Health Reform:
Filling Leadership Gaps in Health Systems

An overview of ideas from the Harvard University Advanced Leadership Initiative Think Tank

2010

Harvard University
Advanced Leadership Initiative
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An Overview of Ideas from the Harvard University Advanced Leadership Initiative Think Tank

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May 6-8, 2010
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Introduction: The Think Tank Premise

The Advanced Leadership Initiative (ALI) at Harvard University is dedicated to educating and deploying a leadership force of experienced leaders who can address challenging national and global problems. An important part of the process is stimulating discussion among experts and advocates about the gaps that can be filled by advanced leaders, including the Advanced Leadership Fellows at Harvard who are preparing to transition from their primary income-earning years to their next years of service. Each year, ALI convenes three solution-finding workshops called Think Tanks to delve deeply into the nature of social problems, their potential solutions, the barriers to change, and the ways advanced leaders can make a difference.

On May 6-8, 2010, leaders in the field of health gathered to share experiences and identify future actions for reform. The Think Tank was chaired by Barry Bloom, Distinguished University Service Professor at the Harvard School of Public Health. Despite some successes, health systems across the globe have struggled to improve population health, offer financial risk protection, and create patient satisfaction. Rising costs are a fiscal threat, especially in Europe and the United States. The problem of access is an issue not only in the United States but also in lower-income countries where national health systems remain unstable. A large percentage of citizens in developing countries, where the majority of the globe’s citizens live, have little choice but to seek care from private providers and pay out of pocket for low-quality care. Meanwhile, aging populations, bioterrorist threats, climate change, and epidemic risks have created the need for a new global health system. Although reforms have begun internationally and in the U.S., much work remains.

Addressing an unmet social need or unsolved problem, such as the reform of health systems, differs from assigning tasks or formulating strategies in established organizations or exercising leadership in a domain with existing pathways and institutions. Rosabeth Moss Kanter, Ernest L. Arbuckle Professor of Business Administration at Harvard Business School and ALI Chair and Director, observed that even seemingly simple ideas for change require multiple strategies in multiple domains, taking various stakeholders into account. Advanced leaders must work within complex and unorganized social contexts, where authority is diffused, resources are dispersed, stakeholders are diverse, and goals are vague, ambiguous, or conflicting. Forging change thus requires a special kind of leadership. When leaders lack formal authority over an unbounded system, they need to think systemically while mastering relevant subject knowledge. They must influence individuals and groups to mobilize resources and work together. They need a highly developed sense of contextual and emotional intelligence to understand stakeholder motivations and assumptions. Finally, they have to find ways to create a shared purpose and common ground to get multiple actors to move forward on an issue. Reforming health systems calls for the collaboration of not one but many advanced leaders.

Health system reform includes not only broad policy change but also actions that can be taken through specific projects or at the community level – or both. Kanter urged participants to think not just “outside the box” (to use a popular phrase for creativity) but “outside the building” for solutions. This means going beyond the establishment or, literally, beyond the walls of hospitals and health centers and into the community to change the context surrounding acute care. For example, leaders may seek to move more work to primary care and family medicine groups; use paraprofessionals for screening and immunizations; leverage public schools as prevention and monitoring centers; expand mobile clinics in offices or malls; build technology networks; develop neighborhood programs such as those supporting elders in homes; or encourage collaborations between the health and parks departments. When taken together and multiplied, such innovations
support major health policy reform and can add up to changing the national system community by community.

With this Advanced Leadership frame in mind, over 150 leaders working on the issue of health reform were convened to discuss the problem and identify solutions. While the event included a thorough discussion of health reform in general, it gave specific focus to challenges in the United States and in lower-income countries. This report offers a narrative summary of the gaps identified during the event and highlights opportunities for action, both large and small – inside and outside the building.
What Is Health?

The World Health Organization (WHO) defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” Such a broad framing emphasizes the need for both preventative and curative services in all countries. The WHO’s Constitution also establishes that “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.” A successful health system will need to encompass all the broad health needs of individuals, their families, and their communities.

The formation of health systems that achieve these goals is a multi-faceted process. Health systems are the institutional arrangements by which societies provide for health needs. Although they are complex and uniquely designed based on local historical and cultural preferences, there are general principles that all systems should embody in order to successfully “promote, restore or maintain health.” Systems must improve the health of the population, meet their expectations, and provide financial security. Therefore, they must be managed and structured in such a way that they can provide the workforce and capacity needed to deliver health care services. This requires countries to establish resource allocation priorities and assign specific roles for the public sector, private industry, and the consumer. For example, the decision on how to finance and deliver health services (either publicly or privately) influences how much the government, employers, and consumers will ultimately pay. Finally, Niek Klazinga, Professor of Social Medicine at the University of Amsterdam and coordinator of the Health Care Quality Indicator project at the Organization for Economic Cooperation and Development (OECD), suggested that proper working systems should align incentives, provide transparent information, and be patient-centered.

Yet part of the challenge of systemic reform is that countries have different definitions of goals. According to Marc Roberts and William Hsiao, both Professors of Health Policy and Management at the Harvard School of Public Health, defining goals requires a clear ethical framework. China, Hsiao said, had a clear objective for reform: to provide a basic level of health services to all citizens. Much of their efforts were centered on the goal of equity. The United States, however, was unable to establish a clear ethical framework as policymakers during the last reform effort struggled to agree on what constitutes accessible, affordable, and high-quality care. These questions remained unanswered as the reform legislation process was completed. Instead of achieving true “health” reform, as the WHO would define it, the United States instituted health care insurance reform to begin to cover the estimated 46 million people without insurance. While providing coverage will help more citizens pay for necessary health care services, it is only one piece of a larger puzzle. As Katherine Baicker, Professor of Health Policy and Management at the Harvard School of Public Health, explained, some people with chronic illnesses and pre-existing conditions are simply uninsurable. They do not need health insurance but health care services to improve their overall health.

Policymakers thus sometimes overlook the distinction between health, health care services, and health insurance. They often overemphasize the curative aspects of health and do not focus on preventative measures. Instead of helping build communities that foster the creation of healthy populations, they create systems that can manage and treat people only when they get sick. Another aspect of the definitional problem is that policymakers, especially in the United States, generally believe that improving access, quality, affordability, and equity are the goals of health reform. These, however, are merely intermediate objectives for realizing the ultimate goal of improved population health.
What Are the Problems?

Health system problems may be defined by the inability to achieve ultimate goals – improve population health, give financial risk protection, and provide patient satisfaction – said Marc Roberts, Professor of Political Economy at the Harvard School of Public Health. He asked, How healthy is the population? Is there financial protection for individuals and families? Are citizens satisfied with health services? Meeting these goals requires attention to intermediate objectives, such as improved access, lower costs, higher quality, and more equity. What is the general level of access the population has to health care? What is the quality of the care? How much does it cost? What are the differences in access, quality, and cost within the population? Health systems – in low-, medium-, and high-income countries – succeed and fail in different ways at achieving these objectives.

The assessment of population health is multi-faceted. How healthy is the global population based on specific measures? What types of disease burdens do countries have? How does health vary across groups? While differences in health outcomes exist within and between countries, there is also an increasing convergence.

- Overall, higher-income countries have better health outcomes: Life expectancy is 78 years in the U.S. compared to 36 years in Zimbabwe. The risk of mortality in Iceland among 15-59 year-olds is 65 per 1,000 compared to 765 per 1,000 in Swaziland. “Despite the Volcano, It’s good to be an Icelander,” said Julian Schweitzer, Acting Vice President of Human Development Network and Director of Health Nutrition and Population at the World Bank.

- Disease types differ across countries: Low-income countries, such as those in sub-Saharan Africa, suffer more from communicable or infectious diseases compared to higher-income nations, where the non-communicable ailments of obesity, cancer, and heart disease take precedence. The UN Millennium Declaration, adopted in 2000, sought to address these disparities through the inclusion of health-related Millennium Development Goals (MDG) – eliminate hunger, reduce child mortality, improve maternal health, combat infectious disease, provide safe drinking water, offer affordable medicines. While some progress has been made, it remains slow and uneven. Roughly 35 million people are infected with HIV, with most in sub-Saharan Africa. Annually, there are 8 million new TB and 200 million new malaria infections. In Africa, HIV, TB, and malaria account for 51% of the deaths of women between 15-44 years of age and 21% of the deaths of all children 0-4 years of age. Malnutrition remains the largest cause of child mortality.

- Income alone does not ensure better population health: Although the U.S. is the world’s biggest economy, it has worse population health than Europe, said Cathy Schoen, Senior Vice President of the Commonwealth Fund. Compared to the European population, the overall U.S. population has less access, lower quality, and higher cost as well as worse equity. For the first time in history, the life expectancy of the next generation in the United States is expected to fall.

- Differences in health status exist within countries: Clifton Peay, 2010 ALI Fellow, Medical Director of the American Eye Center, and former Chair of the Board of the National Medical Association, highlighted significant health disparities within the U.S. Unlike the white population, homicide and HIV are among the leading causes of death among African-Americans, who also have lower life expectancies, higher infant mortality rates, and higher
rates of breast, lung, and colorectal cancer. Quality variation across geographical regions also exists in Medicare, said Katherine Baicker.

- But there is an increasing convergence among countries outside of sub-Saharan Africa: Populations in Latin America and Asia, for example, are becoming more urban and are aging. Consequently, the burden of chronic disease has risen, Barry Bloom observed. Rifat Atun, Director of the Strategy, Performance, and Evaluation Cluster at the Global Fund, reported that non-communicable diseases such as diabetes, cancers, and respiratory illnesses now account for roughly 80% of early deaths in low- and middle-income countries. Meanwhile, growing resistance to antibiotics and increasing numbers of people lacking access to health insurance in the United States have created new infectious disease challenges.

Significant problems also exist in the area of financial risk protection, as many health systems from the United States to China and India to sub-Saharan Africa fail to protect patients and their families from the financial ruin that can come from illness. These health costs have collateral effects. Individually, an unexpected illness can burden a family for extended periods of time and can minimize educational and economic opportunities. In the aggregate, high overall costs have the potential to siphon resources from the rest of the economy. The nature of financial risk protection varies across countries.

- Lower-income countries pay more out of pocket than higher-income countries – in some cases as much as 70%, reported David de Ferranti, President of the Results for Development (R4D) Institute. This leaves the poor more vulnerable to the catastrophic economic consequences caused by illness. Conversely, higher-income countries rely more on government and private-pooled financing mechanisms.

- High-income countries use different methods to protect against financial risk. For example, the United Kingdom uses a unified health system with global health budgeting; Canada has a social insurance single-payer system; Germany and The Netherlands adopt a social insurance system with competing plans; and France and Australia have a social insurance plus private system.

Finally, patient satisfaction is often a critical but neglected goal of health systems. Are individuals, families, and communities satisfied with the health system – with the level of access, the cost of care, the quality of the treatment, as they perceive it? Do individual patients find value in the services they receive, whether from private or public health care providers?

- Surveys indicate that the U.S. population is less satisfied than the European population with its health services, reported Niek Klazinga, citing multiple population and service surveys.

- In developing countries, lower-income populations, such as those in rural India or rural China, must wait longer for services at overcrowded public health centers. If they want more responsive service they must pay more to private providers, many of whom work in the public system but create private clinics on the side. Poorer citizens may thus find more satisfaction with local, traditional healers despite the risk of lower-quality care.

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Inadequate systems lead to poor health outcomes. In general, lower-income countries struggle with funding constraints and finding proper ways to allocate their resources, while higher-income countries, including many European nations and the United States, are dealing with rising costs and spending that do not produce better quality services or more equitable care. Broken systems need to be either reformed or strengthened to improve access, quality, affordability, and equity, all of which help achieve the ultimate goals of improved population health, financial risk protection, and citizen satisfaction.

To address these problems, advanced leaders may target what Marc Roberts called the “control knobs” of reform – financing, payment, organization, regulation, and behavior. What financing and payment system should be in place? What is the best organization for delivering services? What role should regulation play? And what kind of behavioral changes can foster reform?
What Are the Challenges to Reform?

Challenges to health reform may be conceptualized as the difficulty of turning the control knobs of reform. To move just one knob, advanced leaders must work through diverse stakeholders, diffused authority, dispersed resources, vague or conflicting goals, and no established institutions and pathways. Adding further complexity, major reform requires leaders to turn several knobs at once, making change an even greater challenge.

Health Reform in the United States
The passage of the Patient Protection and Affordable Act of 2010 represents only the beginning of health reform in the United States, said Robert Blendon, Professor of Health Policy and Management at the Harvard School of Public Health. While it took considerable leadership from President Obama to pass legislation that expands Medicaid, creates state insurance exchanges, and subsidizes the cost of private insurance for lower-income people, the true challenge will come with implementation which will alter the health system’s financial, payment, organizational, regulatory, and behavioral status quo.

Financing mechanisms in the U.S. suffer from diffused authority, dispersed resources, and conflicting goals. Public programs are fragmented at the state and federal level, while private insurers cover a separate set of individuals, Katherine Baicker explained. The number of different payers in the system creates a complex environment. Financing Medicaid and SCHIP (State Children’s Health Insurance Program) is challenging, because each state has a distinct set of resources, eligibility levels, and covered benefit amounts. For example, wealthier states can provide more comprehensive packages to Medicaid recipients, said Alan Weil, Executive Director of the National Academy for State Health Policy. Conflicting goals include the issue of who should pay – federal government, states, private insurers, employers, or individuals. There is a general mistrust of government in the United States, and there is the question of whether consumers and employers should have more “skin in the game,” said Alan Weil. This is a problem, according to Katherine Baicker, because private individual spending is not always targeted at the correct type of care and when employers pay more of the costs, a greater burden is placed on workers. Furthermore, there are issues of how to raise funds to pay. The Medicare trust fund is projected to run out, and the country will soon have to rely on general revenues. However, U.S. citizens are reluctant to pay higher taxes to help stabilize the trust fund.

Conflicting goals, diverse stakeholders, and diffused authority create significant obstacles to payment system reform. The U.S. has a fragmented system which relies primarily on a fee-for-service model, explained Robert Berenson, Senior Fellow at the Urban Institute. Such a payment structure incentivizes quantity over quality, procedures over outcomes. Hospitals, which are paid by case, and physicians, who receive a fee-for-service, also have conflicting incentives. Despite these misalignments, the health reform debate failed to focus on payment issues, observed Dick Pettingill, former CEO of Allina Health System and 2010 ALI Fellow. Payment reform is even more difficult given the different payers and varying amounts of reimbursement. Private insurers, for example, pay higher rates than Medicare and Medicaid. Yet barriers to episode- and quality-based payments include misaligned incentives, inadequate information, and weak measures.

Since the organization of the U.S. provider system is grounded in small, fragmented physician practices, it is difficult to coordinate care among multiple providers. Improved health services require the creation of integrated care networks, several participants argued. But this calls for the creation of new pathways organized around a “medical home” and integrated by technology and electronic medical records as in European nations. It also requires more team-based approaches by
providers. Thomas Zeltner, 2010 ALI Fellow and former Minister of Health of Switzerland, argued that patient-centered care and team-based medicine can not only improve the quality of services but can also reduce costs by decreasing hospitalizations, tests, and procedures.

The state has the power, through regulation, to influence the behaviors of actors. But setting regulation and implementing it is a significant challenge. When left on its own, adverse selection in a private market leads to a lack of coverage for the highest-risk individuals. The government can address this issue through regulation, but how can this be achieved in the face of full opposition by private insurers who must assume the additional risk? Transparency is also an important issue. Patients, for example, may want to know which hospitals are responsible for more medical errors, yet these providers are not willing to make the information public, observed Luicien Leape, Adjunct Professor of Health Policy in the Department of Health Policy and Management at the Harvard School of Public Health. Authority is also diffused between the federal and state governments. In the U.S. health care reform legislation, although states will be in charge of regulating insurance markets, the federal government is responsible for imposing mandates. As Alan Weil observed, health reform is a set of new federal regulations, most of which will be carried out at the state level. Furthermore, some participants, including James Mongan, former President and CEO of Partners HealthCare and Professor of Health Care Policy and Social Medicine at Harvard Medicine School, argue that legislated individual mandates may be too weak.

Behavioral challenges refer to attempts to alter the actions of stakeholders in the health system – from patients to providers. Can employers or insurers, whether private or public, encourage people to live healthier lives? How can the government and private insurers incentivize consumers to make the right health care choices? Through cost-sharing? Through wellness programs? Through other forms of personal accountability?

Similar financial, payment, organization, regulation, and behavioral barriers to change also exist in lower-income countries.

**Health Reform in Lower-Income Countries**

The field of global health has changed since the 1990s. Funding has increased, new players have appeared, and global agendas, such as the Millennium Development Goals, have been set. But huge challenges remain for the 80% of people on the planet that reside in developing countries.

Although the amount of resources flowing into global health initiatives has increased, financing and payment systems are fragmented. Multiple funders, including ministries of finance, public firms, households, and donor organizations, marshal scarce resources to work toward disparate goals that do not always align with the wants or the needs of recipients. Official development assistance (ODA) has roughly quadrupled since 1990, as sources have expanded beyond bi- and multi-lateral donors to include global funds such as GAVI Alliance, NGOs like Oxfam, private philanthropy like the Bill and Melinda Gates Foundation, household remittances, and the private sector such as those linked to corporate social responsibility initiatives. Funds are channeled through intermediaries, including the ministries of health, universities, social health insurance programs, other ministries (e.g., education), private insurance, private firms, donors, and households. They all intersect to fund an array of providers – ministry facilities, university clinics, private facilities, pharmacies, faith-based organizations, and NGOs. Yet reliance on voluntary funding is risky for lower-income countries, making the health system subject to larger economic fluctuations. Nor does increased spending guarantee better health. Coordinating financing and payment systems to optimize impact requires better leadership, meaningful governance, and stronger systems, said Barry Bloom.
Players within global health systems lack alignment and organization. What is the optimal relationship between actors for realizing specific health system goals – within and between countries? In most lower-income countries, public sector systems are weak, with out-of-pocket spending to the private sector accounting for as much as 70% total health expenditures. Health system bottlenecks, as detailed by Rifat Atun, include poor infrastructure, inadequate human resources, duplicated supply chains, and weak monitoring and evaluation (M&E) systems. When layering a complex international ODA assistance architecture over unstable local health systems, it is little wonder that funding increases do not necessarily translate into healthier populations.

Behavioral incentives and regulatory constraints may also help create change, but they are difficult to create. Sociocultural factors are hard to alter. Given gender roles, women may be at higher risk and may have a greater lack of access to care, especially during reproductive age. Local beliefs about the body and the etiology of disease affect how, when, and whether patients seek health care providers. For many ailments, populations in lower-income countries continue to rely on self-help and self-medication, often with the assistance of traditional health practitioners. Incentive systems among modern health providers may also be misaligned, with public doctors channeling clients to private fee-for-service clinics. Governments may also lack the ability to effectively implement regulation, such as the banning of steroids in India.

The often chaotic or uncoordinated nature of health systems in lower-income countries makes it difficult for multiple players to set reform agendas. Trade-offs abound when resources are scarce and diverse actors control them within a context of diffused authority. Barry Bloom asked, Should there be a greater focus on diseases or systems? A biomedical model or a social determinants framework? Prevention or treatment? Disease eradication or control? Vertical or horizontal interventions? Research or implementation? Mandated authority or partnerships? Public or private roles in global health? What role should the World Health Organization play in the new global health architecture – normative or operational?

Yet despite these reform challenges, Think Tank participants managed to identify ways in which advanced leaders could move health agendas forward, highlighting opportunities to continue reforming the system in the U.S while articulating ways to strengthen health systems in developing countries.
**U.S. Health System Reform: Providing Coordinated Patient Care**

The passage of U.S. health reform legislation took place in a hostile and complex political environment. Even after the bill was passed, support for the reform has not increased, with many states seeking to block implementation of the individual mandate. The public remains divided, focusing not on the new regulations with which the majority agree, such as removing an insurer’s ability to exclude people with pre-existing conditions, but on pieces of the reform which separate them. Many economists concur that the legislation, if implemented correctly, would greatly improve individual access to vital health care services. However, as Robert Berenson of the Urban Institute observed, the bill does not reform the actual health care system. Although health insurance reform does not necessarily constitute health reform, participants recognized it as an historic first step.

The future U.S. health care system should be responsible for managing the overall health of individuals when they are both healthy and sick, argued David Cutler, the Otto Eckstein Professor of Applied Economics in the Department of Economics and the Harvard Kennedy School of Government. If an individual is healthy, the system should strengthen prevention and work to keep that person healthy. However, if the person has an acute or chronic illness, the system should provide the resources to ensure that the person either recovers or receives the best medical treatment available. The system must also coordinate care as patients receive primary, secondary, and tertiary services as well as lab tests and pharmaceutical drugs.

While it may seem impossible for the current fragmented system to take on such a managerial role, Cutler suggested that there are opportunities for the government, private industry, and individuals to fill in the missing gaps. Most participants believed that the final result of these efforts should be an integrated delivery system that emphasizes prevention and wellness as well as the treatment of disease. Getting to this end product will require the government and private enterprises to develop innovative ways to align payment incentives, share information, and improve care processes. Only by working together can these stakeholders help to reform a fragmented system and provide coordinated and integrated care to patients.

**The Government’s Role as Regulator and Driver of Innovation**

The government’s role in health care is often understated in the United States. The federal and state governments not only administer and finance services to millions of Americans but also subsidize the cost of private market insurance coverage from employers and regulate the individual and small group markets. As Niek Klazinga stated, the government plays a crucial role in all sectors of the health care system, even if some of the influence is not completely understood by the public. The federal government probably has the most power to change consumer and provider behavior because of the sheer size and political sway of Medicare. Most private insurers use Medicare payment rates for inpatient and outpatient services as a benchmark for determining their own rates and policies. However, Medicare payments have not been renovated since the 1990s when William Hsiao introduced the Resource Based Relative Value Scale as a method for paying providers. Medicare continues to pay fee-for-service to most providers, which contributes to the problem of care fragmentation. Since many practitioners work in small practices and do not operate in teams to treat patients, it is simply easier to reimburse them independently for each service provided.

Encouraging providers to join multi-specialty and integrated delivery systems will in part require the development of new compensation systems for providers. According to Meredith Rosenthal,
Associate Professor of Health Policy and Management at the Harvard School of Public Health, Medicare has begun to evaluate new approaches. Besides introducing pay-for-performance payments in an attempt to promote value over volume, Medicare has begun to pilot bundled payments, either in the form of episode-based or complete global payments. Some of the projects include integrating larger provider groups with hospitals or bundling payments for certain easily defined episodes such as coronary artery bypass surgery. Thus far, pilot results have been positive, showing an improvement in quality and outcomes that stemmed from enhanced care coordination. However, Rosenthal cautioned that these types of bundled payments can only work for providers in integrated delivery networks, not in small, isolated practices. The dilemma in crafting policies is that integrated delivery systems need to exist in order for payment reforms to have a positive effect. Medicare and other private managed care plans have tried to develop global payment contracts with provider organizations in order to create accountable care organizations (ACO) and patient-centered “medical homes.” While the exact structure of these new organizations is still quite speculative, many participants believe that by emphasizing team-based medicine, they can eventually provide higher-quality care to patients at a lower cost.

As Medicare and Medicaid continue to run pilots, the government is counting on private insurers, hospitals, and physicians to learn how to work more seamlessly together, share risk and accountability, and aim towards these types of contracts. Thomas Lee, the CEO of Partners Community HealthCare and Jim Mongan, the former CEO of Partners HealthCare, identified an example of an integrated delivery system in Massachusetts that may be starting to sign onto global contracts with private insurers. The only issue that concerns consumer advocates with these contracts is how expensive they may become. While the goal is to provide these services at a lower cost, large provider groups are currently able to negotiate higher reimbursement rates than competitors, either because of their market share or brand name. Therefore, one question that still needs to be dealt with is how the federal or state government can help ensure that integrated delivery systems provide valuable care at an affordable price for consumers.

Although other integrated networks such as Kaiser, Geisinger, and the Mayo Clinic are flourishing in other states, one obstacle to the development of these organizations is a lack of state oversight. Massachusetts is a rare example of a state with tough regulations that encourage interaction among providers and a movement towards bundled payments. In 2006, Massachusetts passed a reform law that instituted an individual and employer insurance mandate, expanding coverage to over 97 percent of the population. Even before the passage of the reform law, Massachusetts passed a variety of regulations that protected consumers by limiting private insurers from using risk-selection policies, i.e., excluding people with existing medical conditions. With this, the state built the necessary foundation to begin developing new ways to contain costs and reform the payment system. As Jon Kingsdale, the Chair of the Commonwealth Health Insurance Connector Authority, stated, one of the many benefits of health reform in Massachusetts was that it brought many stakeholders to the table and enabled them to work together to develop solutions.

However, other states seem to lack the information, leadership, and infrastructure to institute the necessary reforms that could lead to delivery system reforms. According to Alan Weil, the Executive Director of the National Academy for State Health Policy, states do believe that changing supply-side or payment incentives can lead to lower-cost and more integrated care. Furthermore, states have developed medical home and ACO pilot projects using their Medicaid managed care plan enrollees. While many states are putting in the effort, they are facing tremendous opposition from providers, hospitals, and consumers who do not want to change the status quo and prefer the current fee-for-service system. They are plagued by under-funding, weak capacities to oversee and manage projects and programs, and insufficient data to evaluate specific results and make
improvements. In order to create change, Alan Weil emphasized the need for state officials to develop a vision to see past partisan conflicts and limited capacities, and think ethically about what the price is for doing nothing. Without reforming the delivery system, people even with insurance will still be unable to afford to see physicians.

The Private Sector: Forging the Path towards Care Integration with New Technologies
While states are starved for leaders, they also desperately need the support of private industry in the areas of data collection, process improvement, and care management. States around the country have begun to publicly report quality and cost measures on consumer-friendly websites. Furthermore, some states as well as the federal government require inpatient and outpatient facilities to submit claims data for people with specific conditions. However, as Thomas Lee suggested, the current measures that are being reported do not enhance the value of the services being offered. Many hospitals and providers do not believe that the measures in themselves improve processes, quality of care, or outcomes. Furthermore, most of the data that are collected is on Medicare patients, and even these data are of limited usefulness because of the absence of established electronic medical record systems in the majority of health care settings and problems of interoperability between provider and insurer databases.

The private sector thus has an opportunity to establish a niche in the health care information technology market. There are over 200 vendors that currently sell electronic medical record (EMR) system packages to physician practices and hospitals. The uptake of these products is meager primarily because of the high upfront and maintenance costs. Even with the upcoming federal subsidies to providers, there is concern among experts that health care institutions will still be unable to find the necessary capital to invest in this technology. Although EMRs have the potential to reduce costs and improve quality, according to Ashish Jha, an Associate Professor of Health Policy and Management at the Harvard School of Public Health, initial results showing the effectiveness of EMRs have been mixed, perhaps since there is no clear definition of an electronic medical record. The federal government, through the Office of the National Coordinator, has tried to create a “definition” of an EMR by establishing certain minimum requirements called meaningful use that institutions must meet to receive subsidies. These standards include capabilities that are intended to reduce medical errors, such as electronic prescribing, as well as functions that allow for data sharing between multiple parties.

Sophisticated and standardized EMRs can, in theory, help bridge different components of an integrated health care delivery system. However, there are many EMR systems that currently cannot share information with each other. If patients switch providers or networks, their records would not necessarily follow them. While one option could be to limit the number of vendors or to require every EMR to be universally compatible, David Cutler suggested a more realistic solution. In his view, the lack of EMR integration presents a great business opportunity for private entrepreneurs. Private management companies can collect data from different health care institutions and help providers coordinate with others responsible for a patient’s care. Developing new technologies that can digest and communicate data is, in Cutler’s opinion, the future of health care technological innovation.

But private industry may play another role. While most companies are concentrating on developing new machines, procedures, and tests from which they can profit in a fee-for-service dominated system, with the upcoming move towards bundled payments, industries might start trying to think of ways to make processes and treatments more efficient and effective. Companies such as CVS Caremark have already introduced a disruptive innovation to the regular primary care system. Under the leadership of Troyen Brennan, the CEO of CVS Caremark Corporation, CVS employs
Minute Clinics that provide basic services to consumers at affordable prices and convenient times. Instead of having to wait to see their primary care physician on Monday to treat a simple illness like the flu or strep throat, people can go to their local CVS store and see a nurse practitioner. Minute Clinics have a highly developed electronic medical record system, which includes detailed protocols that nurses can follow to ensure that patients receive the proper treatment. Furthermore, these records can be sent electronically or faxed to a patient’s regular primary care doctor.

There is skepticism among experts about to what extent these kinds of clinics will replace primary care functions and facilities. The main concern is that instead of providing a way to integrate care, the business instead segments a component of patient care and creates a separate process. Supporters of this model, such as Troyen Brennan and Richard Bohmer, Professor of Management Practice at Harvard Business School, state that there are ways to ensure that these clinics share all of the information and data they collect from patients with providers in traditional health care settings. Furthermore, in their view, health care should make the most use out of these businesses, since they are better equipped at analytically looking at processes and finding ways to reduce waste and increase productivity. Bohmer used the example of Virginia Mason, in Seattle, Washington, to illustrate the success of an institution that used an industrial approach to improve the quality of care they provided. Virginia Mason employs its own version of the Toyota Production System (TPS), which establishes a structure that gives staff members the ability to come up with ways to increase efficiency and stop mistakes before they happen. While industries can definitely standardize processes in cases where there are established protocols and guidelines, Bohmer believes that it will be up to individual providers and hospitals to improve processes for treating complex diseases. When patients have multiple diagnoses or cases that do not follow specific pathways, it is simply impossible to predict single course of treatment for everyone. However, as new diseases and treatments for these diseases are discovered, more diagnoses can go into this “standardized” category.

Employers and Consumers: Encouraging Responsibility

In a system where 60% of people are covered by insurance through their places of work, employers definitely can play a significant role in health care management and the coordination of care for their employees. However, given of the high cost of health care, most of employer efforts around health care have simply been aimed at the goal of reduced spending by cutting benefits or shifting more of a plan’s costs to employees. Furthermore, some employers have pushed workers to purchase plans with high deductibles and low premiums. Another approach, recommended by Sean Hogan, the Vice President of Global Healthcare Delivery at IBM, and Michael Critelli, 2010 ALF Fellow and former Chairman and CEO of Pitney Bowes, focuses on strategies that will decrease absenteeism and increase the productivity of employees. Through a combination of rewards and penalties, wellness programs can motivate an individual to make careful health care decisions and change their exercise, eating, and smoking habits.

Since employers are providing preventative services (such as weight loss sessions or free gym memberships) or curative services (such as onsite clinics) outside of traditional settings, they must develop ways to share results and data with hospitals and other health care institutions. One method of integrating care is through the use of personalized and easily transferable health records owned by patients. Personalized records are now being developed by individual provider networks as well as by Google and Microsoft. Not only can they give providers access to laboratory or test results from remote locations, they also enable patients to view and add to their records. Other mobile technologies can also help patients manage their care. For example, cell phones eventually should be able to allow patients to receive appointment reminders, find test results, or monitor their glucose levels if they are diabetics.
Although employers are pushing employees to become more responsible for taking care of their health care needs, consumers may not be able to understand all of the complexities surrounding the health care system and their specific conditions without some guidance. Engaging consumers will require the combination of media and educational campaigns. Charles Denham, 2010 ALI Senior Fellow and head of TMIT, suggested that the media is a great tool to reach consumers and to engage leaders. His documentary film, “Reaching Zero,” teamed with actor Dennis Quaid, whose children were victims of medical error, uses stories of individuals to create awareness and impel hospitals to improve the quality of their services. If patients themselves are to play an active role in coordinating their own care, they must have the proper knowledge, technology, and assistance that will help lead them through the system.

**Coordinating Care: The Need for Integrators**

Health reform is a dynamic and complex process that requires coordinated effort from all stakeholders involved in patient care. In a movement towards reform, the federal government, private industry, and employers are trying to develop innovative ways to deliver and manage services. From pilot projects that test out new payment methods to private industry’s attempt to improve and streamline processes, multiple actors seem to be working toward the goal of an integrated delivery system. However, as Bohmer suggested, each effort is currently operating independently in its own “ecosystem,” with no integrator helping to make all of the innovations work together. All of these great new ideas may be fruitless if there is no way to “connect the dots.”

There are several possibilities for what form this integrator can take. Private industry definitely has the means to develop new technologies to collect and manage all the data that are currently scattered throughout the health care system. Federal and state governments have the authority to change financial incentives and incentivize providers and hospitals to work together and share information. Patients can certainly take a more proactive role in both the prevention and management of their chronic illnesses. No matter who decides to accept the challenge and integrate all the new improvements and innovations, this person or entity will need tremendous leadership skills to reach across traditional boundaries, appease the opposition, and create the necessary structure and system-wide capacity needed to accomplish this task. The opportunities for advanced leadership in health reform are innumerable, and, as Cutler believes, the person who figures out how to reach this goal might soon find him or herself on the next *Forbes* 400 most wealthy people list.

However, taking advantage of the available opportunities for strengthening the health systems of developing countries may require different forms of collaboration among a different cast of actors who relate to one another in different ways.
Strengthening Global Health Systems: Collaborating for Impact

Numerous participants agreed that the reform of health systems in lower-income countries should focus more on systems strengthening rather than “vertical” interventions for specific diseases. But how can this be achieved? Marc Roberts emphasized the importance of first setting priorities and then identifying what control knobs mechanisms may be used to achieve specific goals. Julio Frenk, Dean of the Harvard School of Public Health and the former Minister of Health for Mexico, cautioned that reforming the overall structure of a health system may suffer if there is a lack of clear priorities. He suggested the use of a “diagonalization” approach – horizontalizing successful vertical disease-targeted programs or initiatives into general health care systems, thus strengthening the health systems. Rifat Atun offered examples of malaria and HIV interventions in sub-Saharan Africa which, when combined with systems strengthening efforts in the form of the training of health care workers, helped create lower disease rates. Regardless of the specific strengthening strategy chosen, successful outcomes will depend on the collaboration of public, private, non-profit actors and civil society in the governance, financing, planning, delivery, monitoring and evaluation, and demand generation of services.

Government-led Reform: Strengthening through Agenda and Goal Settings

Health system performance varies significantly between countries, even when they have similar income levels. These differences may be attributed to what Julio Frenk called LIST – leadership, institutions, systems design, and technologies, enumerated in decreasing importance. In each, the role of government differs based on local historical, political, economic, and sociocultural circumstances. Consider the cases of Mexico and China.

When Julio Frenk became Mexico’s Minister of Health in 2000, over half the country’s citizens or 55 million people lacked health insurance, with 52% of all expenditures paid out of pocket. These expenditures placed a significant burden on the country’s poorest citizens. Those that made less paid more, with roughly 4 million families bankrupted every year. Frenk grounded Mexico’s reforms on three pillars – technical, ethical, and political. An initial step was technical – to make the problem visible and identify a solution. Once Frenk and his colleagues described the nature and scale of the issue, they worked backwards. They estimated the financial cost of extending insurance and determined that they could cover 55 million people over a seven-year period by adding one percent of GDP to the health budget. Next, Frenk identified a clear ethical case for reform. Access to health care was neither a service nor a privilege but a right stated in Mexico’s constitution. In the vast majority of cases, when people fall ill it is not their fault. They deserve protection. If they lack it, the system is unfair. Frenk then leaned on these technical and ethical pillars to make his political case to legislators, ministers, and the public. He combined his ethical plea with an economic argument aligned with a core national goal – health reform could and should serve as the centerpiece to economic development. Once the three pillars were laid and legislation passed, subsequent efforts consisted of what Frenk calls the ABCDEs – a clear agenda that helps compete for resources, a budget invested with priority, investment in capacity focused on service delivery and human resources, tangible deliverables that cement public support, and concrete evidence that empowers actors.

China’s reforms followed a different pathway. In the 1980s, as China moved toward a market economy, health expenditures began to shift from the public to private sector, leaving the country in a position similar to the U.S. Access to health care had fallen while costs were rising. By 2002, China’s health system had lost its prior emphasis on prevention, public facilities were underfunded,
80% of the population lacked insurance coverage, perverse administrative incentives were driving up unnecessary procedures and costs, and the delivery system was fragmented between preventive, primary, and tertiary services. With a strong central government, political leaders articulated clear principles of reform focusing on the balancing of economic and social development and emphasized the goals of equity – provide all citizens affordable access to care and financial protection against catastrophe. Benefiting from an economic boom, the central government reallocated 1 to 1.5% of the GDP to the health sector. Reforms included government subsidies to extend insurance to the lower-income population, renewed focus on prevention, investment in community primary care centers, and the bulk purchasing and distribution of essential drugs to drive down prices and make them more accessible. According to William Hsiao, China will achieve its goal of universal access. However, the country still has not adequately addressed the issue of cost inflation and service fragmentation. “How can China transform money into efficient and effective health services?” Hsiao asked. Options range from government-centered to market-regulated approaches. When viewed through the lens of Frenk’s three pillars, China’s initial reforms were enabled by a clear ethical position, while centralized authority minimized initial political obstacles. However, the technical solutions for cost control remain unclear, renewing political debate among the country’s leaders as the role of the private sector has not yet been worked out.

Private-led Reform: Strengthening through Privatization

The private sector often accounts for half or more of total health expenditures in lower- and middle-income countries. Successful health system reform must work with and through the sector to achieve the scale needed to improve population health, argued Michael Chu, Senior Lecturer at Harvard Business School. For Chu, one may look at the social objective of health interventions by asking, “What is the most effective option at the lowest price for the largest number of people in the least amount of time?” While there are multiple ways of distributing resources, the market, despite certain weaknesses, often offers the best opportunity because it helps simplify decision-making, aligns objectives through supply and demand, clarifies payments, can streamline delivery, and institutes market accountability. These advantages help drive scale, permanence, efficacy, and efficiency. Chu cited Farmacias Similares, which offers low-cost medicines and health provider access in Mexico; Narayana Hrudayalaya, which creates a tiered pricing system which subsidizes heart surgeries for the poor in Bangalore, India; Aravind Eye, which uses a similar model for ophthalmology in Madurai, India; and the privatization of the Manila water system in the Philippines.

Prior to privatization in 1999, only 60% of Manila’s households had piped water, a situation which affected a greater percentage of the city’s poor who purchased water from vendors at seven times the price of connected households. In the first year of private operation in eastern Manila, the new company lost $1 million due to theft and leakages. Less than 40% of the water used was invoiced. But by 2006, after nearly $500 million in investment, access rose from 325,000 to 909,000 households or 98% of the more than five million people leaving in eastern Manila, with 70% of water invoiced. Profit had risen to $49 million. Community groups were satisfied enough with the service that, during regulatory hearings in 2006, they chose to support the company’s request to increase tariffs.

Bottom-of-the-pyramid projects have shown exceptional promise. Wendy Woods, Partner and Managing Director of the Boston Consulting Group and leader of the consultancy’s work in global public health, highlighted two models used by Hindustan Unilever, the consumer goods giant’s India subsidiary. Project Shakti enlists and trains women to act as sales agents reaching 250 million consumers in 80,000 villages otherwise out of the reach of the country’s distribution system. Since 70% of India’s roughly 1.2 billion citizens live in rural areas, the project has proven vital to the
company’s business. Shakti outreach activities include health education via school-contact programs and village get-togethers. A second project is Lifebuoy Swasthya Chetna or “Glowing Health,” a diarrhea prevention program which targets children and mothers to teach them how the use of soap kills bacteria leading to the illness. The program included village health days, school presentations, diarrhea management workshops, and health clubs. Soap sales grew by 30% in the project sites.

But there are limits to what business can and cannot do, Chu concluded. Business is good at offering focused solutions where there is a clear value. However, business cannot provide all public goods. Private goods complement public goods, and government is the final guardian of population health. “The private sector is not a substitute for public health,” Chu said. “But its power to improve health is largely to be tapped.” One way of exploiting these opportunities lies in better use of public-private partnerships (PPP).

**Private-Public Partnerships: Strengthening through Alliances**

One framework for understanding public-private partnerships was offered by Wendy Woods. Actors range from the public sector to NGOs, faith-based organizations, and foundations to the commercial private sector. Funding may come from public entities, donors, or the private sector. However, the most effective partnerships go beyond funding. Assets shared include a vision, political and community influence, project management and coordination expertise, human resources, products, distribution capacity, and technical knowledge, often in the form of best practice ideas.

Consider the example of the Rwanda Tracnet HIV/AIDS program, a health information system set up by the Ministry of Health in partnership with other public and private sector entities. The private companies share core capabilities. Two telephone companies give away numbers and network time for the system, while an international software firm provides IT support. Meanwhile, the public sector partners help with funding, training, quality supervision, and distribution. Trac, a Rwandan government entity, runs the system and trains workers. A separate public entity manages the stock of antiretroviral drugs, a national lab performs blood tests, and the U.S. Center for Disease Control extends general support.

Particular success has also been achieved in product development partnerships (PDPs). In the late 1990s, there was little focus on developing vaccines for communicable diseases such as malaria. By 2009, there were 14 PDPs with roughly $500 million in total funds dedicated to creating health products for developing countries. Alliances have now formed to work on vaccines for HIV/AIDS (IAVI), TB (Aeras), malaria (MVI Path), dengue (Pediatric Dengue Vaccine Initiative), diarrhea (International Vaccine Institute and Path Vaccine Solutions), and respiratory illnesses (Meningitis Vaccine Project).

However, reform does not necessarily have to be led by the government or industry. Non-governmental organizations have learned to partner with both and spearhead interventions, especially at the community level.

**Non-profit-led Reform: Strengthening from the Ground Up**

The role of non-governmental organizations has increased in importance since the 1990s, not only in the area of financing but in project implementation. For example, Hugo Tempelman, CEO of Ndlovu Care Group in South Africa and Visiting Professor at Utrecht University, has led the development of an integrated community medicine model dedicated to improving community health in South Africa, especially in the area of HIV/AIDS.
For several years, Tempelman explained, the South African government failed to take more proactive steps to address HIV/AIDS, allowing the disease to spread rapidly and cause incalculable damage. Between 5.5 to 7.2 million of South Africa’s 48 to 50 million citizens have HIV. The equivalent of two commercial jets full of people dies every day in the country from the illness. The treatment gap is large. The Ndlovu model seeks to fill this need through a set of community health initiatives targeting different stages of the disease. It works on prevention by educating through clever billboard campaigns about the importance of condom use. It provides local community clinics for testing and treatment service, not only for HIV/AIDS but for other ailments such as TB. It encourages family involvement, engages traditional healers, and integrates into primary health care services. It ensures patient retention and treatment adherence by providing lay counselors, cell phones, entrepreneurial opportunities, and offering the community childcare, sports, drama, and music programs. Tempelman suggested that the model may be scaled in South Africa and interfaced with the country’s national testing initiative. Yet doing so requires more private-public partnerships, with Ndlovu as the implementing and management agency, but with the aim of strengthening the national government’s district health service delivery system.

In light of transitions in the global health landscape, including funding increases, the multiplication of actors, and shifting demographics, Barry Bloom suggested that future global health system reform should focus on five areas – agenda setting and governance; financing and resource allocation; research and development; implementation and delivery; and M&E and learning.

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In short, health system reform is not just a matter of a bold stroke of public policy, nor can it take place only through private sector demonstrations, whether on a not-for-profit or for-profit basis. It is part of a complex system of actors and structures, requiring both innovation and collaboration across various parts of people’s lives, whether in work organizations where employers can set the context or in communities where many institutions intersect.
Leadership for Change:  
System Elements Advanced Leaders Can Address

Reforming or strengthening health systems requires advanced leadership skills to coordinate diverse stakeholders, marshal diverse resources, and align interests to achieve impact. To change systems, actions must be taken on multiple fronts simultaneously. For Rosabeth Moss Kanter, advanced leadership in health reform may be conceptualized as tasks on a “change wheel.” At the center of the wheel is the initiative’s goal. Surrounding the goal, extending like spokes, are elements of action. They include a shared vision; symbols and signals; governance and accountability structures; education, training, and action tools; champions and sponsors; quick wins and local innovations; communications and best practice exchange; policy procedures and system alignment; measures, milestones, and feedback; and rewards and recognition. To initiate change, leaders must begin to address these leadership tasks. But to create change, they will eventually have to address all components.

- **Shared vision:** A vision inspires and rallies actors around the common goal. “Reaching Zero” is Charles Denham’s vision for a U.S. medical system free of medical error. In China, the goal of equity-aligned politicians. In Mexico, Julio Frenk articulated a vision built on an ethical pillar of health as a right and a technical pillar of how to get there. In the U.S., however, reform leaders failed to create a shared vision. How can the federal and state governments, the private sector, employers, and citizens rally around the common goal of creating integrated delivery systems that promote patient-centeredness and coordinated care?

- **Symbols and signals:** Leaders may use signs or symbols to convey seriousness of action and further convince constituents of the importance of change. When Michael Critelli began to make small changes in the provision of health services and wellness programs at Pitney Bowes, employees had tangible evidence of what the change would mean for them.

- **Governance and accountability structures:** Project success depends on who controls resources, makes decisions, and has responsibility for tasks. Efforts to address malaria were greatly enhanced by the creation of a global governance structure to oversee international efforts, and engagement of all sectors of national programs funded by the Global Fund for AIDS, TB, and malaria, including public, private, NGO, and civil society, said Barry Bloom. Private-public partnerships, such as the Rwanda Tracnet HIV/AIDS program, benefits from clear division of labor. However, at the level of international donors, a better governance model is needed to coordinate the increase in the number of players and amount of new resources and demands for accountability in the global health system.

- **Education, training, and action tools:** Education helps convey the why and how of change, and training provides people with the tools to implement change. The film “Reaching Zero” creates awareness around the problem of medical error and what citizens can do about it. The use of billboards by Ndlovu in South Africa teaches citizens about HIV/AIDS. Workforce training in sub-Saharan Africa by the Global Fund increased the impact of disease interventions and strengthened health systems. However, more education and training is needed. People in the U.S. continue to lack awareness about the influence of unhealthy lifestyles on their health. The globe is facing a global shortage of health care workers.
• Champions and sponsors: Champions are impassioned leaders of change. Sponsors support champions and are in positions of power to provide backing. Foundations, for example, may sponsor innumerable change agents – and not just with financial support. Charles Denham, who had medical expertise, and Dennis Quaid, a visible and passionate spokesperson, developed a partnership to communicate their vision of change. But is there a way to better connect champions and sponsors?

• Quick wins and local innovations: Quick wins demonstrate the possibility of change and show what it will look like. During the reform of the Mexican health system, Julio Frenk recognized the importance of giving tangible deliverables that cemented public support to promote longer lasting and effective health care reform, which would take seven years to complete. A major challenge in the U.S. health reform will be whether leaders can point to early evidence of success.

• Communication and best practice exchange: During change, leaders must know what is happening in multiple areas in order to better guide efforts. Those implementing change must also have knowledge of what is working elsewhere within or without an organization. Virginia Mason, for example, has achieved success by employing elements of the Toyota production system. Julio Frenk called for better documentation and sharing of national reform efforts that ministries of health could learn from. There are less than 200 countries in the world, and the opportunity for learning cannot be missed, he said. In the U.S., 50 states will be required to implement federal legislation, but how will they learn from one another?

• Policy procedures and system alignment: Organization structures, policies, and processes must be reassessed and aligned to achieve objectives. China, for example, clearly articulated goals and ethical framework for how to provide affordable care to all. However, it did not adequately address the system’s administrative processes and incentives, which continued to drive up health care costs. Leaders will encounter similar challenges in the reform of the U.S. health system, especially in financing, payment, and information systems.

• Measures, milestones, and feedback: Measures are needed to determine whether impact has been made. These measures encourage the use of better feedback mechanisms and help keep projects on track. The creation of the Millennium Development Goals in 2000 was a monumental achievement, which has helped align efforts toward concrete global health objectives and targets for developing countries. But what measures and benchmarks will be used during the implementation of U.S. health reform? Intermediate milestones help motivate stakeholders to make it through the difficult middles of change, Kanter said.

• Rewards and Recognitions: Leaders must create award and recognition systems that motivate stakeholders both in the middle of change projects and at their completion. After all, change is not an event but a campaign, Kanter reminded. Unless actors – be they sponsors, champions, or members of the initiative – feel as if their work is appreciated and that they are making a difference, change efforts may stall.
Conclusion: Where Do We Go from Here?

Despite the complexity of health systems, opportunities for change abound. The key, said Harvey Fineberg, President of the Institute of Medicine and former Provost of Harvard University, is to first have a clear conception of what kind of value the system should deliver and then exercise the leadership needed to alter the incentives and create the innovations for achieving that goal.

Leaders must be careful in how they define value. Value is an equation consisting of benefits divided by costs. But value for whom and at what cost for whom? A notion of patient-centered value, for example, may not capture all aspects value. Are costs understood as private and individual or public and social? Fineberg suggested defining value for a health system as the ratio of population health outcomes divided by the total costs to achieve it. Transforming systems also calls for aligning incentives and forging innovation. All actors in the system – be they patients or doctors; payers or providers; public, private, non-profit or civil society – must be motivated to make decisions that will improve the system’s overall performance. Improved performance consists of incremental advancement but it also depends on innovation – in technology and organization. New information systems in the form of Electronic Medical Records can better integrate care, but so, too can new business models or administrative processes, even of the simplest kind, such as streamlining patient flow through hospitals in order to maximize the number of beds used. Opportunities for reform exist, especially in the U.S. following passage of health care legislation, but it will take leadership to take advantage of them.

Health is an enormously complex system in any country, Barry Bloom concluded. Change cannot be made without leaders – with vision, with a respect for evidence, and with the ability to inspire people. Furthermore, systemic change cannot be led by one leader. It is a collective effort, requiring coordination among many advanced leaders in multiple sectors working toward the collective goal of improving the health of the global population. And that is why Harvard’s Advanced Leadership Initiative hopes that discussions such as this Think Tank may contribute to development of leadership in health and beyond.
Think Tank Agenda

Thursday, May 6

3:00-3:15   Introduction to Advanced Leadership and the Challenges of Big Social Change

3:15-4:30   Session 1: Health Care Reform: The Big Picture
Moderator: Barry Bloom
Speakers: Julian Schweitzer; Katherine Baicker

4:30-6:30   Session 2: Lessons from the Most Developed Economies
Moderator: Barry Bloom
Speakers: Cathy Schoen; Niek Klazinga

7:00-9:00   Dinner with Keynote by Julio Frenk

Friday May 7, 2010

8:30-10:30  Session 3: Health Care Reform in Developing Countries: The Challenges of Health System Strengthening, Implementation, and Scale
Moderator: David De Ferranti
Speakers: Rifat Atun; Marc Roberts; William Hsiao; Henry Chow; Pablo Pulido

10:45-12:45 Session 4: Health Care Reform in the U.S. – What we have missed at the policy level and what does it mean?
Moderator: David Cutler
Speakers: Robert Berenson; Lucian Leape; Jim Mongan; Dick Pettingill

12:45-2:00  Lunch with Keynote by David Cutler

2:30-5:30   Session 5: Health Care Reform in the U.S. – What still needs to be done to improve health care performance?
Moderator: Arnold Epstein
Speakers: Jon Kingsdale; Bob Blenden; Charles Denham; Ashish Jha; Meredith Rosenthal; Clifton Peay

5:45-6:45   Break Out Sessions – What innovative projects could make a difference?

7:00-8:30   Dinner with Keynote by Alan Weil

Saturday May 8, 2010

8:00-10:00  Session 6: Innovations in Health: Reform from the Ground Up
Moderator: Rosabeth Moss Kanter
Speakers: Thomas H. Lee; Sean Hogan; Paul Farmer; Rear Admiral Susan Blumenthal; Dr. Hugo Tempelman

10:00-12:00 Session 7: The Role of the Private Sector in Improving Health
Moderator: Michael Chu
Speakers: Wendy Woods; Troyen Brennan; Richard Bohmer; Michael Critelli

12:15-1:45  Lunch with Keynote by Harvey Fineberg
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Rapporteurs: Matthew Bird and Jeffrey Davis
Recording and transcription services donated by Chuck Denham and TMIT