“Higher Education and Health Care”

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We are at a critical juncture in the evolution of our nation’s ability to provide adequate education and health care for its citizens. It is increasingly evident, as reflected in the persistent gaps between the performance of those who are affluent and those who are poor, that the United States is not living up to the promise of providing equal educational opportunity for all. It is imperative that we begin investing increasing amounts in the education of all Americans, from pre-kindergarten onward. Although it is indisputable that there is huge variability in the efficiency with which our nation’s public schools are administered, the horrendous attrition rates and all-too-common substandard performance of our students cannot be attributed solely to multilayered bureaucracies or malingering teachers. At the same time we ratchet up our support of public education, however, we must not neglect investment in the health of the public. Only if we balance the goal of health care for all with educational opportunity for all will our nation’s citizens emerge as a truly healthy and appropriately educated people.
A plethora of studies indicates that education and health status are inextricably linked: those who are more highly educated are more likely to seek preventive care, to maintain a healthful lifestyle, to receive medical care in a timely manner, less likely to develop chronic as well as infectious diseases, and, predictably, to live longer.

But we currently do not have the social infrastructure to remedy these huge disparities. Since Congress is saddled with recurring expenditures that they regard as sacrosanct (such as continuing the war in Iraq and sustaining farm subsidies), they are left with grossly inadequate revenues to address the pressing educational and health care needs of our nation. In a word, the picture before us is bleak. The Bush administration, rebuffed in its efforts to privatize health insurance, recently has proposed several less ambitious initiatives to rein in the dramatic increase in medical expenditures and simultaneously ameliorate the inadequate health care available to all Americans. One proposal, in which they have been joined by the national Federation of Independent Businesses, would allow trade associations to sell group health plans “to their members on a national or regional basis without having to offer all the benefits mandated by states in which the workers are employed.”
The Foundation for Taxpayer and Human Rights contends that this “legislation could mean the loss of state protections, such as California’s requirement that women have a right to visit a gynecologist,” and that all patients would lose the right to a doctor’s second opinion. A basic shortcoming, also evident in the Health Savings Accounts proposal, is that at best they do little “to help the uninsured and favor the healthiest and more affluent Americans.” As if the problems raised if these proposals are enacted were not staggering enough, the Medicare cutbacks proposed by the President “are likely to result in more crowded clinics and emergency rooms in poorer communities, as well as higher bills for private insurers and patients themselves.”

The number of medically uninsured Americans has grown from 40 million in 2000 to 46 million in 2004. During the past two years, nearly 82 million Americans were without medical insurance at some point. Those people, in addition to the huge number who are underinsured, are in urgent need of health care. Regrettably, none of these proposals I just reviewed will adequately deal with the medically uninsured and underinsured.
Although universal coverage is an admirable goal, the current political climate is not conducive to it. And given the fact that health insurers made $100 billion in profits last year, as the economist Jonathan Gruber has pointed out, “industries of that size are first not legislated out of business. Consequently the discussion regarding adequate nation-wide health insurance has been paralyzed for years.

We simply must not continue on our current path. To plead for an investment in higher education without considering a concomitant investment in the provision of health care is both myopic and, in the long run, fiscally irresponsible. If we deny access to health care to any segment of our society and fail to offer intervention early in the pathogenesis of disease, the total cost to our society will be staggering—huge—not only in the expense of treating these patients, but in absenteeism causing loss of productivity in the workplace, as well as premature death removing those from the labor force who are skilled and extensively trained workers. The money we spend on the front end in preventive care is an enormously better investment than palliative treatment of technology and labor-intensive care on the back end.
As Elias Zerhouni, N.I.H. Director recently observed, the difference between investment early in the pathogenesis of disease and toward the end of the disease’s progression is logarithmic.

Most of our research universities conduct scientific examination of the effect of disparities in access to health care on our health status, and also train the overwhelming majority of health care providers. But apart from relatively isolated teams of investigators conducting large-scale intervention studies and far-reaching disease prevention programs over extended periods, our universities generally have neither shouldered the burden to foster policies nor initiated comprehensive programs that will stimulate widespread and deep-seated amelioration of the prevalent inequities in education and health care. I believe strongly that our universities should be regarded as laboratories for discovering possible solutions for our nation’s health care ills, and our academic health centers the incubators in which new models of financing health care can be tested and developed.
All of us who are presidents of comprehensive research universities have a broad array of administrative responsibilities, and for the overwhelming majority of us that includes oversight of academic health centers. However, most of us find the demands of these jobs so consuming that we feel we’re doing all we can just to keep our heads above water. Together with our academic health center administrators we are so overwhelmed by the staggering day-to-day demands of our respective organizations that we feel powerless to deal with the enormity of these health deficiencies and their staggering social and economic costs.

In part because the proportion of physicians giving charity care dropped from 76% in 1996 to 68% in 2005, the teaching hospitals at our research universities make up only 6% of our nation’s hospitals, yet care for more than 50% of all uninsured Americans who seek hospital care. As if the issues before us are not complex enough already, there is also a gap within academic health centers caused by the transformation from hospital-based care to community-based, ambulatory care. Although it need not be the case, clinical faculty tend to labor in one or another of these vineyards.
The gravity of this entire situation is profoundly exacerbated by the politically popular anti-tax mantra, evident in the ubiquitous pledges taken by legislators swearing that they will never raise taxes. As current election campaigns and political pronouncements from Democrats as well as Republicans vividly illustrate, an even more dire prospect looms on the horizon: usually the person who can shout loudest the chant of cutting taxes—a posture more Draconian than pledging not to raise taxes—has the greatest likelihood of being elected.

When I meet with elected politicians in secluded settings, and present the overwhelming need for additional revenues for pre-kindergarten through Ph.D. education and greater access to health care, I almost invariably receive sincere expressions of support for these agenda. However, such confessions of empathy are quickly followed by a threat that if I ever publicly acknowledge their desire to enhance access to health care and educational opportunities by raising revenues to deliver them, they will deny vehemently such sentiments (and, implicitly, never speak to me again).
Several legislators have put it to me this way: “If I ever openly advocated raising taxes to pay for education and health care, it would be a consummate act of political suicide.” The nearly uniform consensus among our elected officials regarding that position suggests that we need to consider sources other than legislative appropriations to provide the health care that so many millions of Americans desperately require but cannot afford.

In 1959, the English physicist and novelist C.P. Snow delivered the Rede Lecture at The University of Cambridge, and titled it: “Between Two Cultures.” In it, he lamented the chasm between the basic sciences and the humanities. He knew the divide well, because he traversed it all of his professional life – doing science and writing novels. During the four decades I have been a professor, then medical center administrator, and latterly, a university president, I have observed another chasm within comprehensive research universities: it’s between academic health centers and the rest of the institutions in which they are housed.
More often than not they are geographically separated from one another, with perhaps the most extreme example being Cornell University—whose Medical Center is 220 miles away from the rest of the University. Although Harvard Medical School in Boston and Harvard College in Cambridge are separated by the relatively narrow Charles River, it takes a minimum of 1½ hours to make a round trip between the two, portal to portal. My own experience on the Harvard Medical School faculty was that for all the intellectual intercourse among the respective faculties Harvard College, the home of the Arts and Sciences faculty, could just as easily have been in Springfield, Massachusetts, about 100 miles away.

Perhaps the most important factor contributing to the gap Snow described, but which has grown exponentially in the intervening decades, is the increasing atomization of knowledge and the concomitant proliferation of sub-disciplines and sub-specialties. A salient example of what is happening is the supremely ironic transmogrification of the general practice of medicine to a specialty—family medicine. To compound the irony, many of its practitioners refer to themselves as sub-specialists within family medicine.
An unintended, but nonetheless regrettable, consequence of this evolution is that it serves to inhibit dialogue between faculty in medicine and other scientific fields, as well as between the sciences and the humanities.

Another of the factors contributing to this chasm is the lingering resentment of many non-health care faculty towards their medical colleagues, whom they often have viewed as awash in money, and who could, if they were willing, transfer vast sums of wealth to their impecunious colleagues. Although this approach accurately reflects the reality of an earlier era, it isn’t even remotely close to our situation today. The dramatic changes in health insurance and the increasing reliance on academic medical centers to care for those who are medically indigent, in addition to skyrocketing rates for medical malpractice insurance, the aggressive practice of defensive medicine laced with frequently unneeded tests to avoid lawsuits, and substantial elevation of the costs of ever more sophisticated technology, which both the lay public and medical professionals are increasingly eager to exploit, have combined to alter dramatically the financial situation of academic health centers over the past two decades.
Thus it is imperative that we avoid pitting our academic health centers against the other entities of which our universities are comprised.

Yet another impediment to bridging the gap between these two cultures is that extremely few presidents of comprehensive research universities have been administrators in academic health centers. Consequently, most presidents choose to make ever-so-brief and episodic forays into the unfathomable abyss of IRBs, clinical trials, complex medical practice plans, shifting reimbursement policies, irascible patients, prima donna sub-specialists, soaring medical malpractice insurance, heightened security of laboratory facilities and information technology, complaints about technology and equipment that was regarded as state-of-the-art when it was purchased but now is uniformly derogated as hopelessly obsolescent, increasing governmental concern about biosecurity safeguards, histrionic protests against all animal research, as well as endlessly proliferating accreditation agencies, to say nothing of neighborhood opposition to expanding hospital and clinic facilities. If that weren’t enough, one often witnesses disputes among schools comprising the academic center – more often than not directed to the perceived if not real arrogance of the medical school faculty -- that generate liberal amounts of paranoia and ill will.
Once university presidents wind up in this morass, they typically perceive these dilemmas as irresolvable, and say to themselves: “Help! Let me out of here. I feel more comfortable solving the myriad problems of the non-health center part of the university. I’ll let my V.P. for Health Affairs deal with the complex and bewildering array of problems that fester in the academic health center. I’m going to keep an arm’s length from this mess,” and thus perpetuate the chasm between the two cultures.

Most presidents in this circumstance feel an admixture of anxiety and confusion, and many cunning vice-presidents of health affairs capitalize on their respective presidents’ discomfort and naiveté by encouraging such administrative distance because it gives the health centers greater autonomy. Yet this situation often has disastrous albeit unintended consequences for the entire university in that academic health centers and their sister institutions in the same institution too often wind up at the antipodes of philanthropy and legislative appropriations.
Another phenomenon whose effect is to diminish access to health care for the uninsured and thus widen the gap in health status is the “conversion” of troubled non-profit hospitals and insurance entities, many Blue Cross plans among them, so that they can have access to private capital markets. This process has been subverted by senior management and boards of directors at such organizations who seek to abandon the explicit charitable and benevolent status of their respective charters to benefit themselves instead of their constituents.

As but one example, the insurance regulator in Maryland recently issued a scathing 342-page report denying the application of the Blue Cross plans to abandon their non-profit status and merge into a publicly traded company. The top eight executives at the insurer had arranged compensation for themselves totaling $119 million of charitable assets to be diverted into their own pockets. One cannot help but wonder how the hundreds of thousands of uninsured people in the mid-Atlantic region would regard $119 million being diverted to non-profit executives whose company is supposed to be the insurer of last resort, providing charitable and benevolent access to quality health care.
What’s unique about this situation is that the perpetrators were exposed and their avaricious efforts stymied. I describe this situation as unique because, regrettably, many comparable schemes succeeded with at most muted public criticism. This trend, which is being replicated throughout the country, will clearly exacerbate access to health care for the indigent as these hospitals intentionally abandon their charitable and benevolent status.

The net result of all these developments, such as non-profit insurance plan and hospital conversions, as well as recurrent manipulation of Medicaid and Medicare funding formulas, place more of the fiscal burden on the patients and consequently on our teaching hospitals which, in spite of what many patients feel to be exorbitant fees reflected in annual double-digit increases, are strapped financially. Ironically, the academic health centers are, certainly unintentionally, exacerbating their own problems: because they are usually among the largest employers in their respective communities and offer generous staff benefit packages, increases in their health care charges ultimately drive up the insurance premiums that they themselves pay.
Indeed, “the cost of providing health benefits to employees rose an average of 14% in 2003, the fourth consecutive year of double-digit premium increases by insurers.”

It is high time for university presidents to discover ways in which we might collaborate effectively with health center CEOs, as well as community and business leaders, to convince federal and local legislators of the enormity of our fiscal problems. But at the same time we must be resolute in refusing to abandon the medically uninsured as well as underinsured. It’s too early to tell, but it may be that the remarkably innovative health insurance plan being developed in Massachusetts will lead the way for the test of the nation.

We also need to become more active in working with the deans of medical schools, schools of public health, nursing schools, pharmacy schools, dental schools, and those of other health professions to enhance our investment in health care. That includes enhancing access to education in the health professions. We anticipate a huge shortfall of health care professionals, including biomedical scientists, within the next decade.
Only if we give passionate support to balancing access to medical care for all with educational opportunity for all, will our nation’s citizenry finally emerge as a truly healthy people.