



Health Reform

Delivering for Those Who Deliver Health Care

By Robert A. Berenson and Ellen-Marie Whelan

Introduction and summary

There is a growing national consensus that the U.S. health system needs substantial change, and strong reason to believe that this time long-term ideological and political divisions can be overcome. In today's climate it is also apparent that health professionals can play a decisive role in assuring that a broad health reform proposal that has their needs in mind is enacted into law.

In recent rounds of efforts to achieve substantial health care reforms, health professionals have been largely relegated to commenting on important but ultimately peripheral issues, while lawmakers, insurance and pharmaceutical companies, and patients' groups took center stage in proposing and opposing insurance coverage expansion and restructuring of health care delivery. This time it is clear that the interests of clinicians to best serve their patients are aligned with the American public's desire for a health care system that works, and that both of these goals can only be met through health reform that no longer accepts the unacceptable status quo. Today's evolving consensus on health reform targets precisely the issues that have frustrated clinicians and hampered their ability to do their jobs.

There is near universal agreement that the current system is broken and cannot be tolerated any longer. The clear first priority of reform is to provide every American with good health care coverage. While building on the current mixed public and private health system, health reform will eliminate the worst parts of private insurance markets, including exclusion of individuals from insurance based on pre-existing conditions, the lack of transparency about payment rates and reimbursement rules, and administrative waste associated with fragmented insurance markets. Under the envisioned competition between private plans and a public health insurance plan, it is likely that the performance of both private and public plans will improve. This approach would surely produce positive changes to the health system. If the evolving consensus produces a legislative package that falls short in some areas, additional steps can be taken in the inevitable subsequent rounds of health system reform improvements.

The core elements of the emerging health reform package include insurance coverage expansion, delivery system reform and payment innovation, a focus on prevention and wellness, enhanced primary care and chronic care management, and comparative effectiveness. Each element will help ensure that providers are better able to serve their patients in the following ways:

- **Insurance coverage expansion:** In a system in which all Americans have adequate health insurance coverage, health professionals will be able to provide needed care to all Americans without cutting corners.
- **Delivery system reform and payment innovation:** Integrated delivery systems, in which physicians play a leadership role, can promote collaborative team-based care to better serve patients' complex care needs, especially in the area of primary care and chronic care management. These systems also can promote adoption and enhancement of electronic health records, including patient access to a personalized health record via customized web portals. They can also mount and sustain systematic quality improvement and patient safety efforts.
- **Prevention and wellness:** Health reform will enhance community-based care capacity by improving public health services and enabling health professionals to provide quality wellness and prevention care for individual patients.
- **Chronic care management:** Coordinated care management will reduce confusion within the system and help health professionals manage patients' chronic conditions.
- **Comparative effectiveness:** Comparative effectiveness research will permit patients and their health professionals to make better decisions about care based on evidence.

Providers have an essential role to play in shaping each of these reforms and helping to improve the system, and an improved system will also help health care professionals better serve their patients—as we discuss in detail in this paper. Each of these five elements is important in itself—but implemented together they can produce a health care system that will indeed become one of the best in the world.

How health reform can help health professionals

In 2009, physicians, nurses, and other clinicians experience the failures of the current health system every day and know that the status quo is no longer acceptable—neither for their patients nor for their professional work. They have experienced too many compromises in their commitment to serve their patients' best interests—not because of their own lack of will and dedication but rather because of profound flaws in the health system over which they have had little control.

At its best, health care in the United States rivals any in the world. Indeed, U.S. professionals and the organizations in which they work are often on the cutting edge of improvements that produce longer life expectancies and a higher sense of patient well-being, whether through the use of powerful new technological advances or in the development of multidisciplinary teams that provide enhanced care for the growing cohort of patients with multiple chronic conditions.

At its average, however, U.S. health care has woeful flaws. The World Health Organization in 2000 ranked the United States as having the 37th best health care system in the world—sandwiched between Costa Rica and Slovenia.¹ Health professionals as a group are probably the least surprised by the mediocre ranking because they face the system's failings every day. Pragmatic and results-oriented professionals have long attempted to “work around” the barriers providing a single standard of high-quality patient care. They contribute time to free clinics and work overtime in financially strapped facilities to help out; alter preferred diagnosis and treatment plans to accommodate patients with absent or inadequate insurance coverage; and conscientiously work with seemingly arbitrary private and public payers' regulations and limitations.

Serving patients' best interests can be a challenge for health professionals, who must rise above their own self-interest in the face of a dysfunctional health care system. Health reform offers the realistic possibility that health professionals will no longer be expected to act “heroically” to conduct their professional activities but rather will be able to participate in a system that actually works for patients and for health professionals. And health reform has the potential to clear the cynicism that too often creeps into professional attitudes about health care.

Given the complexity of the health care system—it constitutes one-sixth of the nation's economy—and the diverse set of groups who have a legitimate interest in health reform, it is not surprising that there is no consensus on many of the issues that must be addressed; there are sincere and important differences in values, especially about the role of government in the our political economy. In past attempts at reform, some health professionals proved unable to look beyond their particular perspectives to participate in collaborative efforts to achieve real health care reforms. This year, some health professionals believe that current health reform proposals do not go far enough. Instead they support a single-payer approach, such as Medicare for all. Others are skeptical of any expanded role for government and want expansion only through private plans or more reliance on direct patient payments, with insurance playing a less important role. Similarly, there are diverse views on how best to address the problems of “defensive medicine,” caused partly by the litigious environment in which health professionals work.

Health professionals must put aside some of these deeply felt differences of opinion to embrace their position as an essential part of the coalition needed to enact the emerging consensus approach to reform. A number of health professional associations have indi-

vidually endorsed health reform principles that share many common themes and are in the mainstream of the emerging consensus about the elements of a reform package.² These principles are consistent with the framework for reform that is emerging in Congress and the Obama administration. The core elements of the emerging health reform package include: insurance coverage expansion, delivery system reform and payment innovation, prevention and wellness, enhanced primary care and chronic care management, and comparative effectiveness. The rest of the paper will address how these elements of health reform will affect patients and the health professionals who care for them.

Insurance coverage expansion

One pillar of a reformed health care system is that all Americans have some form of coverage, mostly through private plans. In such a system health professionals will no longer have to face tough decisions about providing care that may go uncompensated, and patients will no longer face the consequences of being unable to afford needed care.

Earlier this decade, the Institute of Medicine issued six reports concluding that available evidence indicates that “being uninsured was hazardous to people’s health” and recommended that the nation move quickly to implement a strategy to achieve health insurance coverage for all. For various reasons since then, health insurance coverage has declined, and there is no reason to believe that the current trends will reverse without legislative action.

The consequences of being uninsured and underinsured are well documented. There is clear evidence that having good insurance matters over a range of clinical conditions, despite the dedicated efforts of safety net providers and health professionals caring for the uninsured. The Institute of Medicine notes the following examples:

- Uninsured adults experiencing an acute ischemic stroke are more likely than insured adults to experience extremely poor outcomes, including intracerebral hemorrhage, neurological impairment, and death.
- Uninsured adults are more likely than insured adults to be diagnosed at an advanced stage of cancer.
- Uninsured adults are less likely than insured adults to be aware of hypertension and, if hypertensive, more likely to have inadequate blood pressure control.
- Uninsured children are less likely to have access to a usual source of care, to receive well-child care and immunizations to prevent future illness, and to receive appropriate asthma care and basic dental services.³

These and other avoidable outcomes do not result from lack of effort by health professionals, but instead are a consequence of a lack of insurance coverage. Clinicians continually find themselves caught in a bind when conducting their professional activities. They must compromise on clinical recommendations because of the reality that patients lacking good insurance are financially unable to follow the right approach. This dilemma for professionals is worsening, as more diagnostic and therapeutic interventions that can reliably head off or alter the natural course of acute and chronic conditions are simply unaffordable for those without good insurance coverage.

Screening tests—such as mammograms and colonoscopies—to detect cancers in early treatable stages are one such category of procedure that is often unaffordable for the uninsured. Safety net institutions—those hospitals and systems that provide care to low-income populations or those who may not otherwise have access to care—may not be able to subsidize these preventive services because of growing financial pressures. The result is that physicians wind up treating later-stage cancers at a human and financial cost to society. Pharmaceuticals used early and regularly in secondary prevention of common conditions—such as hypertension and hyperlipidemia—can prevent severe complications and death from strokes, heart attacks, and renal failure. Yet clinicians are often unable to prescribe the preferred medicine when they know that patients without insurance will not be able to fill the prescriptions. Increasing availability of generic drugs helps, but in many situations clinicians know that patients cannot afford straightforward treatments, and as a consequence they see patients suffer avoidable complications. The ever-growing number of uninsured and underinsured means that clinicians will continue to be forced to compromise their judgment to accommodate their patients' financial circumstances. This ultimately takes a toll on health providers' professional morale and self-respect.

Uninsurance also may undermine health care for the insured population. A recent follow-up study to a 2003 Institute of Medicine report finding confirms that insured adults in communities with relatively high levels of uninsured individuals have difficulties accessing adequate health care. These individuals are often less satisfied with whatever care they can access compared to insured individuals in other communities.⁴ Uninsurance and underinsurance contribute to the preferential concentration of providers and capital investments in health care facilities and technology in well-insured and relatively affluent areas, to the growing reluctance of physician specialists to assume on-call responsibilities for emergencies, and to a range of interrelated, hospital-based problems such as insufficient inpatient bed capacity, strained emergency services, and barriers to timely trauma care.⁵

A growing phenomenon in U.S. health care is the increasing gap between so-called “have” and “have-not” hospitals, whose financial fates are tied closely to geographic location and payer mix. The distribution of lower-income patients among providers has long been skewed, as the majority of care for indigent populations tends to cluster among a relatively small proportion of institutional providers.⁶ Recent evidence suggests that these divisions of segregated care and their consequences are hardening.⁷

A result is that relatively well-endowed facilities are able to invest in new technology; offer desirable work environments and salary levels to attract needed nurses, medical technicians, and other essential health professionals; and be better positioned to take advantage of new approaches to third-party payer contracting initiatives. Insurers, for example, will sometimes issue bonuses to hospitals that can prove they have certain processes in place—such as health information technology—to help reduce medical errors. It is often only the well-endowed hospitals that can put these systems in place while the poorer hospitals—due to no fault of their own—cannot take advantage of these financial incentives.

Predictably, the “have” hospitals build on their initial advantages to attract an even more desirable payer mix and higher payment rates from commercial insurers, while less fortunate hospitals struggle to carry out their missions to serve their uninsured and underinsured populations. Health professionals often find themselves in the difficult position of deciding whether to abandon less fortunate practices for those that permit them to serve their patients with state-of-the-art interventions and to receive compensation commensurate with their skills and effort.

Health reform will dramatically alter this unfortunate imbalance for patients and the health professionals caring for them. All Americans will have good insurance coverage—mostly in private insurance plans. The insurance dollars will follow the care patients receive, and the term “uncompensated care” can hopefully be retired. Similarly, “price discrimination,” “cost-shifting,” and other jargon-heavy practices that place a burden on providers can be reduced and eliminated over time. The time hospitals must spend worrying about having the proper payer mix is a diversion from taking care of patients. This will be virtually eliminated if everyone has access to quality health insurance.

Delivery system reform and payment innovation

Another key component of health care reform is improving the way patients receive care—the care delivery system—and the way providers are compensated for that care. Health reform offers the promise of decreasing delivery system fragmentation that characterizes health delivery today. These reforms will help ensure quality and value in accordance with the Institute of Medicine’s definition of quality health care: care that is safe, timely, effective, and patient centered, and delivered in an equitable, efficient manner.⁸ Important initiatives to improve quality and value include conducting more comparative effectiveness research studies via public-private partnerships, improving the quality and efficiency measures on which clinician and provider performance are judged, introducing newer provider payment methods to better reward desired health outcomes and to promote greater collaboration among clinicians, and reducing wasteful administrative costs in the system.

Health professionals have long been expected to assume personal responsibility for meeting standards of their profession in providing one-on-one care to patients to the best of

their ability. It is now recognized that individual excellence is necessary but not sufficient to best serve patients with ever more complex clinical needs. Clinicians themselves increasingly see that their best efforts in isolation do not produce the best results for patients.

Integrated delivery systems, in which physicians play a leadership role, can promote collaborative team-based care to better serve patients' complex care needs, especially in the area of chronic care management. These systems can also promote adoption and enhancement of electronic health records, including patient access to a personalized health record via customized web portals, and mount and sustain systematic quality improvement and patient safety efforts.

A number of case studies have documented examples of organizations that have initiated programs to improve quality and decrease costs for patients and payers only to find that they could not sustain the direct costs of running the program and the decreased revenues that resulted from their success. With greater transparency regarding performance, payment approaches need to reward rather than penalize cost-reducing behavior. The approach used in the Medicare Physician Group Practice demonstration—the “shared savings” approach that permits large physician group practices and Medicare to share in financial savings when the group successfully reduces total Medicare spending—seems a practical approach for adoption initially to promote integrated care systems. In this demonstration, when the physician groups provide “better” care—for example through care coordination which is not reimbursed in the current fee-for-service program—and save money by reducing hospitalizations, the physicians share in the costs they saved the Medicare program.⁹

Integrated delivery systems offer the potential of reducing costs while maintaining or even improving quality by providing such an array of services within a single system. One major problem a reformed system must address is that the current fee-for-service approaches to payment often penalize these large organizations financially for proactive interventions that ultimately reduce costs and improve well-being; as a result, we do not realize the full potential of these organizations. There is an emerging consensus that it is time to move away from “one size fits all” payment systems that cause these perverse results. Medicare, for example, produces a fee schedule for physician services and prospective payment based on diagnosis-related groups for all hospitals, but does not allow financial rewards for providing services that may cost more on the physician side even though they may result in lower hospital costs.

The integrated delivery organization model should be available to a diversity of providers, including small, single-specialty practices. Currently, relatively few groups of physicians practice in integrated delivery systems. Most are part of much larger multi-specialty medical groups, such as the Mayo Clinic and Geisinger Health System. All physicians should be eligible for a population-based payment—a certain amount every month to provide care for a roster of patients regardless of the services used—instead of receiving payment for each service individually, as with the standard fee-for-service payment system.

Several established organizational models already function well and could serve as a model for new forms of care delivery. Independent practice associations (IPAs) typically contract with particular health plans for commercial enrollees and Medicare Advantage and Medicaid beneficiaries in what is called the “delegated-capitation model.” IPAs are associations that allow separate medical practices to join together for various reasons such as contracting, providing better quality improvement, and managing costs. Some practices—mostly located in California and several other parts of the country, including Phoenix, Denver, and Rochester, New York—perform well as integrated-care organizations even though the physicians have not formally come together into a multispecialty group.

IPAs are increasingly engaging their constituent practices in quality improvement activities, and even purchasing electronic health records for individual practices while ensuring interoperability across practice sites. The IPAs often house chronic-care management professionals who can interact with physicians in virtual teams to support patients with chronic conditions and the frail elderly at home.

True multispecialty group practices and physician-hospital organizations might also be relied on initially to reorient health delivery if supported by new payment approaches—first in Medicare and then presumably across most other third-party payers. We must also acknowledge that not all clinicians are ready to participate in integrated delivery models. Intermediate payment reforms, such as gain sharing between hospitals and physicians (arrangements that encourage hospitals and physicians to collaborate in eliminating excessive hospital operating costs while maintaining or improving the quality of patient care) and bundled payments for episodes of care, have been proposed as improvements on standard payment models. These will be tested in health reform and, if successful, adopted as experience is gained and health delivery innovations proceed.

Prevention and wellness

Health professionals know better than anyone that we must change the focus of health care activities from reactive care for those patients who have developed acute and chronic illnesses to preventive approaches to forestall development of many conditions in the first place. Emerging interest in providing community-based prevention and wellness capabilities—including enhanced activities in schools and the workplace—would provide an overdue complement to the role of clinicians in providing personal health care. Health reform will emphasize better wellness and prevention efforts on the individual and community levels, bolstered by a primary care workforce of physicians, nurses, and other clinicians supported by major investment in health information technology.

Clinicians have long been frustrated by the lack of reference resources and collaboration tools available to them, so that they may bring the same kind of expertise and dedication to instilling a sense of patient responsibility about health habits that they bring to diagnos-

ing and treating serious disease. Implementing a community-based capacity to true prevention and public health will address this need, and complement the skilled professional's care for individual patients.

One place this has already worked is the laborious and often contentious efforts to decrease cigarette smoking over many decades. The efforts have succeeded: Now, a relatively small percentage of adults smoke. Our most prevalent public health challenge now is overweight and obesity, which lead directly to a number of chronic conditions, including type-2 diabetes, hypertension, heart failure, degenerative arthritis, and chronic, recurrent back pain. These conditions interact to compound adverse health effects. For instance, people with disabling degenerative arthritis of the knees or back can't easily exercise, which in turn makes sustainable weight loss almost impossible.

A reformed health delivery system could better support primary and secondary efforts to prevent or minimize the development of chronic conditions and acute life-threatening events. As already discussed, ideas for moving away from fee-for-service reimbursement for discrete services and toward paying provider organizations for caring for populations and making them accountable for the health outcomes of the patients under their care would help the health system refocus on maintaining health rather than treating illnesses.

Most medical practices today simply cannot afford to hire and support the range of personnel, including nutritionists, psychologists, and health educators, which, as a team, could be responsible for the needed reorientation in care delivery. With real community-based resources and expertise on prevention and wellness, affected populations could be expected to take greater personal responsibility for their health and well-being.

Enhanced primary care and chronic care management

The 20 percent of Medicare beneficiaries with five or more chronic conditions account for two-thirds of Medicare spending, see about 14 different physicians, visit an office 40 times, and fill 50 prescriptions in a year.¹⁰ Just 5 percent of Medicare beneficiaries are responsible for 43 percent of program spending¹¹, and data from commercial payers and Medicaid programs find similar concentrations of spending associated with a small cohort of enrollees, often with chronic illnesses. Nevertheless, public and private insurer benefit designs for the most part ignore the importance of established chronic illnesses in generating disproportionate demands on the health care system and escalating health care costs. Care remains fragmented across all of the conscientious and hard-working professionals and providers—with no one really in charge of coordinating the care. As a result, the total care is often less than the sum of the parts, with patients hearing conflicting diagnoses and treatment recommendations; receiving duplicative or incompatible medications; and suffering avoidable medical errors due to lack of coordination.

Interoperable electronic medical records, which will be a prominent feature of health reform, should improve the situation. However, given the challenge posed by patients with complex, multiple chronic conditions, there is an urgent need to enhance the care coordination role of primary care clinicians. What's more, coordinated care implemented immediately will help recognize the desire that most patients share to seek care from a trusted professional who helps the patient navigate the increasingly specialized health care system. We have a clear need for a different health professions workforce to meet the needs of an aging population with chronic conditions: a much greater supply of primary care physicians, primary care nurse practitioners, and physician assistants. More specifically, the frail elderly need a much greater supply of geriatricians to care for them.¹²

Yet, current physician payment policies in Medicare ignore these workforce priorities. By rewarding increasing specialization with higher reimbursement, these policies also ignore other important workforce shortages, such as general surgeons and mental health professionals. Health reform can help reignite the sense of mission that drove most health professionals to become doctors and nurses in the first place through expanded use of loan forgiveness programs, an expansion of service opportunities to health professional shortage areas through the National Health Service Corps, and other potential policy approaches.

Private insurers and Medicare have mostly tested models of the so-called “disease management” for chronic conditions, naively thinking that these approaches could improve care coordination and instill enhanced patient self-responsibility. The problem with these demonstrations is that they essentially ignored the core of the physician-patient relationship by outsourcing the management and paying a private “disease management” organization. Payers can reorient by supporting medical teams caring for patients with chronic conditions rather than bypassing these teams. These newer approaches will be a core component in health reform designs.

Comparative effectiveness

Despite assertions to the contrary, comparative effectiveness initiatives are designed to support clinician-patient decision-making, not interfere with it. Physicians and other health professionals generally rely on studies published in peer-reviewed journals to inform their clinical decision-making. These studies compare a study intervention against the natural course of the condition, either with or without the accepted standard diagnostic and treatment interventions. In short, comparative effectiveness is already at the heart of professional efforts to stay up-to-date on emerging clinical developments within specific clinical fields.

Unfortunately, these comparisons are not always rigorous or complete. And too often the evidence-base on which study authors make comparisons is inadequate. In the case of clinically important conditions for which patients and clinicians need better comparative information on which to base clinical decisions, there may be scant comparative effective-

ness information. There are myriad approaches to the clinical management of chronic low back pain, for example, including pain management with analgesics, exercise and physical training, spinal manipulation, anesthetic and anti-inflammatory agent injections, and a variety of surgical procedures. Yet, there is little clinical evidence that provides head-to-head comparisons of these and other clinical approaches for subgroups of patients with different low back pain syndromes.

The new focus on comparative effectiveness is designed to synthesize existing information into useful, updated formats for clinicians and patients to help improve shared decision-making, identify important data gaps, and prioritize federal research efforts to fill those gaps. Comparative effectiveness has become needlessly controversial, because some who oppose health reform for ideological reasons have seized on the comparative effectiveness concept to suggest that health reform advocates have designs for the government to substitute its judgment for that of clinicians serving their patients.

In fact, the clear-cut objective of an enhanced role for comparative effectiveness is to permit clinicians and those paying for care to be better able to make evidence-based decisions—to support professional judgment and not to supplant it. Virtually all professional organizations, consumer groups and other major health reform stakeholders agree that supporting practical, relevant clinical research that is objectively synthesized for practical application by clinicians and patients can improve health care—and actually would serve to ward off arbitrary cuts in benefits and payments.

Conclusion

With active support by all stakeholders, and especially those who have devoted their lives to improving our nation’s health, our country can actually achieve the twin goals of universal coverage and delivery system reform that produces much greater value for patients, and a better and fairer deal for the health professionals who have struggled to provide excellent health care in the face of major obstacles. Today, health professionals—physicians, nurses, physician assistants, therapists, dentists, chiropractors, and many other dedicated individuals—are where they deserve to be: at the forefront of efforts to achieve these goals.

Endnotes

- 1 The World Health Organization, "The World Health Report 2000—Health Systems: Improving Performance" (The World Health Organization, 2000), available at <https://www.who.int/whr/2000/en/index.html>.
- 2 White papers of professional organizations can be found at:
[American Medical Association, or AMA](#)
[American College of Physicians, or ACP](#)
[American Academy of Family Physicians, or AAFP](#)
[American College of Surgeons, or ACS](#)
[American Nursing Association, or ANA](#)
[American Academy of Nursing, or AAN](#)
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