



American Heart Association | American Stroke Association

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American Heart Association Principles on Health Care Reform

The American Heart Association has a longstanding commitment to approaching health care reform from the patient's perspective. This focus – including the important roles that health care providers, biomedical research and the health care delivery system play – is reflected in AHA's past and current positions on meaningful health care reform.

In 1992, AHA's Board of Directors approved five key principles for access to health care. They concentrated on patient access to preventive services and quality health care and continued biomedical research to improve the prevention and treatment of heart disease and stroke.

More than 15 years later, some progress has been made in achieving this vision – particularly with regard to developing guidelines for appropriate patient care and methods to measure quality, evaluate outcomes and determine cost-effectiveness.

However, more Americans than ever lack health insurance, presenting a major barrier to receiving quality health care. These include children with congenital heart disease, who formerly would have died, but now survive to confront these challenges. And after an initial doubling, the National Institutes of Health's budget has fallen flat with an actual reduction in purchasing power because funding has failed to keep pace with biomedical research inflation.

In this summary document, AHA updates what it believes to be the six critical principles that must be addressed if health care in the United States is to be effective, equitable and excellent.





Principle 1:

All residents of the United States should have meaningful, affordable health care coverage.

Every individual should have affordable health care coverage that provides access to appropriate health care services and guarantees protection from extraordinary or catastrophic medical costs. This is particularly important for those with chronic disease.

Over the past decade, both the number and percentage of Americans without health insurance have increased significantly, including individuals with heart disease and stroke. At the same time, a growing number of people with coverage are underinsured, meaning that their insurance does not provide adequate financial protection when they are sick.

The detrimental health effects of being uninsured for individuals with heart disease and stroke are well documented. For example, people without health insurance experience a 24-to-56 percent higher risk of death from stroke than their insured counterparts. On the other hand, gaining health care coverage provides the greatest benefit for those with a history of heart disease, stroke, high blood pressure and diabetes.

However, in the current health care system, individuals not covered by Medicare with chronic diseases such as heart disease and stroke find it extremely difficult to obtain comprehensive, affordable health insurance. They are often denied coverage or charged premiums beyond their means.

For example, young adult patients with congenital heart defects face enormous barriers, particularly when they reach adulthood and are no longer covered by their parents' health plan. Given their medical history, few health insurance companies are willing to underwrite them, or the cost is prohibitive.

Rather than continue to allow people with chronic diseases to join the ranks of the uninsured or underinsured, health care reform must create a fair and equitable system that does not discriminate against these individuals. And investments in quality health care services will yield dividends for both individuals and society.

True, the cost of meaningful, affordable health care coverage for all Americans is considerable, and rising expenditures for publicly-funded health care, such as Medicare, threaten our nation's financial health. However, this problem is not insurmountable, and AHA believes that the initiation of a meaningful dialogue among the major stakeholders to resolve this problem in a cost-sensitive manner must be given the highest priority.



Principle 2: Preventive benefits should be an essential component of meaningful health care coverage, and incentives should be built into the health care system to promote appropriate preventive health strategies.

All public and private sector health insurance should provide for the identification, monitoring and treatment of risk factors that lead to heart disease and stroke in patients of all ages. These preventive benefits should be based on AHA's scientific guidelines, the U.S. Preventive Services Task Force recommendations and findings of other authoritative, nationally-recognized clinical consensus bodies.

At a minimum, the benefits should include monitoring of blood pressure, cholesterol and blood glucose levels, and an assessment of smoking, nutrition and physical activity. Health care reform initiatives should also be coupled with public health initiatives to promote community-based prevention of obesity and other heart disease and stroke risk factors.

Effective prevention strategies that are implemented early and followed over the long-term also have proven to mitigate the tremendous burden of heart disease and stroke. However, there are too many missed opportunities. Sixty-nine percent of people who have a first heart attack, 77 percent who have a first stroke, and 74 percent who have congestive heart failure also have high blood pressure. One-hundred-six million Americans have elevated total cholesterol levels. One-third of people with diabetes – a major risk factor for heart disease and stroke – are unaware they have the disease.

Moreover, health care coverage for preventive services also varies greatly among insurers and many do not include evidence-based risk identification, monitoring services supported by the best available science. Cost-sharing for preventive services can also present challenges to those patients with, or at risk for, chronic illness.

However, the good news is that some employers have lowered or removed cost sharing for certain preventive benefits and interventions, such as prescription drugs used to treat high blood pressure, cholesterol and diabetes.

These forward-looking employers concluded that a strategic investment to control risk factors can reduce the serious and costly consequences of heart attacks, strokes and other forms of heart disease. Such efforts should be encouraged and provide a valuable model for consideration during the upcoming health care reform debate.



Principle 3:

All residents of the United States should receive affordable, high quality health care.

Health care reform should promote both improvements in and evaluation of quality of care. These efforts should adhere to clinical practice guidelines and help consumers evaluate health care quality. Reform initiatives should be designed to: (1) improve the value of care delivered; (2) minimize unnecessary interventions and treatment; and (3) ensure that individuals always receive appropriate care that is safe and efficient.

In its landmark report, *Crossing the Quality Chasm*, the Institute of Medicine (IOM) declared: “Between the health care we have and the care we could have lies not just a gap, but a chasm.” In fact, those residing in the U.S. receive the care recommended by best practice guidelines only half of the time.

To improve health care quality, AHA develops clinical practice guidelines that translate clinical evidence into specific written recommendations to inform health care provider decision-making. AHA integrates these guidelines into quality improvement tools for both providers and consumers to evaluate health care choices. These sophisticated tools and rapid advances in health information technology provide a glimpse of how health care reform could promote informed clinical decision-making.

Through the development of performance measures that are integrated into quality improvement tools, AHA also partners with the health care community to report and assess quality. This work has clearly demonstrated the importance of evaluating quality using risk-adjusted, standardized and evidence-based measures.

Cost-effectiveness measures should also be integrated in the health care delivery system. Health care reform initiatives should consider mechanisms for better aligning payment with improving health care quality. Pay-for-performance programs are increasingly being adopted as a means of addressing variations in health care quality. However, there is limited evidence to date of their success and these and other potential mechanisms should continue to be tested to measure their impact on costs and outcomes and to ensure that there are no unintended consequences.



Principle 4: **Race, gender and geographic disparities in health care must be eliminated.**

To address health care disparities, reform proposals should at a minimum encourage monitoring, reporting and evaluation of data regarding the consistency and equity of health care delivery. Standardized, evidence-based quality measures should be used. In addition, health care reform should promote cultural awareness in training programs for health care professionals, and health literacy for all, particularly for vulnerable populations.

The presence of disparities in health care has been recognized for more than 20 years, going back to the groundbreaking *1985 Task Force on Black and Minority Health* report. And in 2003, the IOM noted that, “studies of racial and ethnic differences in cardiovascular care provide some of the most convincing evidence of healthcare disparities.”

Indeed, compared to whites, African-Americans at any given age are two to three times more likely to die from heart disease or stroke. And the overall decline in heart disease and stroke death rates has not been distributed equally among racial and ethnic groups, especially in the Southern United States. Research has also shown disparities in heart disease and stroke risk factor management, such as controlling high blood pressure and cholesterol and treating diabetes and obesity.

AHA convened the *Minority Health Summit 2003* to examine health care disparities involving heart disease and stroke and to develop recommendations in a number of areas, including public policy. The issues are complex, involving differences in access to care, health behavior, cultural and environmental factors, socioeconomic factors, genetics, and perhaps, bias. Health care reform should incorporate a multifaceted approach to addressing these issues.

The delivery of health care services should also be monitored using standardized clinical measures of care that are evidence-based and risk-adjusted, such as those developed through AHA’s clinical guideline and performance measurement development processes. These measures should be reported by race, gender and geography to identify any potential inconsistencies or inequities in health care delivery.

Moreover, efforts should be made to improve health care providers’ knowledge of diverse cultural and behavioral traditions that may influence patient understanding of and adherence to recommended health care regimens. This knowledge should also be incorporated into clinical training and continuing medical education. Additional approaches that should be pursued include increasing the number of minority health care providers and investigators; involving diverse populations in clinical trials; and outreach to improve health literacy for vulnerable populations.



Principle 5:

Support of biomedical and health services research should be a national priority, and inflation-adjusted funding for the NIH must be maintained and expanded.

Health care reform initiatives should support increased investments in biomedical research to accelerate the identification of causes and the cures for disease, especially heart disease and stroke. Research should also continue to document and develop effective health care delivery strategies and financing models that support the best clinical care and patient outcomes. And research should be structured to deal effectively with the unique challenges posed by specific populations, including children and racial and ethnic minorities.

The benefits of research are clear. Death rates from heart disease fell by 40 percent and death rates from stroke by 51 percent between 1975 and 2000 and many of these advances were driven by public investment in biomedical research.

Today, the U.S. spends more than \$7,100 per person each year on health care services. However, it spends only \$95 per person on NIH biomedical research. Research investments must keep pace to improve clinical outcomes and the cost-effectiveness of health care.

For example, the sequencing of the human genome has opened the next frontier in scientific advancement and offers significant possibilities for reducing the devastation of heart disease and stroke. This potential, however, will be realized only through an enhanced commitment to invest in biomedical research.

However, Congressional funding has not recently kept pace with biomedical research inflation. It is estimated that NIH's heart disease and stroke research budget is 15 percent lower in 2008 than in 2003. NIH has lost purchasing power, which in turn, has severely curtailed new research project grants that could lead to cures for heart disease and stroke. A real commitment to future research is also essential so that young researchers understand that meaningful career-paths still exist in the sciences.

We also need a renewed effort to translate clinical research into practice through health services research, such as AHA's Get With The GuidelinesSM program, an evidence-based program for in-hospital quality improvement.

Lastly, the Agency for Healthcare Research and Quality (AHRQ) coordinates the federal agenda for improving health care quality. Yet, the nation spends only \$1 per person on AHRQ's work. A much larger commitment to its research is necessary.



Principle 6:

The United States' health care workforce should continue to grow and diversify through a sustained and substantial national commitment to medical education and clinical training.

Any health care reform proposal should provide sufficient public health and medical education funding and clinical training resources to improve chronic disease management, care coordination and patient-centered care. It should also support and promote the development of new models of care delivery, including those that emphasize team-based approaches using allied health professionals.

The retirement of the baby-boomer generation will present the health care system with large numbers of older patients with more complex and chronic health needs. Among the more significant challenges will be how best to ensure a sufficient health care workforce with the knowledge and skills to provide needed care.

Some experts, such as the Council on Graduate Medical Education, are predicting a physician shortage in the coming years. In addition, the Association of American Medical Colleges called for a 30 percent expansion of U.S. medical schools and changes in federal reimbursement to meet growing demand. In this light, others suggest changing how we use health care services and the way physicians practice.

Rather than increasing the supply of physicians, some argue we should reduce disparities in the distribution of the physician workforce, including reallocating medical education funding to favor primary care, geriatric and palliative care, which are areas that have the potential to improve care coordination and chronic disease management.

There is also a nursing shortage that is likely to become acute by the aging of the baby boomers. Inadequate levels of nursing staff jeopardize patient care safety, reduce care coordination and weaken efforts to improve chronic disease management.

As the health care system responds to these changing workforce dynamics, new models of care delivery are evolving, including greater use of non-physician providers, allied health and public health professionals. The long-term care of people with chronic diseases such as congestive heart failure and diabetes demand a coordinated approach involving all types of such professionals. And new service delivery models offer new opportunities for enhanced care coordination and reducing the burden of chronic disease.



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The sources for all statistical information, studies, and other statements contained in this document are located on the World Wide Web at: www.americanheart.org/healthcarereformprinciples

