for physicians, groups, not individuals)
Closing Thoughts

• The ACA provides the private sector space for experimentation
• It is difficult to ride a bike while repairing it
• Theory has outpaced operations capabilities
  – Unlike other industries, operating changes need to adjust for the “inverted power distribution” in the healthcare supply chain