THE RECORD

Interagency Institute for Federal Health Care Executives

Volume 30, Issue 2

Fall 2017

From the Director…

We were very fortunate that the 131st Interagency Institute had a strong international composition. In addition to having a Canadian participant, COL Dan Farris, we were very pleased to have MAJ Steve Adamson, a Royal Australian Army Medical Corps officer, currently assigned in San Antonio, as a participant. Over the years we have hosted participants from Australia, Canada, Thailand and the United Kingdom. I hope that we will continue this practice as it enriches our discussions and broadens our perspectives on many of the topics covered in the Institute.

The book selected for the 131st Institute was 'An American Sickness' by Dr. Elisabeth Rosenthal. As has happened on many occasions in the past, with regard to the authors of books selected, we were very fortunate to have Elisabeth as one of our faculty members. She spoke about her assessment of the current state of health care in the United States and what could be done to make the 'system' and its outcomes better for patients, providers and payers. One of the small groups was assigned her book as their focus. Their report is included in this newsletter. It is clearly a very important topic for our society although I feel that the current level of 'debate' on health policy is moving us backwards rather than forwards. Time will tell but I am not optimistic that, as a nation, we are prepared to confront the fundamental questions and issues which have resulted in the costly and dysfunctional state of health care we observe in 2017.

The guest speaker for the 131st Participants and Alumni dinner held at the Key Bridge Marriott Hotel was the Honorable Lawrence L. Piersol, a distinguished federal judge from South Dakota. Judge Piersol gave a most interesting talk about his life experiences, the role of the federal courts and his reflections based on his distinguished legislative and judicial careers.

I am very pleased to report that VADM Raquel Bono, MC, USN, Director of the Defense Health Agency, has been selected to receive the Federal Health Care Executives Institute Alumni Association Distinguished Service Award for 2017. In addition to being a graduate of the Interagency Institute, Admiral Bono has been a regular faculty member as well. Her dedication to the goals of the Institute, her consistent support and friendship are sincerely appreciated. I hope that many of you will be able to attend the Alumni Breakfast meeting at AMSUS on November 30th.

With best wishes,

Richard F. Southby, Ph.D. (Med), F.F.P.H.
Director

L to R: Dr. Southby; Dr Josef Reum, IAI faculty; The Hon Lawrence Piersol, Dinner Speaker; VADM Forrest Faison, III, MC, USN, Surgeon General, USN.

Letter from the President, FHCEIAA

Congratulations to the alumni of the 131st Interagency Institute and welcome to the Federal Health Care Executives Institute Alumni Association! We are thrilled you have joined us. A special thank you to Health Net Federal Services, LLC and Express Scripts, Inc. for their generous support of our Institute dinner on 20 Sep 2017 at the Key Bridge Marriott. It was a truly exceptional dinner, venue and gathering with insightful remarks presented by our guest speaker, The Honorable Lawrence L. Piersol.

This time of year brings the advent of autumn and hurried schedules when school is back in session. With the transition of seasons, we enjoy an amazing array of fall colors and welcome cooler weather. Along with these changes comes an infusion of new energy into the Interagency Institute and the opportunity to tap into the incredible resourcefulness and continued resilience of this amazing group of leaders in federal health care.

We have a social media presence on Facebook! Please check out our site and stay tuned for updates. You are highly encouraged to use this tool to post your own updates, maintain connections, collaborate and respond. You can locate us by name search or through our direct link: https://www.facebook.com/Federal-Healthcare-Interagency-Institute-1805076689707896/

Please join the FHCEIAA if you have not already done so. Membership ensures the maintenance of essential connectivity and collaborative wisdom to maximize our resourcefulness and effectiveness. Additional noteworthy opportunities for members include receiving the FHCEIAA newsletter, the ability for dependent children or grandchildren being able to apply for the FHCEIAA scholarship, becoming active in alumni association leadership, and more. If you have any questions or would like to inquire, kindly contact CAPT (ret) Gayle Dolecek at gjdolecek@verizon.net.

Administratively, I ask that you add CAPT (ret) Gayle Dolecek's e-mail address to your contacts to avoid timely FHCEIAA correspondence ending up in your spam folder.

I encourage you to attend the **FHCEIAA Annual Business Meeting**, which will occur during the 126th Annual AMSUS Meeting, 28 November – 1 December 2017, at the National Harbor MD (Washington, DC Metropolitan Region). **Our annual meeting will be held at the Gaylord Convention Center on 30 Nov 2017 at 0645 – 0745 in National Harbor Rooms 2/3. Continental breakfast is available for a reduced rate of $25.** I hope you will join us to be an active and valuable part of the discussion. You may register for the breakfast meeting through your AMSUS registration or by calling Ms. Janet Neiman at 301-828-1589.

As always, we look to tap into the energy and enthusiasm of our highly respected alumni for fresh ideas on how to advance the alumni association. If you are interested in serving as a board member, kindly express your intent by sending an email to me (aaron.p.middlekauff@uscg.mil) or CAPT (ret) Dolecek (gjdolecek@verizon.net).

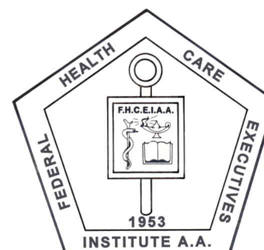
I am honored and humbled to be your president this year and strive to make myself readily available to meet your needs. I look forward to achieving extraordinary accomplishments together!

Sincerely,

Aaron

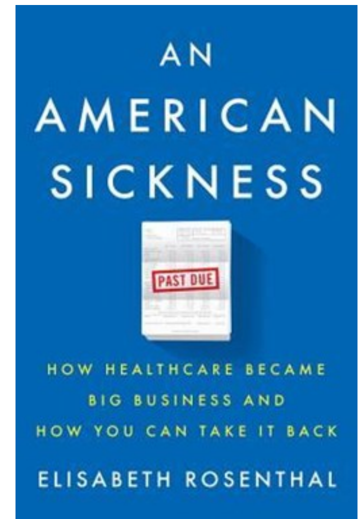
CAPT Aaron P. Middlekauff, Pharm.D., USPHS
U.S. Coast Guard Headquarters - Pharmacy Program Chief/Consultant/Force Manager Coast Guard HIPAA/
Privacy Service Representative Quality and Performance Improvement Division COMDT, USCG HQ (CG-1122)
2703 Martin Luther King Jr. Ave SE, Office #9Y21-22, STOP 7907
Washington, DC 20593-7907
(202) 475-5181

Visit the FHCEIAA website:
http://www.fhceiaa.org



***An American Sickness: How Healthcare Became Big Business and How You Can Take It Back,* was selected as the book for this Institute and a copy provided to each participant. The author, Dr. Elizabeth Rosenthal, spoke at the Institute and responded to questions.**

A small working group was asked to address the following:



- What are the major findings and recommendations drawn by Dr. Elisabeth Rosenthal in her book, 'An American Sickness'?'
- In the current political environment in the United States, what impact do you feel Dr. Rosenthal's research and advocacy will have on changing health policy and practices at the federal, state and local levels?
- What are the implications for health care provided through the military health system, the Department of Veterans Affairs and the US Public Health Service?

Group I Members: COL Patrick Garman, USA; CAPT Ramsey Hawasly, USPHS; Col(S) Dan Lamar, USAF; CAPT Rachel Lewis, USN; CDR Khon Lien, USN; Col Karyn McKinney, USAF; CAPT(s) Frank Mullens, USN; Col Michael Roberts, USAF; and Ms. Carol Weese, VHA.

Major Findings and Recommendations: The overarching finding of Dr. Rosenthal is that the American health system has become purely a business model oriented at maximizing revenue without significant concern for patient experience or health outcomes. A primary concern is rapid increase in healthcare costs, in addition these costs are unpredictable and an increasing amount of the cost is borne directly by the patient. A dysfunctional market leads to paradoxical results: competition leads to increased prices, less choice and medically ineffective overuse of services.

Dr. Rosenthal recommends a patient call to arms with increased awareness of costs and willingness to confront/question all aspects of the health care system. Doctors need to be aware of the cost of their prescribed treatments and assist the patient in choosing the most efficient option. Hospitals should develop transparent pricing with an itemized, inclusive billing structure that may foster competition and limit unexpected patient financial liability. Insurance companies need current provider network listings that clearly define covered services to limit out-of-network penalties. In addition, changes to the underlying structure of insurance plans to include reference pricing, bundling of payments and designed to meet patient needs (i.e. sliding scale co-pays based on medical necessity) would be helpful. Drug costs could be addressed through negotiating national pricing, importing from lower cost locales, reforming patent system to reward true innovation, giving pharmacists prescribing power. Information technology within health care should allow the patient to control/possess their medical data and facilitate one-stop scheduling with payment requirements known prior to the appointment.

Impact in the Current Political Environment: Dr. Rosenthal's suggestions will probably not change health care policy at the federal, state, or local levels at this time. At the federal level, there is no political will. Although the Republicans have majorities in the House and the Senate and the Presidency, they not are not able to repeal and replace the Affordable Care Act. This hyper-partisan era precludes moderates from achieving compromise for the good of the United States. If a congressman is willing to compromise, strong Political Action Committees and other lobbyists will support and fund an opponent in the primary elections.

Lobbyists have an enormous effect on legislation. President Obama tried to control healthcare costs in the original draft of the Affordable Care Act, but due to intense lobbying by drug companies, insurers, and hospitals, language was modified to get Congressional support.

Hospitals have gone from being philanthropic agencies to for-profit organizations. As a result, legislation that is seen in cutting into their profits will be met with major resistance. Healthcare is currently controlled by a third-party payer system, namely insurance agencies that not only control premiums and deductibles but also how much will be paid for medical procedures. Likewise, hospitals and drug makers seek profits and lobby against price controls; thus, health care costs will continue to increase. At the state level, lobbyists also have a major influence and at the local level not much can be done to meaningfully affect health care.

Due to the current gridlock in Congress, there will be no change of the status quo and health care costs will rise astronomically. It is at the point where patients are afraid to go to the hospital because of unknown costs. It will take a perfect storm so to speak for any change to occur.

Implications for health care provided through the military health system, the Department of Veterans Affairs and the US Public Health Service: The U.S. federal health care system is not rigged against the patient; rather it should be viewed as a possible model for the American Health Care System. When looking for ways to reform the National system, the already established governmental systems that DoD and VHA operate should be used as potential frameworks. The U.S. Federal Health Care entities are not driven by profit, unnecessary testing, and facility fees; instead, they embody the author's three tools to reign in cost: bulk negotiating, single payer, and transparency. Successful aspects of these Federal Systems encompass the use of the author's three tools. This allows health care providers to focus on patient care rather than the business-driven civilian model. These tools, which are already being utilized by Federal Health Care entities, can be used as a foundation to reform the American Health System.

Elisabeth Rosenthal, M.D., is the editor-in-chief of Kaiser Health News. Prior to joining Kaiser Health News, she spent 22 years as a correspondent at the New York Times.
The following is taken from page 8 of her book, "*An American Sickness: How Healthcare became Big Business and How You Can Take it Back*:"

Economic Rules of the Dysfunctional Medical Market

1. More treatment is always better. Default to the most expensive option.
2. A lifetime of treatment is preferable to a cure.
3. Amenities and marketing matter more than good care.
4. As technologies age, prices can rise rather than fall.
5. There is no free choice. Patients are stuck. And they're stuck buying American.
6. More competitive vying for business doesn't mean better prices; it can drive prices up, not down.
7. Economies of scale don't translate to lower prices. With their market power, big provide can simply demand more.
8. There is no such think as a fixed price for a procedure or test. And the uninsured pay the highest prices of all.
9. There are no standards for billing. There's money to be made billing for anything and everything.
10. Prices will rise to whatever the market will bear.

With 46 percent of Americans unable to cover a $400 emergency expense and the average hospital stay costing $4,300 a day (according to 2013 numbers), it's no wonder that medical bills are the leading cause of personal bankruptcy and has been for years. Source: https://www.pbs.org/newshour/economy/making-sense/column-5-questions-ask-hospital-stay
To protect your financial health while in hospital, and soften the blow of medical bills, Dr. Rosenthal proposed five questions to ask during your stay. **Turn to page 13 to see the recommended precautions.**

HEALTH CARE REFORM

Small Group Assignment: 'Health Care Reform' has been a regularly recurring topic in the United States since the 1920's but our 'system' is still criticized for not considering health care as a 'right' for every citizen, its inability to guarantee access to comprehensive and coordinated health care, the misdistribution of health professionals, by specialty and geography, uneven quality performance, tremendous variability in outcomes, and excessive costs, especially for institutional care and pharmaceuticals.

Even with the limited implementation of the Patient Protection and Affordable Care Act, the United States still has as many people without health insurance, or inadequate coverage, as the total population of Australia.

What steps do you recommend should be taken, by the public, private and civil society components to reform our health system, at the federal, state and local levels?

Group II Members: MAJ Steve Adamson, Australian Army; Dr. Lisa Backus, VHA; Col Jeffrey Bailey, USAF; Col Dawn Brooks, USAF; LTC(P) Clayton Chilcoat, USA; CDR Scott Coon, USN; CDR Bart Cragen, USN; COL James Grady, USA; COL Melissa Hoffman, USA; Dr. Narayan Nair, USPHS; Col(S) Andrew Stoy, USAF.

Introduction: The recent political wrangling to have the Affordable Care Act removed and replaced has placed much needed attention on the United States health care system. The United States spends a higher portion of its gross domestic product on health care than any other country but the World Health Organization ranks it 37th out of 191 countries according to its performance. With estimates of $3.4 trillion spent annually on services, health care costs are nearly 20% of the nation's GDP. Access, distribution of health care providers and specialists, quality, outcomes, and especially outrageous costs for procedures and pharmaceuticals are just a sample of the criticisms. Health care reform, and the right for each citizen to receive health care, has been debated for over 150 years. Reform is a complex, multifactorial problem and many would agree there is no ideal solution. There are several components, however, if addressed properly at the federal, state and local levels, could help improve the health care system.

Public Insurance Option: A potential measure would be to create a public insurance option, a government-run health insurance agency that would compete with private health insurance companies. This option is not the same as publicly funded health care but is proposed as an alternative health insurance plan offered by the government. The public option would allow citizens to buy into the Medicare program and their premiums would finance their participation. Supporters contend that a government insurance company could successfully lower rates and help control costs by using greater leverage than the private industry when negotiating with hospitals and doctors and have administrative costs substantially lower than private insurance companies. Such an option was introduced in January 2013 in the House of Representative (H.R.261 the "Public Option Deficit Reduction Act") which would have amended the 2010 Affordable Care Act to create a public option. The bill would have set up a government-run health insurance plan with premiums 5% to 7% lower than private insurance with the Congressional Budget Office estimating a reduction in the US public debt by $104 billion over 10 years.

Insurance and Pharmaceutical Reform: In addition to the public insurance option, improvements in current insurance options and pharmaceutical reform could be implemented allowing insurance companies to sell health insurance plans and consumers to purchase health insurance across state lines. This would allow consumers to buy health care coverage with a greater choice of plans and an option to purchase lower cost insurance, especially residents of a state with expensive health plans. This would improve competition, reduce cost and improve the value for consumers.

Another measure could be to allow individuals and insurance companies to purchase drugs from Canada and other countries providing leverage to negotiate prices nationally and internationally. This would be done by easing pharmaceutical import regulations to allow pharmacies, wholesalers, individuals, HMOs and insurance companies to import prescriptions drugs, however, quality control would have to be addressed.

Increased Transparency: Health care reform must include opportunities to improve the value proposition of health care by optimizing benefit and controlling costs. Optimization of care and service benefits through transparency in quality and service measures is a driver of improvement. While governmental regulatory control of payer

and provider pricing is unlikely to gain political traction in a pluralistic health economy, control through marketplace competition may be more congruent with public sentiment. Emerging evidence suggests that provider and payer transparency in pricing, quality measures, services, and outcomes improves opportunities for informed patient decision-making and is associated with the improvement in the leading metrics of cost and patient satisfaction. Improvement in health and health care outcomes is a lagging metric yet to be validated, perhaps owing to the limited experience in a transparency paradigm. Advocating for a full transparency requirement in health care reform will strengthen patient-centered choice and enhance payer and provider performance in care and service through competition.

Tort Reform: One key component for healthcare reform includes overhaul of the tort system dealing with medical malpractice. Experts estimate that the medical malpractice legal climate results in costs of 50 billion dollars to the healthcare due to the practice of defensive medicine. There is evidence that capitation limits on noneconomic damages can reduce these defensive practices, claims and compensation payments, and malpractice insurance premiums. Also, limited data that suggests that decreased medical claims may result in increased patient quality. Any malpractice reform should provide a forum for fair and efficient compensation to individuals who suffer an injury due to a medical error. The current legal system can result in medical malpractice judgments that are arbitrary and capricious. Malpractice systems in New Zealand and Scandinavia could serve as a model for the United States. These countries forgo using regular judges and juries to decide medical malpractice in favor of a special set of judges who make decisions based on input from subject matter experts. Not only is this system popular with the public and medical establishment but also results in individuals receiving faster compensation and lower costs.

Community and Individual Efforts: Finally, health can be improved at the community and individual level by promoting or dis-incentivizing behaviors and activities that impact health and health risks. Current programs to dis-incentivize negative behaviors, such as taxation of tobacco products to increase cost and strict enforcement and punishment of driving while intoxicated, should be continued and enhanced to decrease these behaviors. Similarly, novel approaches to incentivize positive health behaviors should be identified and aggressively enacted. A potential approach could be government stipends or credits to individuals with positive health metrics (body fat index, serum cholesterol, blood pressure, etc.) as documented by a healthcare provider. While healthy behaviors such as decreased sugar consumption and increased fruit and vegetable consumption and exercise may be difficult to document, new technological advances (to include the current boom in wearables) may soon be able to provide multiple objective metrics of healthy behavior to target for reward.

Conclusion: This report has identified five components, that if addressed properly at the federal, state, and local levels, that could help improve the health care system. As a country, we must reduce our costs and, at the same time, improve our population access to quality outcomes and prevention.

References:

http://www.prnewswire.com/news-releases/value-based-purchasing-authority-dr-thomas-valuck-joins-discern-228753331.html Last accessed 19 September 2017

https://www.healthcatalyst.com/Key-Overcoming-Challenges-Transparency-in-Healthcare Last accessed 19 September 2017

http://healthaffairs.org/blog/2015/06/09/promoting-transparency-and-clear-choices-in-health-care/ Last accessed 19 September 2017

Mello MM, Chandra A, Gawande AA, Studdert DM. National costs of the medical liability system. Health Aff (Millwood) 2010;29:1569-1577

Mello MM, Chandra A, Gawande AA, Studdert DM. National costs of the medical liability system. Health Aff (Millwood) 2010;29:1569-1577

The impact of tort reform and quality improvements on medical liability claims: a tale of 2 States.Illingworth et al, . Am J Med Qual. 2015 May;30(3):263-70

Mello MM, Kachalia A. Medical malpractice: evidence on reform alternatives and claims involving elderly patients. Washington, DC: Medicare Payment Advisory Commission, December 2016 (http://www.medpac.gov/docs/default-source/reports/dec16_medicalmalpractice_medpac_contractor.pdf)

THE PREPAREDNESS OF DoD HEALTH PROFESSIONALS FOR GLOBAL DISASTER RESPONSE

***"*DoD can bring critical capabilities to a disaster response both in terms of specialization ("specificity") and mass ("quantity"), and DoD has significant capacity that can rapidly deploy with little external support. However, it must understand potential requirements as clearly as possible and build this understanding into its planning activities."**
https://www.rand.org/content/dam/rand/pubs/research reports/RR1300/RR1301/RAND RR1301.pdf

Small Group Assignment: Recent events in the United States, India, and Pakistan, have emphasized the importance of disaster preparedness and response. Health services and public health are essential components of the responses to these devastating situations. What should be done to ensure that when future incidents occur we are as well prepared as possible to respond as health professionals?

Group III Members: CDR Marion Gregg, MC, USN; CAPT Kis Hale, USPHS; COL Christine Kramer, USA; CAPT Kevin McGowan, USN; Col Mark Nassir, USAF; Col Kyle Pelkey, USAF; COL Colleen Shull, USA; Col Julie Stola USAF; Mr. Stephen Trynosky, VHA; and LTC Jolanda Walker, USA.

Introduction. In an increasingly interconnected world, global health security represents a critical challenge for all national governments. The daunting complexity and growing frequency of man-made and natural disasters challenges the ability of governments and non-governmental organizations to ensure the health security of their populations. U.S. military medical assets comprise part of the international disaster response architecture and are regularly requested to provide support to domestic and global disasters. The demand for US military medical assets to provide disaster response is projected to grow for the foreseeable future. Given this situation, the current reorganization of the Military Health System (MHS) presents a unique opportunity to better synchronize and standardize medical disaster preparedness and response capabilities across the Department of Defense (DoD).

Situation. Since 2005, DoD deployed significant medical response resources to a series of disasters and public health emergencies that required a global medical response. Representative examples of these crises include Pakistan earthquake response (2005); Haiti earthquake response (2010); the West African Ebola outbreak (2014); the Western Hemisphere Zika outbreak (2016); Nepal earthquake response (2017); and devastating hurricanes in the United States (2005, 2012, and 2017). DoD medical personnel currently have aided areas impacted by Hurricanes Harvey, Irma, and Maria.

The Centre for Research on the Epidemiology of Disasters estimates that the five nations most frequently impacted by natural disasters during the last decade were China, United States, Philippines, India and Indonesia. Their disasters accounted for approximately 68% of reported global disaster mortality in 2012. The scale of these incidents often overwhelmed internal response capabilities and required additional assets coordinated through NGOs, the United Nations and U.S. government agencies such as the U.S. Agency for International Development (USAID) and DoD.

DoD has repeatedly demonstrated its ability to bring significant medical and humanitarian assistance capabilities to global and national disasters. While these efforts have saved countless lives worldwide, DoD's global disaster medical response activities are planned in an episodic and ad hoc fashion with the medical assets available at the time a disaster strikes. Requests for medical forces from the responsible Geographic Combatant Commanders are processed and verified by the Joint Staff and resourced across DoD. The current process for resourcing DoD medical capabilities for global disaster response is inherently reactive and draws providers from across the military services with inconsistent knowledge, skills, and abilities to provide optimal support.

In the 2017 National Defense Authorization Act (NDAA), Congress directed the Military Health System (MHS) to initiate a comprehensive modernization to ensure that the "right care is delivered in the right time and right place." A component of the NDAA's charge to the MHS focuses on strengthening operational medical force readiness. This ongoing MHS transformation presents a unique opportunity to develop an appropriately resourced joint disaster medical response coordination cell to ensure standardized policies and training requirements across the individual services.

Recommendations. To best plan for, coordinate, and resource the projected need for recurring post-disaster medical and humanitarian response missions, we recommend that DoD pursue two strategic aims:

1. ***Establish a dedicated capability that can provide ready, off-the-shelf responsiveness to disasters as needed.***

DoD medical assets from all three Services can contribute to this joint response capability. The exclusive coordination focus of this proposed cell is emergency medical response missions both foreign and domestic. The designated establishing agency will develop the structure, policies, and standardized training requirements necessary to ensure this capability. The Defense Health Agency (DHA) or the Office of the Joint Staff Surgeon could potentially provide governance for this activity.

2. ***Build and maintain relationships with governments, NGOs, and other stakeholders frequently involved in global and domestic disasters.***

DoD needs to ensure that strong and trusted relationships exist before crises emerge. Regular and sustained collaboration is one way of ensuring that local authorities are capable of training, equipping, and mobilizing their own disaster response resources proactively. Modest, up-front investments in local capacity building may ultimately reduce the need to deploy US military medical assets after global disasters. DoD can influence capacity building through international and interagency training opportunities, the dissemination of disaster response lessons learned, and maintaining open and transparent lines of communications with international and external partners following the completion of active disaster response activities

References:

Auerbach, P.S., Norris, R.L., Menon, A.S., Brown, I.P., Kuah, S., Schwieger, J., Kinyon, J., Helderman, T.N., Lawry, L. (2010). Civil-Military Collaboration in the Initial Medical Response to the Earthquake in Haiti. *New England Journal of Medicine.* 2010 Mar 11;362(10):e32. doi: 10.1056/NEJMp1001555. Epub 2010 Feb 24.

Diehl, G., Bradstreet, N., Monahan F. (2016). The Department of Defense at the Forefront of a Global Health Emergency Response: Lessons Learned from the Ebola Outbreak. *Health Security.* 2016 Sep-Oct, 14(5):366-74. doi: 10.1089/hs.2016.0022

Eiseman, B., Chandler, J.G. (2006). Military Medical Surge Capacity in Times of War and Natural Disaster. *The Journal of Trauma*. 2006 Jan;60(1):237-9.

Lezama, N.G., Riddles, L.M., Pollan, W.A., Profenna, L.C. (2011). Disaster Aeromedical Evacuation. *Military Medicine*. 2011 Oct;176 (10):1128-32.

Snyder, M. R. (2016). War on Disease? Zika Sheds Light on Growing Military Role in Global Health. *International Peace Institute Global Observatory. February 5, 2016*. From: https://theglobalobservatory.org/2016/02/zika-ebola-military-world-health-organization/

Weaver, J.M. (2015). The Department of Defense and Homeland Security Relationship: Hurricane Katrina through Hurricane Irene. *Journal of Emergency Management*. 2015 May-Jun;13(3):265-74. doi: 10.5055/jem.2015.0240.

Worse Than Ebola: U.S. Not Preparing for the Next Bio-Threat by Maggie Fox, May 1, 2017
https://www.nbcnews.com/storyline/zika-virus-outbreak/worse-ebola-u-s-not-preparing-next-bio-threat-n753526

“The United States needs to be ready ahead of time, with stockpiles of drugs, vaccines and equipment, plans for deploying them and someone with the authority to make fast decisions, Cole (Rep. Tom Cole, R-Oklahoma, chairman of the House Appropriations subcommittee that overseas biomedical research) and other experts said. The 2017 budget agreement worked out early Monday by Congress would provide just $57 million specifically to prepare for a new pandemic of influenza.

"You can't create it the day you need it," Cole said.

Andrew Weber, a former assistant secretary of defense for nuclear, chemical and biological defense, agreed.
"We just can't wait until the day after an attack," said Weber , who is now at the Belfer Center for Science and International Affairs at Harvard’s Kennedy School of Government.”

NAFTA'S IMPLICATIONS ON HEALTH POLICY AND PRACTICES

Small Group Assignment: NAFTA, the North American Free Trade Agreement, is currently under revision by Canada, Mexico and the United States. What are the advantages and disadvantages, across the major sectors of these three nations, from this international agreement?

What do you consider are the implications for health policies and practices within the NAFTA framework and what should be changed in these areas if the agreement continues?

Group IV Members: CAPT Melissa Barnett, USN; Col Kristen Beals, USAF; Col Paul Brezinski, USAF (withdrew from course); Col Cat Catalasan, USAF; LTC John Detro, USA; CAPT Tracy Farrill, USPHS; COL Dan Farris, CAN; CDR Christopher Hamlin, USN; CDR Pete McGowan, USN; and LTC Brian Spangler, USA.

Introduction: The North American Free Trade Agreement (NAFTA) established a free-trade zone in North America; it was signed in 1992 and went into effect on January 1, 1994. Canada, Mexico, and the United States signed the agreement which progressively lifted most tariff and non-tariff barriers to free trade and investment between these three countries and established rules for said activities.

NAFTA Advantages / Disadvantages

Canada	Mexico	United States
Strong gains in cross-border investment	Boosted farm exports - tripled	Trade has tripled with Canada and Mexico
Lowers production costs	Increase of auto manufacturing jobs	Foreign investment increased
Exports to the US tripled	Foreign investment increased	Imports oil from Mexico for less
Increase in bilateral US-Canada agricultural flow tripled	Improved Mexican Economy by 1.3%	Exported finance and healthcare services
Allows domination of the NA market by a single player	Unemployment rose due to US farm compensation	Created about 5 million jobs but lost about 700,000 manufacturing jobs
Attacks core values and/or cultural aspects	Mexican workers exploited	Suppress wages in auto industry
	Environment deteriorated	Lost jobs due to cheaper wages for Mexican labor

NAFTA has been the object of much political debate over the years and part of presidential platforms for the past eight years. NAFTA has become an area of concern and re-negotiations are ongoing.

Health Policy and Practice Implications and Recommendations for Change with Renegotiation:

Preservation of Intellectual Property

NAFTA protects intellectual property rights in many ways. Intellectual property rights encompass trademarks, patents, recordings and written works. Without protections for such property, investment in research and development of new technologies and pharmaceuticals, engineering designs, advertising and entertainment productions would be discouraged. The ability of another entity to unfairly benefit from the extensive up-front costs of developing these goods and services for mass production could provide a disincentive for research into more areas with more marginal potential.

NAFTA currently guarantees that each country, at the minimum, enforce certain codified international norms regarding the protection of intellectual property. Protection must apply equally to both domestic and foreign firms. This provision fosters investment, which benefits the entire trading block through enhanced quality of life and productivity. This guarantee should be maintained.

Maintain trade and production of Medical Technology and Devices

Mexico is a big market for all types of medical devices. Imports of medical equipment, instruments, disposable and dental products were more than $4.1 billion in 2014. Imports of U.S. products are duty free if they comply with the NAFTA certificate of origin. U.S. products are appreciated because of their high quality, after sales service and good prices compared to competing products of similar quality.

U.S. companies should take advantage of geographical proximity to start or increase their presence in Mexico. Production costs are less due to lower labor costs in Mexico and because the medical device industry buys much of its raw materials and capital machinery from American suppliers' duty and tariff free. Maintaining the free trade afforded by NAFTA ensures better pricing for medical devices produced in Mexico, despite the Mexican government's inability to ensure facility security at all locations.

Health Care Services

CANADA: There are areas that were excluded from NAFTA: telecommunications, health care, education and cultural industries. The push for the reduction or elimination of barriers to US investment "in all sectors" in the NAFTA countries would end Canada's restriction on American investments in these areas. Health Care in Canada is viewed as an expression of core national values, deserving of protection as a fundamental right of citizenship; it will not be politically astute to allow the erosion of this core value through the infiltration of for-profit healthcare. Commensurate with this view, Canada has the federal legislative framework to support their Medicare program, allowing the vision of health care as a right to be supported; this may serve a further barrier to free trade, or represent a further area to attack to defend the trade policy desires of the U.S. and Mexico.

MEXICO: Exporting U.S. services to Mexico can expand access to specialized services and thus improve access to and quality of healthcare provided. Here the biggest challenge is regulation and the supply of non-cost-effective services, including those which require the use of expensive medical technologies. Hospitals in Mexico financed with U.S. capital have produced an inflow of foreign exchange, more jobs, and widespread access to state of the art technology which will ultimately strengthen the Mexican health industry's infrastructure. At the same time, this commercial presence comes with the risk of increased healthcare costs in Mexico and the potential for overuse of imported technology such as CT and MRI scanners. Trans-border mobility of healthcare personnel can also expand access to high quality health services and facilitate the exchange of information and clinical procedures.

Summary

Since NAFTA entered into force in 1994, the U.S. economy and global trading partnerships have undergone progressive changes and have overcome challenging interpretations. Trade across the borders improves access to more economical pharmaceuticals and medical devices. While NAFTA requires modernization, maintaining the trade agreement will promote a market system that functions more efficiently, leading to reciprocal and equilateral trade among the three nations.

Preservation of the Public Health Systems Integrity should be maintained with renegotiations of NAFTA. The stability of Canada's Public Medicare System would be compromised by the introduction of for-profit health services. The decision to add this nomenclature to the health system would be made if Canada introduces for-profit services in any of its territories.

Though NAFTA has been in place for over 20 years, the impetus to change it seems to be politically driven rather than deliberate and intentional.

References:

Office of the United States Trade Representative: Executive Office of the President. July 17, 2017. Summary of Objectives for the NAFTA Renegotiation.

https://www.thebalance.com/nafta-pros-and-cons-3970481

LARGE POPULATION MIGRATIONS

Group V Members who produced the following report: CAPT Richard Adcook, USN; CAPT Lisa Braun, USN; LTC(P) Irma Hartman, USA; CAPT Matthew Hebert, USN; Dr. Alan Hirshberg, VHA; Col Christopher Hudson, USAF; COL Michael Oshiki, USA; COL Manuel Pozo-Alonso, USA; Col Linda Rohatsch, ANG; CDR Joel Schofer, USN; and Col Lynn Shinabery, USAF.

Introduction: Wars, political and economic instability, environmental disasters, illegal drug activity, and other destabilizing forces are leading to mass displacement of people worldwide. The scope is unprecedented, and reports indicate that the amount of displaced people is the highest it has been since World War II. The annual global estimate of migrants has risen from a total of 3.6 million in 2013 to 5.2 million from Syria alone in 2017.[1, 2] The physical and behavioral health challenges posed by these migrations are straining many resources of the involved countries and adversely impacting the health and welfare of millions of migrants. This report provides a brief review on the effectiveness of the medical response to date and proposes some short, medium, and long-term solutions to this growing health problem.

Responses to Mass Migrations: Most responses to mass migration play a minimal role in international disease control and, to date, there has not been an organized, unilateral response to the migrant crisis. Humanitarian responses for migrant populations, which are required by law in receiving countries, are quarantine based. These responses rely on exclusion and isolation operations that are often difficult to implement during global migration. Public health efforts are often challenged by a variety of disease threats which may potentially spread by population mobility. Secondary effects of quarantine operations may include exacerbation of psychological trauma in the migrant population, already significantly challenged by their displacement. These challenges may continue despite efforts to provide "culturally sensitive" behavioral health (BH) services.[3]

Global aid and assistance is a key determinant in migrant integration and delivery of necessities (food, water, shelter, and healthcare). This aid has been jeopardized by in-country militant threats, particularly against aid workers. In addition, donor fatigue may lend to the inability of humanitarian organizations and aid workers to purchase needed supplies and provide services.

The United Nations (UN) is an international organization that facilitates peacekeeping missions through cooperative international law/security, human rights, and social programs and provides financial support for foreign aid programs. The U.S. State Department is a large contributor of funding to the UN's budget, providing nearly 22% of the budget in 2010.[4] In its 2018 "America First" budget, however, the U.S. outlined plans that reduced funding by 28% to the State Department and has proposed to draw USAID under the department which may hinder the provision of goods and assistance to relieve health-impacting issues facing the large numbers of displaced migrant populations globally.[5]

Suggested Actions to Safeguard the Health of Migrants:

Short-Term.

- Emergency evacuation of those at risk of immediate harm
- Initiate partnerships with governments, local health agencies, religious organizations, and NGOs
- Institute immediate health screenings, including mental health screenings
- Ensure interpreters are available for medical personnel
- Set a goal processing time of 72 hours

Cultural sensitivity is necessary in determining population needs and area threats. A de-medicalized and holistic approach that integrates physical and psychological health screenings in addition to a social services assessment may prove more effective.[3]

Medium-Term.

- Clarify and address the process for determination of refugee status, including a health assessment
- Create additional processing centers with appropriate social/medical resources
- Provide medical resources to the countries that contain the "areas of first contact" or processing centers

- Address the health/social systems of the countries where the refugees came from to facilitate health care and integration back into their country of origin

Facilitating opportunities for refugees to “tell their story” can be therapeutic and provide additional opportunities to identify individuals in need of BH care.[3]

Long-Term.

- Encourage development of the medical systems in the countries with refugee issues
- Ensure efforts from all US departments and agencies providing medical aid are integrated
- Assist countries in the development of their medical systems
- Reverse the destabilizing forces that lead to the migration

NGOs should work with local and nation-state leadership to integrate the services needed services and efforts among the various supporting departments and agencies involved in mass migration and refugee response. The development of systems to provide basic and essential services to refugees can relieve identified stressors that may exacerbate underlying psychological trauma; thus, reduce the incidence of clinically significant BH pathology.[3]

Conclusion: The impact of migration differs with the magnitude and geographical area involved. Migration has impacted neighboring nation-states for centuries and has challenged resources of governments at all levels. Current measures focus on providing humanitarian assistance to include shelter, food and water security, and a comprehensive evaluation of health threats. Identification and treatment of physical and emotional trauma through culturally sensitive measures and the development of a local and state health infrastructure are necessary steps to facilitate the health of migrant populations and potential reintegration efforts. These endeavors may involve initial military support, but NGOs are the key to establishing liaisons between the migrant population and local governments. NGOs lay the foundation for future stability endeavors/operations between local, state, and international communities which the military would be unable to maintain long-term.

References:

[1] Department of United Nations Economic and Social Affairs, Population Division. Monitoring Global Population Trends. Available at: http://www.un.org/en/development/desa/population/migration/publications/ Accessed: 9/21/2017.

[2]International Migration Report 2015: Highlights. United Nations. New York, New York. 2016.

[3]Watters C. Emerging Paradigms in the mental health care of refugees. Social Science and Medicine. 2001. 52:1709-11718.

[4]Browne MA, Blanchfield L. United Nations regular budget contributions: Members compared, 1990-2010. *Congressional Research Report for Congress*. 2013. https://fas.org/sgp/crs/row/RL30605.pdf. Accessed 9/21/2017.

[5]Toosi N, Everett B. Trump wants 37 percent budget cut to state, USAID. http://www.politico.com/story/2017/02/trump-budget-cuts-state-department-usaid-235505. Updated 2017. Accessed 3/20/2017.

[6]Kirmayer LJ, et. al. Common mental health problems in immigrants and refugees: general approach in primary care. CMAJ. Sept 6, 2011. 183(12):E959-E967.

[7]Restrepo D, Mathema S. A Medium- and Long-Term Plan to Address the Central American Refugee Situation. Center for American Progress. May 5, 2016.

[8]Wolgin PE. A Short-Term Plan to Address the Central American Refugee Situation. Center for American Process. May 5, 2016.

Addendum: Col Chris Hudson, USAF, MC, provided this example of an effective health care response for immigrants. Siloam Health, a faith-based, nonprofit health outreach in Nashville TN focuses on immigrants, refugees and the uninsured. Caring for patients and clients from over 90 nations, Siloam is vital to providing cross-cultural care in the Mid-state’s larger healthcare safety net, which includes Federally Qualified Health Centers, other charitable clinics and the local health department. Since 2003, Siloam has overseen all refugee screening medical exams for the state of Tennessee, creating their first exposure to the health system while ensuring a safe transition for refugees and their community alike. Committed to holistic care, interdisciplinary teams address the social, emotional, and spiritual determinants of health through programs specifically designed to address language, cultural and financial barriers to health and health care access. Borrowing an idea from the developing world, Siloam has taken an “upstream” approach to care one step further by developing a Community Health Outreach program led by lay health workers from the immigrant communities to foster trust and facilitate access to health care and other needs for these displaced persons. Siloam is a founding member of the Tennessee Charitable Care Network and a leader in the Christian Community Health Fellowship, a nationwide consortium of clinics and individuals dedicated to serving indigent and marginalized persons.

PRECAUTIONS RECOMMENDED BY DR. ELISABETH ROSENTHAL FOR PATIENTS TO CONSIDER

In her opinion, asking the right questions when in hospital may help patients protect their financial health.

1. Hospitals have built a huge oversupply of private rooms, though insurers frequently won't cover their cost.

If you are assigned to a private room, make it clear that you did not request it and would be happy to occupy a room with another patient. Otherwise, you might be hit up to pay the "private room supplement" by your insurer.

2. In the pages of admitting documents you'll have to sign, there is inevitably one concerning your willingness to accept financial responsibility for charges not covered by your insurer.

Before you sign, write in "as long as the providers are in my insurance network." You don't mind pay-ing the required co-payments or deductibles, but not out-of-network charges. For every medi-cal encounter, Olga Baker, the San Diego lawyer, adds a "limited consent" clause to the chart, indicating that "consent is limited to in-network care only and excludes out-of-network care." It has worked well for her, and at the very least, this annotation will give you a basis for arguing later.

3. Be clear on the terms of your stay in the hospital: Are you being admitted or held under "observation status"? Ask point-blank.

The answer will have big implications for your wallet. Hospitals can keep you for up to three days (two mid-nights) on observation status. Though you will be in a hospital bed, you will be considered an outpatient and be responsible for outpatient co-payments and deductibles, which are generally far higher than those for an inpatient stay. If you are on Medicare, the government insurer will not count days on observation status toward its required three days of hos-pitalization required for coverage of a stay in a rehabilitation center or nursing home after discharge. Ask why you cannot be fully admitted. If there's not a good answer, insist on going the inpatient route.

4. If you're feeling well enough, ask to know the identity of every unfamiliar person who appears at your bedside, what he or she is doing and who sent him or her.

If you're too ill, ask a companion to serve as gatekeeper and guard. Write it all down. Beware the nice doctor who stands at the foot of your bed each day and asks if everything's going OK. That pleasantry may constitute a $700 consultation. There's an epidemic of drive-by doctoring on helpless inpatients. These medical person-nel turn up whether you need or want them, with the intent of charging for their services. Remember that you can say no. Everything done to you or for you in the hospital will be billed at exorbitant rates.

5. If the hospital tries to send you home with equipment you don't need, refuse it, even if it's "covered by your insurance."

This is a particular concern if you've had an orthopedic procedure. Avoid $300 bills for slings you could buy for $10 at a pharmacy, $1,000 knee braces, and $2,500 wheelchairs, all billed to insurance and cluttering up your front closet.

Reference: Rosenthal, E. An American Sickness: How Healthcare Became Big Business and How You Can Take It Back. New York, Penguin Press, 2017, 264-266.

THE SPIRIT OF HAIDA GWAII

Quoted from the plaque in front of this artwork on the plaza of the Embassy of Canada, Washington, DC:

The Canadian Embassy is proud to be the home of Haida artist Bill Reid's largest and most complex work of sculpture: a bronze-cast sculpture of a canoe containing thirteen mythological Haida figures.

Among the creatures and humans represented are the Raven, the trickster of the Northwest Coast, holding the steering oar, under his tail is the Mouse-Woman, the traditional guide to travelers between the human and non-human realms of Haida myth.

In the bow is the Grizzly Bear; paddling of the port side is his human wife, the Bear Mother. Between them are their children, the Two Cubs.

Behind the Bear Mother is the Beaver, an uncle of the Raven, who hoarded all the fresh water and fish in the world. Behind him is the Dogfish Woman, a shape-changing creature, part human and part shark.

Across from the Bear Mother is the Eagle. Beneath him, perched on the gunwale, is the Frog. Arched across the center of canoe is the Wolf, with his claws in the Beaver's back and his teeth in the Eagle's wings. Behind the shoulders of the Wolf is a human paddler whom Reid calls "the Ancient Reluctant Conscript." At the centre of this menagerie stands the shaman, known in Haida as "Kilstlaii." His robe and staff, sculpture within sculpture, portray the Seabear, the Raven and the Killer Whale - allusions to other stories central to the Haida view of the world.

The canoe contains both Raven and Eagle - the two sides of the Haida social order, women and men, a rich man and a poorer man, animals and human beings. It is an image not only of our culture but the entire family of living things: Not all is peace and contentment in this crowded boat, but whatever their differences, they are paddling together in one boat, headed in one direction.

Wherever their journey takes them, let us wish them luck.

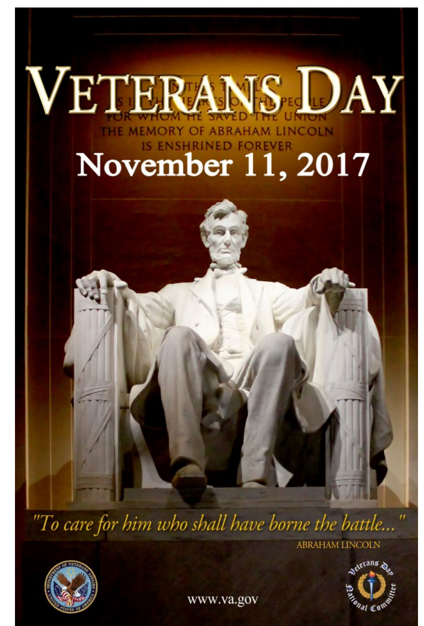
Quoted in appreciation to the Embassy of Canada for their hospitality hosting a day of Institute sessions with a special thank you to Lt Col Andrew Currie, Health Services Attaché, and the embassy staff for organizing the event.

131st Interagency Institute for Federal Health Care Executives September 11 - 22, 2017

Left:

Classroom ready to go!
Uniformed Services University

Below left and bottom of page:
Small groups at work.



FHCEIAA Annual Meeting, November 30th, National Harbor, Maryland

The annual business meeting of the Federal Health Care Executives Institute Alumni Association will be held in conjunction with the AMSUS meeting. This year, the AMSUS meeting is taking place from 28 November to 1 December at the Gaylord Hotel, National Harbor, Maryland.
The annual breakfast business meeting of the alumni association will take place on Thursday, 30 November from 6:45 – 7:45 a.m. at the Gaylord National Harbor, Rooms 2/3. A continental breakfast will be will be served at a reduced $25 rate for alumni.

If you are registering to attend AMSUS (http://www.amsusmeetings.org/home-2/) there is a link on the registration form to also register for the alumni breakfast. If you are not registering for AMSUS or have difficulty in assessing the link, please call Jeanette Naiman, AMSUS Director of Meetings, at 301-828-1589, to register directly by providing your name and credit card information and she will register you for the breakfast meeting.

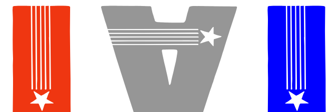
We are very pleased to have Dr. Richard W. Thomas, President, Uniformed Services University of the Health Sciences, as our guest speaker at the meeting. We have also invited the 2017 Distinguished Service Award Recipient, VADM Raquel C. Bono, MC, USN, Director, Defense Health Agency, to attend the breakfast.

IMPORTANT NOTICE!

FHCEIAA is transitioning from USPS to e-mail notification of alumni activities.
Submit your e-mail address to receive alumni mail to **gjdolecek@verizon.net.**

To continue receiving the newsletter, FHCEIAA membership and current address are necessary .
Send changes to: CAPT(R) Gayle Dolecek, FHCEIAA Treasurer, 10280 Shaker Dr, Columbia MD 21046 or gjdolecek@verizon.net.

Annual dues - $25, Lifetime membership - $100



ADDRESS SERVICE REQUESTED

THE INTERAGENCY INSTITUTE FOR FEDERAL HEALTH CARE EXECUTIVES

Dr. Richard F. Southby
Director
Distinguished Professor of Global Health & Executive Dean Emeritus, GWU
5325 MacArthur Blvd NW
Washington DC 20016