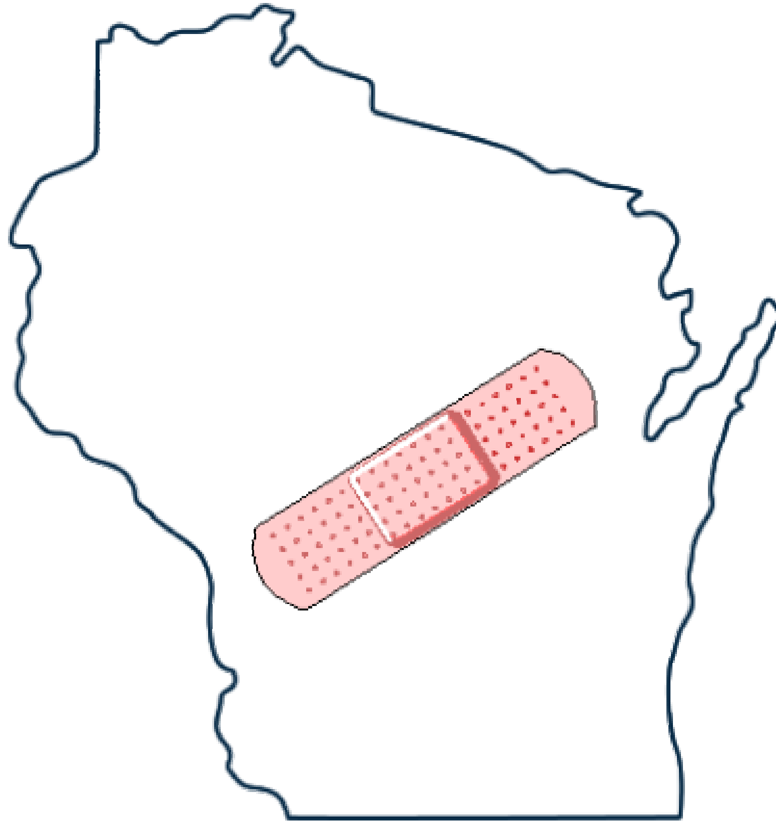

The Health Care Cost Crisis in Wisconsin:
An Economic Development Prognosis

Wisconsin Economic Summit IV
Health Care Workgroup

October 28, 2003

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I. Executive Summary

The health care cost crisis facing Wisconsin is extraordinarily complicated. Any assessment of its elements, cost drivers, stakeholders, challenges and potential solutions is, therefore, equally complex. This **Executive Summary** is intended to serve as an accessible context and framework through which the more detailed analysis of the health care cost crisis that follows can be more readily grasped.

Under the auspices of the *Wisconsin Idea*, the Wisconsin Economic Summit IV Health Care Workgroup was convened by UW System President Katharine Lyall to “bring forward the best thinking on the subject of health care” and to try to “move these ideas toward resolution.” Specifically, over the course of five months, the Health Care Workgroup addressed:

- The rising costs of health care and health insurance in Wisconsin;
- The growing numbers of individuals who cannot afford basic health care;
- The elements of the current environment that drive up costs;
- The public's dissatisfaction with the current state of affairs.

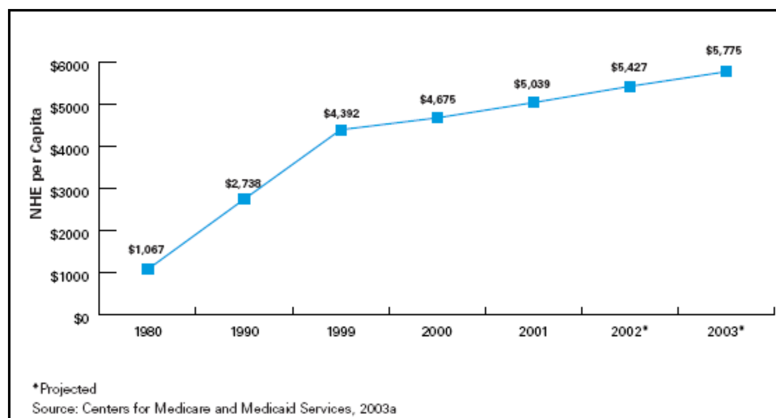
The Workgroup began its deliberations by recognizing that we are fortunate to live in a state like Wisconsin which has many positive health care features, including:

- A strong tradition of employer-based health insurance;
- Comprehensive state government health programs through Medical Assistance and Badger Care for certain low income persons who do not have access to, or are unable to participate in, employer-based insurance;
- Innovative safety-net programs through federal and state-funded Community Health Centers;
- Two world-class medical schools committed to training 21st century physicians;
- Several integrated health care systems providing state-of-the-art health care;
- A progressive tradition, recognized nationally, of collaboration among rural providers;

- Health care providers who partner with their communities to address health issues in an effort to reduce the long-term need for health care services.

Nevertheless, Wisconsin and the nation are in the midst of a health care cost crisis that, if ignored, will severely hamper our ability to care for our citizens, grow our economy and improve the quality of health care. As the graphic below illustrates, national health care expenditures per person increased by 24 percent in just three years (2000-2003).

National Health Expenditures per Capita, 1980-2003



The workgroup spent considerable time listening to experts in the field, including many of its own members who authored ambitious reform proposals, participate in state, national or industry-related committees on the issue or who work in the field of medicine. Given the natural inclination for competing interests to diverge and the enormous challenges posed by the health care cost crisis, the workgroup elected to "begin at the beginning" by discovering those values and beliefs that united its thinking and by addressing those issues it agreed, in principle, needed immediate attention.

That said, you will not find herein the "silver bullet" solution to the health care cost crisis. But you will find a thorough discussion and careful analysis of the extent of the crisis, the primary "drivers" that are causing health care costs to escalate and some suggested ways that we as a society might frame and address this situation.

During our deliberations, a consensus developed among us about how our ideas could help inform a solution, or series of solutions. Included among our shared notions was our agreement that:

- We will not be able to solve the **price** issues of health care if we do not first tackle the issue of **cost**
- Attacking pockets of costs that can be "fixed" (i.e., non-computerized operations that can drive up health care costs 10-20%) could help bring costs down
- Implementing quality disciplines such as disease management, wellness, etc. could reduce costs
- Restructuring processes to improve quality could reduce costs
- High quality does not necessarily lower overall costs and may, at times, increase costs
- We need to change consumer behavior/engagement
- We need to reform health care processes and systems
- Any/all change will be fundamental and incremental, but we have to stick with this issue **for the long haul**

With these shared principals in mind, the Health Care Workgroup broke into several subcommittees in an effort to focus attention on specific agenda items and to try to clarify what could be done, by whom, about what and when. But given the exigencies of time and the magnitude of the challenge, the subcommittees were not able to make as much progress, as more time would have allowed, nor coalesce around a handful of well-articulated solutions.

Nevertheless, several valuable recommendations for addressing health care in both the long and short-term were suggested by the **Aligning Incentives** and **Thinking out of the Box** subcommittees, including:

- Articulate a clear and unifying Wisconsin vision and statement of purpose to serve as a guide for the myriad of new initiatives relating to quality measurement and reporting.
- Adopt a targeted and concise set of performance measures which can be reported in a consistent manner, thereby enhancing consumer engagement and easing the burden of reporting for hospitals and physicians
- Streamline the collection and assessment of the public reporting of standard measures of health care costs, utilization, outcomes and medical errors.

- Link payment to performance
- Encourage public/private sector collaboration on health care purchasing initiatives
- Establish information technology as an enabler of change
- Undertake a broad-based and comprehensive educational initiative (led by the University of Wisconsin System) to prepare Wisconsin citizens for assuming more responsibility for health care decision-making
- The costs for information technology infrastructure be shared among purchasers, government, providers and the public;
- Evidence-based clinical practice guidelines be incorporated into daily practice to avoid historic wide variation in practice and resulting increased costs by overuse of services;
- Payers, purchasers, insurance, government **align incentives** to pay for performance, with the results being better care and motivation to continuously improve care;
- Schools of medicine produce a health work force trained in scientific-based clinical practice, team-centered care design and state-of-the-art medical computer technology;
- All aspects of the health care system – hospitals, provider groups and established integrated health care systems – be integrated to provide the safest, effective, patient-centered, timely, efficient, and equitable health care for our state and for our nation.

As a final point, while not all of us advocate each and every one of the ideas in the paper, we strongly agree that the overriding importance of solving this crisis outweighs our differences.

The unifying thread of this paper is that Wisconsin must tackle the health care crisis now, ask the right questions, bring all competing interests to the table and try to put workable models for change and reform into action. We have accomplished this on a small scale within our group, and we have been impressed with how transformative such thinking can be.

Each of us has a stake in this issue and needs to be committed to comprehensive reform in the long-term. This white paper represents a start, a framework if you will, for dealing with the crisis. But, we have a long way to go, mindful of the words of Sir Winston Churchill: “This is not the end. It is not even the beginning of the end. It is the end of the beginning.”

Let us now, in the words of our inspiring state motto, begin to move **“forward.”**

II. Health Care Workgroup

This group of individuals, each of whom has a significant interest in health care, was called together by University of Wisconsin System President Katharine Lyall to address the issue of the rising cost of health care in Wisconsin. Under the auspices of **Wisconsin Economic Summit IV** and the *Wisconsin Idea*, the Health Care Workgroup was charged to "bring forward the best thinking on the subject of health care" and to try to "move these ideas toward resolution."

The Health Care Work Group held several meetings between May and October, listened to an array of health care experts, reviewed the current literature and debated the myriad of issues that impact the cost of health care in Wisconsin and the nation. While they were not able to arrive at a breakthrough solution, they did plow new ground on demonstrating how all the stakeholders in health care can work together.

This paper is presented as a reflection of the good work undertaken by the Health Care Work Group, their insightful analyses and their suggestions for possible ways to resolve the crisis.

Members: Wisconsin Economic Summit IV Health Care Workgroup

Name	Affiliation	Title
Georgia Cameron	Black Nurses Assoc.	Past President
Jim Nellen	Competitive WI	President
Steve Bablitch	Cobalt Corporation	Chairman and CEO
Sharon Cook	Cook & Franke S.C.	Govt. Relations Advisor
Al Kemp	Dean Health System	CEO and Chairman
Kathy Farnsworth	Marshfield Clinic	Director, Govt. Relations
Robert Phillips, M. D.	Marshfield Clinic	Medical Director
Bill G. Smith	National Federation of Indep. Bus.	State Director
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Tim Size	Rural WI Health Cooperative	Executive Director
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Steve Brenton	Wisconsin Hospital Association	President
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Jim Haney	Wisconsin Manufacturers And Commerce	President
R.J. Pirlot	Wisconsin Manufacturers And Commerce	Director, Legis. Relations
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Jim Riordan	Wisconsin Physicians Service	President and CEO
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(**NOTE**: Given the complexity of the topic and the severe time restraints on the Health Care workgroup, this paper, while representative of some of the more available research and literature, is NOT intended to be a comprehensive, academic or scholarly analysis. Rather, it is a straightforward attempt to provide an informal account of what the members of the workgroup heard, discussed and analyzed. Many of the studies cited in the paper are subject to different interpretations, and while our goal has been to be both balanced and representative of the workgroup's thinking, others may choose to see different implications in what we are reporting. If nothing else, this demonstrates how complicated these challenges are.)

III. Introduction

A recent issue of *Fortune* magazine opines that one reason why Toyota has surpassed Chrysler as the nation's # 3 automaker has to do with the way Toyota structures its medical benefits to its employees; *The New York Times* points out that in prime retirement communities like Boca Raton, Florida, "Medicare's policies are guiding medical practice, with many making calculated decisions about whom to treat and how to care for them based on what Medicare covers, and how much it pays; " the League of Women Voters of Wisconsin argues that "with some control of administrative costs and some consumer co-payments, it would be quite possible to fully fund a basic national program of quality health care at an affordable cost from public sources."

To be sure, rapidly growing health care costs have become THE major concern of payers, purchasers, providers and policymakers nationwide. And with good reason – national health care expenditures now account for nearly 15 percent of the Gross Domestic Product (GDP); the average rate of increase for health care premiums nationwide grow anywhere from 12 to 24 percent annually; and in 2001 alone, there was a 13.7 percent rate of increase in health care spending.[1] It is time we realize that rising health care costs are no longer just an impediment to economic development—they represent a very real crisis.

The situation is no different in Wisconsin. From Bayfield to Beloit, Wisconsin citizens are troubled about the impact of the health care crisis on their personal health, their job choices and their pocketbooks. As concern and anger give way to blame and fear, the public is pressing policymakers to take action. These political pressures will only continue to grow as the typical family is confronted by the unappealing proposition of having to choose between pay cuts and sub-standard health insurance coverage.

At the current rate of increase, the cost of health care premiums will exceed the national minimum salary range of approximately $12,000 per capita in two years, leaving many employers unable to absorb the costs. Employers, then, will have to decide whether to shift much of their health care costs to employees, leaving many low-wage workers unable to

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[1] BlueCross BlueShield Association. *Medical Cost Reference Guide,* Health Care Cost Campaign. Revised June 2003. [http://bcbshealthissues.com/cost/costguide.vtml] 6.

purchase health insurance coverage for their families, or to abandon health benefits for employees or to cut employee positions altogether. Indeed, as insurance premiums go higher and higher, many believe it will be almost impossible to sustain the employer-based health care system in the future.

Such an environment has prompted health care providers, consumers and others to ask pointed questions, such as:

- *Who* should pay for health insurance?
- *What* should be covered?
- *How* should we pay?
- *How much* should be spent?
- *What* are the results and benefits of healthcare expenditures?
- *When* does the cost of financing health care become so burdensome that it threatens business viability, government solvency and the ability of families to pay for basic necessities?
- *What* can be done when financing structures fail?
- *How* can we fashion solid, updated state health care policies that put individual and institutional interests aside to serve the greater public interest?

These are the same kinds of questions that the contributors to this paper have been addressing for several months as we develop ideas for stemming this crisis. We comprise a broad, diverse professional and ideological mix – providers, insurers, consumers, businesses, labor groups, physicians, nurses and the pharmaceutical industry. Several of us have special expertise in health care policy and public administration. Many of us have drafted our own proposals regarding how best to address the issues of cost, access and quality of health care in Wisconsin.

Brought together under the aegis of the University of Wisconsin System and the renowned *Wisconsin Idea*, we talked, listened, brainstormed and differed about these and other health care policy issues. We debated what kinds of steps to take and when to take them. And we agreed it was better to identify the major cost drivers, the competing interests that restrain

genuine cost reform and the misalignment of incentives than to propose a "one-size-fits-all" remedy.

But, while you will not find herein the "silver bullet" solution to the health care cost crisis, you will find a thorough discussion and careful analysis of the extent of the crisis, the primary "drivers" that are causing health care costs to escalate, and some suggested ways that we as a society might frame and address this situation.

In the process, a consensus developed among us about how our ideas could help inform a solution, or series of solutions. **While not all of us advocate each and every one of the ideas in the paper, we strongly agree that the overriding importance of solving this crisis outweighs our differences.**

Trying to "fix" the health care crisis will not be easy. Very difficult choices lie ahead for everyone who has a stake in the problem. Because the magnitude of the situation is so enormous, our ideas will likely generate controversy. Our intent is to present as many feasible ideas as possible so that policymakers can safely examine real options as they work to solve the crisis. To a person, we agree that ideas solve problems—and good ideas turn problems into opportunities. This white paper, we believe, contains many good ideas.

The unifying theme of the paper is that we in Wisconsin must address the health care crisis now, ask the right questions, bring all competing interests to the table and try to put workable models into action. Of course, we realize there will be mistakes and setbacks, problems and disagreements, but we look forward to positive action that may stem the flood of rising health care costs.

At our first meeting, we quickly came to consensus on a **Purpose Statement** about our work:

> *"The purpose of the Health Care Workgroup is to specify the elements that characterize health care in Wisconsin, illuminate possible solutions to identified problems and work in partnership to build a foundation for establishing viable state health care policies."*

Let us as a state, and a nation, come together in respectful and productive dialogue as we begin our passage out of the health care cost crisis. Our paper represents just one conscientious effort to provide realistic, thought-provoking ideas to help us to address this formidable challenge and, ultimately, to serve the best interests of all the citizens of Wisconsin.

IV. Health Care Costs: Quickly Approaching Crisis

The costs associated with maintaining good health are escalating at an alarming rate in the United States and have major implications for those who have a stake in the way we administer receive and pay for health care – payers, purchasers, providers, consumers and policymakers alike.[2] With national health care expenditures accounting for nearly 15 percent of GDP, health care premium costs rising more than 9 percent annually[3] and a 13.7 percent rate of increase in health care spending (in 2001), all of us may fall victim to this national health care crisis:

- Workers will see dramatic cuts in their take-home pay and/or out-of-pocket costs;
- Employers may choose to drop their employee health insurance programs altogether, leaving employees uninsured or unemployed;
- Senior citizens will watch costs associated with Medicare services and prescription drug premiums go higher and higher;
- Health care providers will experience an increase in uncollectible bills
- Citizens will become more and more disturbed about the impacts of the system on their personal health, their job choices and their pocketbooks.

It is time we realized that rising health care costs are no longer just an impediment to economic development—they represent a very real crisis. Through an examination of health care expenditures, the alarming increases in cost nationally and in Wisconsin and the fragmentation of the current system, we hope that the urgency of the health care crisis will become quite evident.

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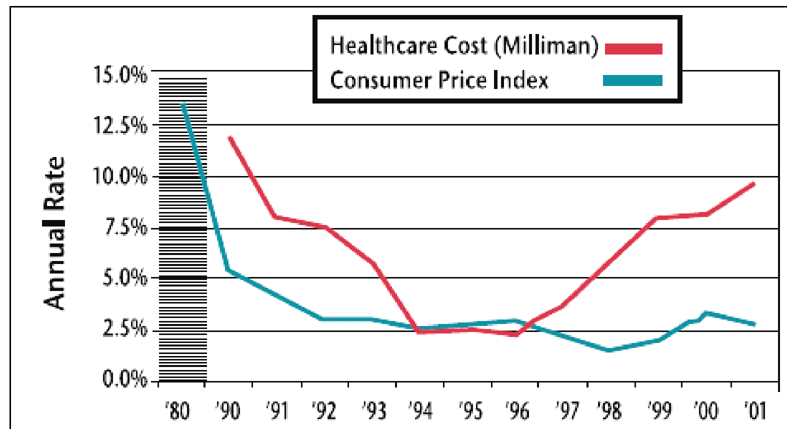
[2] Newsom, R. S., Friedsam, D. *State Policy Options: Health Costs and Financing.* Wisconsin Public Health and Health Policy Institute, Wisconsin Health Policy Forums, Vol. 1, Number 1, 2002.
[3] S. Heffler et.al, "Health Spending Projections for 2001-2011: The Latest Outlook," *Health Affairs* (Mar.-Apr. 2002): 207-218.

►**Background**

In contrast to the substantial cost increases we face today, throughout much of the 1990s health care costs in the United States rose at a relatively modest rate. Following an era of seemingly uncontrollable cost increases in the late 1980s and early 1990s, managed care programs emerged as a leading force in the health care system, contributing to a relatively flat rate of increase through the mid 1990s.[4] In fact, from the early to mid-1990s, health insurance premiums dropped and were at their lowest point in history during the period 1994-1998 (see Figure 1 below).[5]

Figure 1: National Rates of Healthcare Cost Increases

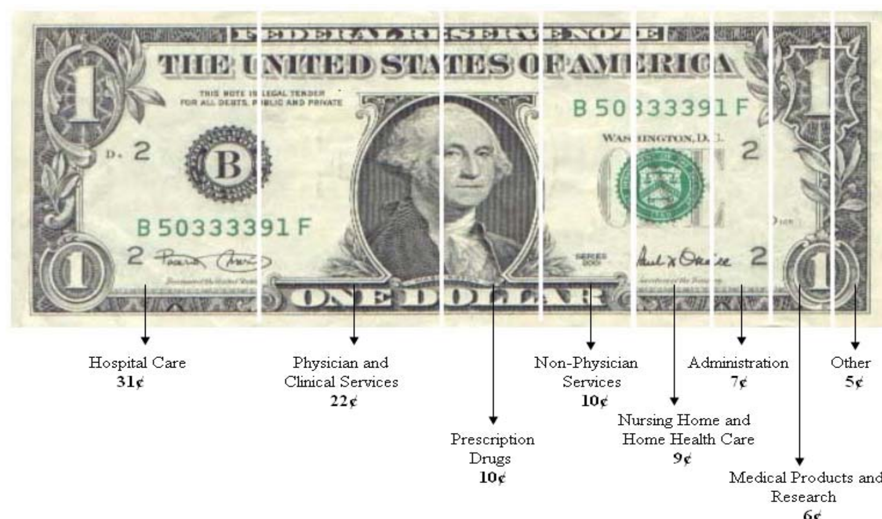


However, by 2000, 13.2 percent of the GDP in the United States was being devoted to health care.[6] With many of the cost constraints that were successful in the 1990s no longer effective, the emergence of new regulations, coupled with the strength of the negotiating power of American caregivers, resulted in destabilizing the leveraging power of health plans and

[4] Price Waterhouse Coopers. *The Factors Fueling Rising Healthcare Costs.* Prepared for the American Association of Health Plans, Washington D.C., April 2002, 1.
[5] Ibid.
[6] Ibid.

insurers.[7] It is likely the same forces that drove health care price inflation in the 1980s will return in force in the coming decades, leaving millions of Americans uninsured or underinsured due to income constraints. Currently, 43.6 million Americans –15.2 percent of the population – are uninsured, an increase of 2.4 million from the previous year, [8] due largely in part to soaring health care costs. In Wisconsin, the numbers are significantly lower, with nearly 9 percent of the population having no health insurance.[9]

Figure 2: The National Health Care Dollar



Source: © Blue Cross/Blue Shield 2003 Medical Cost Reference Guide

The problem of the uninsured and the underinsured is exacerbated by the high and rapidly increasing costs of health care in the United States. With nearly $5,000 spent per capita annually, it is hard to calculate exactly where those dollars are going. Figure 2 (above) represents a breakdown of national health care expenditures for the United States in 2002. Though the figure is a useful representation of where exactly each cent is being spent in terms of health care services in the United States, the high base costs are of less concern in terms of controlling the

[7]Halvorson, George C., Isham, George J. *Epidemic of Care: A Call for Safer, Better, and More Accountable Health Care.* San Francisco, CA: Jossey Bass Inc., 2003, xix.
[8] Pear, Robert. *Milwaukee Journal Sentinel*, pA1

future costs of health care. What is most alarming is the **rate** at which health care costs are increasing on an annual basis, due to individual increases in the components behind each of the major medical service sectors—hospitals, physicians, pharmaceuticals, and technology (see the **Cost Drivers** section below).

Over the past 20 years in Wisconsin alone, personal health care expenditures have increased at an astronomical rate. Figure 3 graphs estimates of the total personal health care costs in Wisconsin from 1980-2002, with personal health care expenditures defined as "the costs of health care goods and services purchased directly by individuals or paid by a third party on behalf of individuals."[10]

Figure 3: Personal Health Care Expenditures, WI (1980-2002)

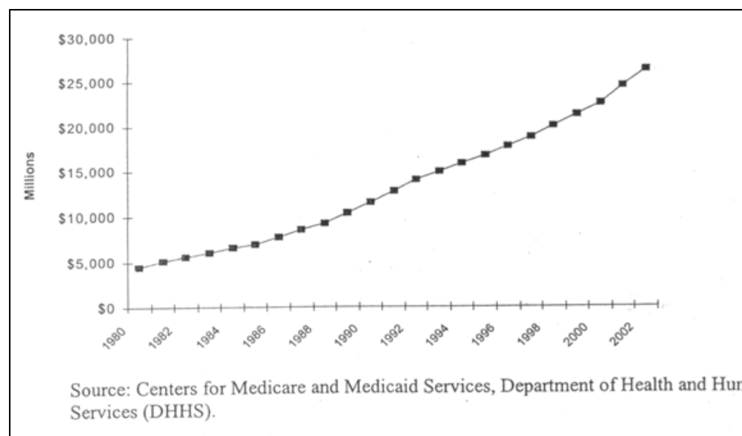


Figure 4 further breaks down expenditures by major provider group. The numbers here exclude the costs of research, construction and administration, which would amount to approximately $3 billion more. The fact that in the past 20 years, personal health care expenditures have risen over **$20 billion in Wisconsin alone** is both astounding and alarming.

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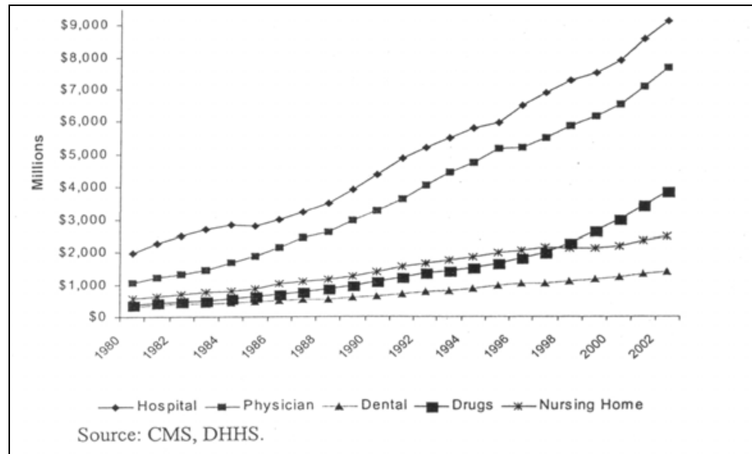
[9] Pear, Robert. *Milwaukee Journal Sentinel*, pA1
[10] Office of Strategic Finance, State of Wisconsin Department of Health and Family Services. *Health Care Costs in Wisconsin: 1980-2002.* Evaluation Section, May 2003, 1.

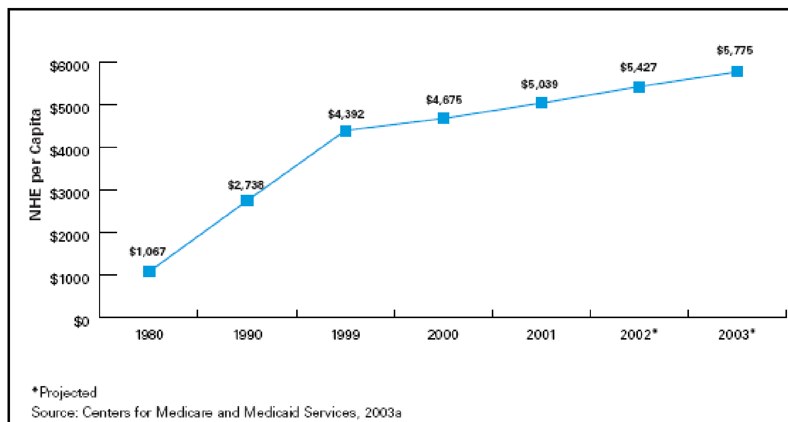
Figure 4: Personal Heath Care Expenditures by Major Provider Group, WI (1980-2002)



Source: CMS, DHHS.

Perhaps even more disturbing is that Wisconsin is not alone. Health care is the largest sector of the entire U.S. economy, accounting for almost 15 percent of national GDP.[11] It has increased at a rate far beyond its competitors of housing (10.3%), food (9.9%), national defense (4.3%), and the automotive industry (3.6%).[12] In addition, industry costs are estimated to continue rising at a rapid and unsustainable rate. As depicted in Figure 5, in the short three-year period between 2000 and 2003, health care expenditures per person will have risen a whopping 24 percent![13]

Figure 5: National Health Expenditures per Capita, 1980-2003



*Projected
Source: Centers for Medicare and Medicaid Services, 2003a

[11] BlueCross BlueShield Association. *Medical Cost Reference Guide,* Health Care Cost Campaign. Revised June 2003. [http://bcbshealthissues.com/cost/costguide.vtml] 6.
[12] BlueCross BlueShield Association 6
[13] Ibid. 5

The federal government is also being battered by the burgeoning health care crisis. Approximately 60 percent of the health care bill in the U.S. is covered by federal appropriations such as Medicare, Medicaid, the Veterans Administration, county hospitals, public employee healthcare, and tax breaks for employer-sponsored health insurance.[14] Today's ever tightening budget constraints, coupled with the near universal unpopularity of tax increases, are forcing the federal government to place dramatic spending limits on federal programs or begin fixing the major flaws in the system that drive up health care costs. With an increase in national health care expenditures of nearly 14 percent for a one-year period (2001-2002), the national economy is desperate for an immediate solution. As with its early 20th century pioneering innovations in social security and unemployment compensation, Wisconsin may once again have to lead the way toward a solution.

►Impasse

In *Epidemic of Care: A Call for Safer, Better and More Accountable Health Car*e, the authors observe that consumers increasingly feel that health care providers are more concerned with profit margins and market shares than with patient well being.[15] Few valid measures of quality, efficiency and outcomes are readily available. And, in the meantime, health care entities variously focus on mission, quality and their underlying business viability. Frustration, in turn, builds among consumers, purchasers and providers in the face of seemingly uncontrollable, rising costs.

Without action to stem this tide, it will eventually reach the point that **no one** will be able to afford his or her own individual health care. Or, at the very least, as Figure 6 illustrates, the American health care "system," if nothing is done, will continue contributing to uncontrollable, rising costs.

[14] Halvorson xxi
[15] Halvorson xxiv

Figure 6: The Coming Crisis

	1977	1985	1993	2001	2009	2017	2025
Health Costs	$1,250	$2,500	$5,000	$10,000	$20,000	$40,000	$80,000
Average Employee Salary	$12,000	$17,100	$24,300	$34,500	$43,300*	$50,000*	$48,000*
Health as a percent of salary	10.4%	14.6%	20.6%	29%	46.2%	80%	167%
Average annual increase in salary	--	4.5%	4.5%	4.5%	2.9%	1.8%	(0.5%)

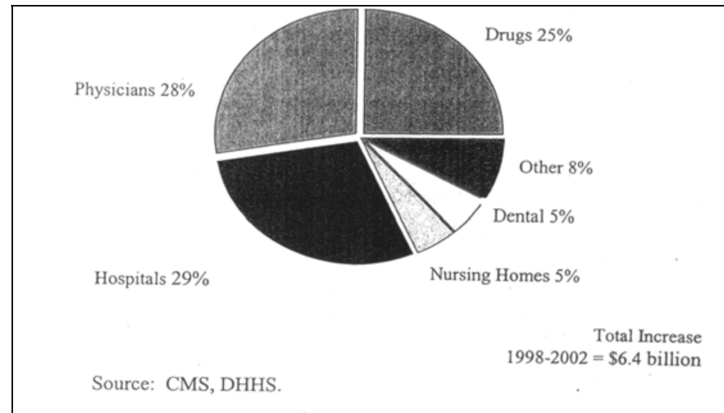
*Assumes annual total compensation increase of 4.5%

Note: The numbers in this table are general values used to illustrate the concept. Actual values will vary by profession. Health costs represent not just health insurance premiums but employee costs as well.

Source: WEA Trust

A plethora of case studies have examined what factors are driving the increases in health care costs. As illustrated in Figure 7 below, the cost increases in Wisconsin between 1998 and 2002 fall into identifiable categories that can be examined and, perhaps, remedied. Pharmaceutical drugs, medical technology, and growing hospital expenses are just a few of the fastest rising costs (see Section V below for an extensive discussion of specific cost drivers).

Figure 7: Distribution of Increased Health Expenditures, WI (1998-2002)



Despite an abundance of specific details regarding the large increases in health care costs, the bottom line is that the high and rapidly increasing costs of health care are negatively affecting every citizen in some direct way. Political pressures will continue to intensify as the average American family faces significant erosions in take home pay, increasing insecurity in their health insurance coverage and further reductions in the quality of their insurance benefits.

On average, the cost to an employer of a family "full" coverage premium is $800 per month, not significantly lower than the monthly minimum wage rate of $893 per month.[16] At the current rate of increase, health care costs will exceed that level of wages in just two years, leaving many employers unable to absorb the costs. Thus, employers will have no choice but to shift much of the cost of health care to their employees, abandon health benefits to employees or eliminate employee positions altogether.

►Remedies

> *"Across the country, companies, states and schools are taking more aggressive—if perhaps passive-aggressive—measures to get an increasingly overweight society to move more and eat less."*

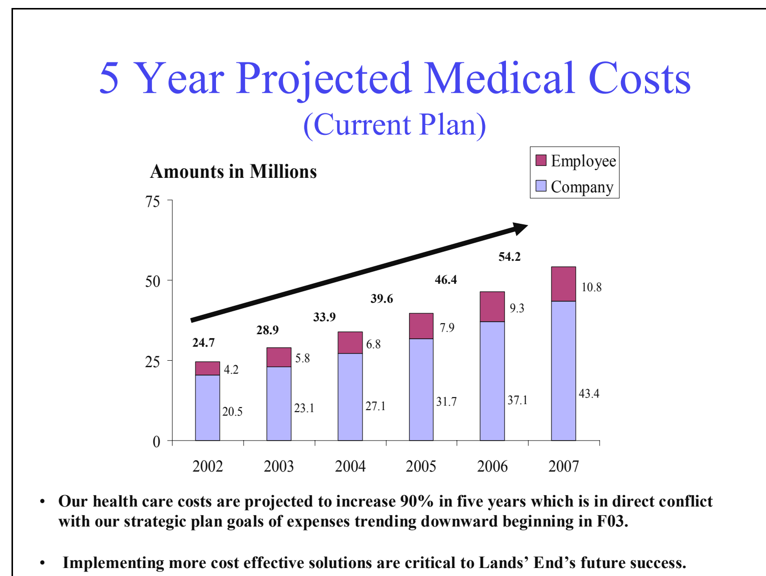
[16] Halvorson xvii

So writes Kate Zernke in the October 12, 2003 issue of the *New York Times.* Her article, "Fight against Fat Shifts to the Workplace," outlines the steps that companies like Sprint, Union Pacific Railroad and others are taking to encourage exercise and proper eating habits among their employees in hopes of reducing their health insurance costs. The motivation? Saving money and, possibly, saving lives.

For example, Zernke notes that a company like Union Pacific is currently offering the latest prescription weight-loss drugs to some of its employees. Since 54 percent of its 48,000 employees are overweight (up from 40 percent in 1990), reducing that percentage by **one point** would save the company **$1.7 million** annually. Reducing that percentage by **10 percentage points** will save Union Pacific **$16.9 million**.

Closer to home, the Lands' End Corporation, an 8,000 employee company founded right here in Wisconsin, provides an example of how one company is addressing rapidly rising health care costs. From 1997-2001, health care costs at Lands' End increased an average of **16.7 percent annually** compared to a modest 3.9 percent annual growth in sales. Company officials projected that if such a trend were allowed to continue, its health care costs would increase by 90 percent over the next five years (Figure 8).

Figure 8: Lands' End 5 Year Projected Medical Costs (current plan)



Needless to say, cost increases of this magnitude make it impossible for companies like Lands' End to be financially viable, or competitive. To stem this tide, Lands' End adopted an unorthodox method of containing costs—it embarked on a health management campaign for all of its employees.

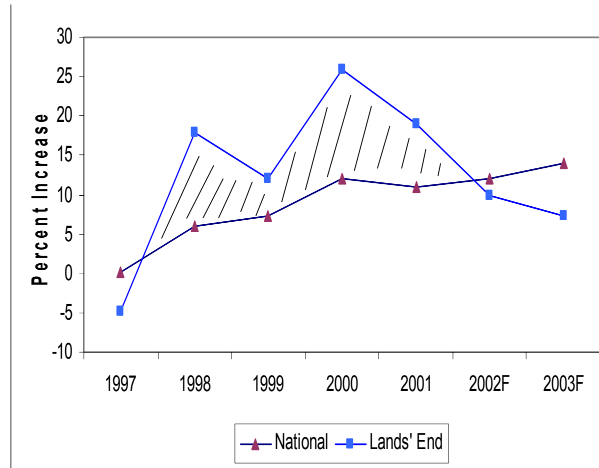
By developing a set of guiding principles, revising its health insurance plan design, empowering and educating employees and partnering with local health care providers, Lands' End was able to create an effective program to control and lower its rapidly rising health care costs. At Lands' End, the work environment became a health conscious environment. The health management campaign allowed employees to view the company as a "health advocate."

The effort focused on:

- Instituting early detection and prevention programs;
- Raising employee awareness of rising health care costs through newsletters, meetings and the web;
- Educating employees on how they as individuals could help reduce costs;
- Offering and promoting new on-site medical services and health improvement programs.

With the addition of a company-endorsed campaign aimed at health and wellness for all employees, Lands' End was able to reduce the rate of increase in its health care costs, as shown in Figure 9 below.

Figure 9: Lands' End Health Care Costs 1997-2003



Another Wisconsin-based company, Highsmith, Inc. of Fort Atkinson, has also experienced success with its employee-based wellness program. A firm of about 250 employees (79 percent of whom are on the company's health plan), Highsmith saw its insurance premiums increase by 2.9 percent in 2002 and 3.1 percent in 2003, numbers far below the average increases in Wisconsin and the nation. Such evidence persuaded our work group that employer-based wellness programs can have substantial, positive impact. **Please consult the Appendix for an example of the Highsmith, Inc. wellness template.**

Despite these and other success stories about controlling health care costs, the fact remains that nationwide, on average, costs are continuously increasing at unsustainable rates. Despite attempts to gain universal coverage, the U. S. spends nearly $5,000 per citizen on health care and yet still has over 43.6 million citizens uninsured.[17] Therefore, the questions remain: is the crisis in health care a product of an inefficient system? If so, should the current system be abandoned completely in lieu of **comprehensive** reform of the entire health care system? Or should it simply be "remedied" through **incremental** solutions that address certain problems?

[17] Pear, *Wisconsin State Journal* p A1.

V. Cost Drivers

While producing healthy citizens is indeed an honorable goal, some of the means our society has used to achieve that goal have caused more harm than good. Some critics classify the American health care system as a "non-system," containing millions of independent and uncoordinated factions with unaligned goals, competing priorities and unequal financial incentives. These critics point to:

- The lack of any systemwide coordinative strategies or regulatory bodies to keep patterns of care or population health in check;
- A scarcity of accountability on measurements for quality, efficiency and/or outcomes at a provider level;
- The fact that each individual health care entity—doctors, hospitals, pharmacies, outpatient clinics, etc.—is focused on meeting its own business goals and realizing its own individual incentives.

Or, as Margaret O'Kane, president of the National Committee for Quality Assurance, contends: "American health care has no central nervous system."[18]

In an attempt to find ways to "cure" the health care crisis, the workgroup brainstormed a list of the key drivers of health care costs and then voted for those that were the most influential. The drivers, listed in descending order of perceived importance, highlighted by the workgroup are:

(1) Misalignment of incentives

(2) Consumer insulation from costs

(3) Cost shifting

(4) Population lifestyle

(5) Worker shortages

(6) Lack of best practices

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[18] Halvorson, George C. and George J. Isham, *Epidemic of* Care, Jossey-Bass, 2003. Pg. xxiii

(6) Clinical practice variation

(6) Inappropriate utilization (over and under)

(7) Fragmentation of administrative costs

(7) Waste due to poor quality

(7) Population demographics

For the sake of discussion, we then grouped these cost drivers into five distinct categories:

1. Hospitals
2. Physicians
3. Prescription drugs
4. Technology
5. Systemic

We believe that identifying the factors that are driving the high rate of increase in health care costs is the first step in developing a plan to better manage the costs of care. Any reform of the current health care system, whether incremental or comprehensive, **must** address costs.

►Hospitals

Hospital care accounts for more of the cost of health care – 31 percent of overall health care spending – than any other component of the industry.[19] The major factors driving increases in the cost of hospital care include:

- Cost shifting
- Increase in outpatient care
- Worker shortages
- Provider consolidations
- Increasing consumer demand

[19] Centers for Medicare and Medicaid Services, 2002

- Facility expansions
- Inflation

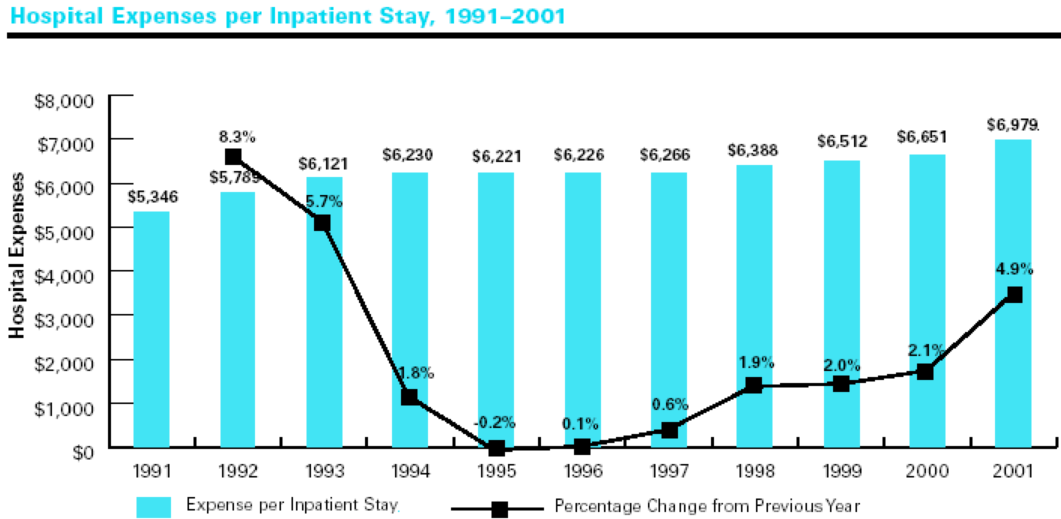
Cost shifting, while identified as one of the major drivers of costs (especially in hospitals), presents another set of issues since it is affected by federal Medicare and Medicaid payments to Wisconsin. Underpayments by Medicare and Medicaid move the burden of cost of paying for these populations on to private payers through increased prices. To the degree that Medicare underpays, it shifts costs to states that should be paid by the federal government. In other words, cost shifting distorts prices overall and increases prices for private insurers but does not *per se* add to the underlying costs of inputs. .

Outpatient care in hospitals has risen rapidly in recent years. In 2001, for example, there was an 8 percent increase in outpatient visits over 2000, compared with just a 3.2 percent increase in 2000 from 1999. There was also a 6.8 percent increase in outpatient care provided through June 2002, compared to the corresponding months in 2001.[20] The increasing outpatient visits add huge costs to overall healthcare spending.

While outpatient visits are increasing, inpatient visits have remained stable since the late 1980s.[21] However, inpatient costs, too, are on the rise. As illustrated in **Figure10**, the cost per inpatient admission increased 4.9 percent between 2000 and 2001, nearly double the increase between 1999 and 2000.[22] In Wisconsin there was an average of a 1.32 percent growth in inpatient expenditures between 1998 and 2001.

[20]Blue Cross Blue Shield Association. "Medical Cost Reference Guide." June, 2002. Pg. 20.
[21] Ibid. Pg. 16.
[22] Ibid. Pg. 17.

Figure 10: Hospital Expenses per Inpatient Stay, 1991-2001



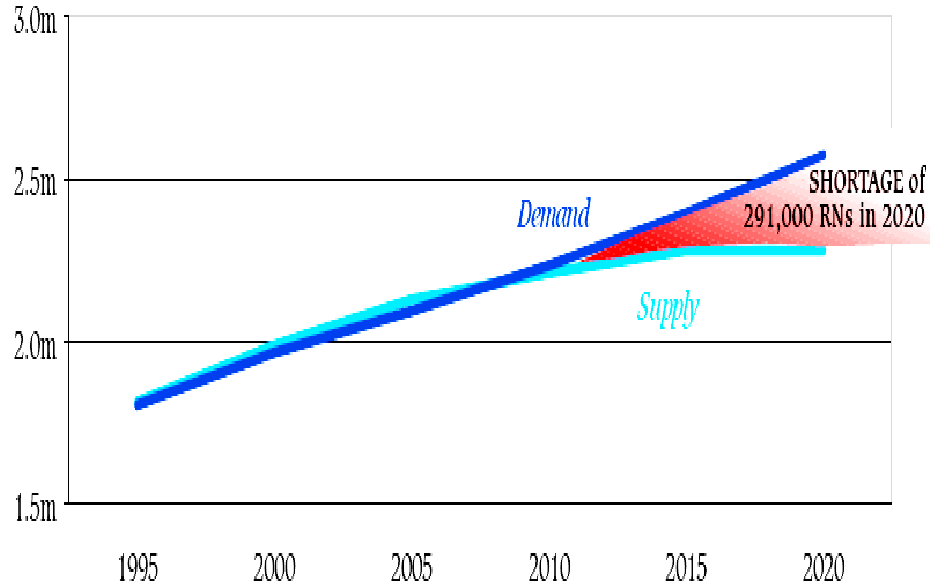
Source: Adapted from American Hospital Association, 2003

Another of the main factors driving the increases in inpatient and outpatient costs is the **shortage of labor** in the health care field, particularly among nursing professionals. Hospital payroll costs rose by 8.6 percent in 2001[23], which was more than double the increase from the previous year. This surge is partially, if not fully, correlated to the labor shortage because nursing costs represent 44 percent of a hospital's direct costs.[24]

As the labor shortage in the nursing field worsens, the wages for nurses will continue to increase because the demand for nurses is increasing faster than the supply. **Figure 11** depicts the widening gap in the supply for nurses relative to the demand. With this massive increase in the excess demand for nurses, the wages of nurses is bound to increase as they gain further negotiating leverage. The resultant increase in nurses' wages will likely cause hospital costs to climb. It is also possible that a shortage of nurses will result in a decrease in quality of care as hospitals struggle to find other ways to provide the services traditionally administered by nurses.

[23] Bradley C. Strunk, Paul B Ginsburg, and Jon R Gabel. "Tracking Health Care Costs: Growth Accelerates again in 2001. Health Affairs. 25 September 2002.
[24] Blue Cross Blue Shield Association. "Medical Cost Reference Guide." June, 2002. Pg. 18.

Figure 11: Nursing Shortage Projections



Source: American Hospital Association TrendWatch, March 1999, Vol. 1, No. 2

The nursing shortage may become an even bigger problem in the future because the nursing workforce is aging. The largest demographic of nurses is the 40-49 year-old age group, accounting for more than 35 percent of the nursing workforce. An additional 15 percent are in the 50-59 age group.[25] This trend is particularly problematic because the general population is also aging, and the increasing demand for medical services will find a health care marketplace with fewer nurses to administer services for the needy baby boomers.

Nursing isn't the only profession in the health care industry that will see a shortage of supply in near future. Figure 12 provides a brief snapshot of several hospital positions that are currently distinguished by a shortage of staff.

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[25] American Organization of Nurse Executives, "Acute Care Hospital Survey of RN Vacancy and Turnover Rates," January 2002, Pg. 9.

Figure 12: Current Workforce Shortages in America' Hospitals

Position	Mean Vacancy Rate
Registered Nurses	13.0%
Imaging Technicians	15.3%
Pharmacists	12.7%
Licensed Practical Nurses	12.9%
Nursing Assistants	12.0%
Laboratory Technicians	9.5%
Billers/Coders	8.5%
IT Technologists	5.7%
Housekeeping/Maintenance	5.3%

N ≥ 600

Source: First Consulting Group, "The Healthcare Workforce Shortage and Its Implications for America's Hospitals," 2001.

In addition, we will be seeing a shortage of specialist surgeons in some areas of care. Researchers at UCLA's David Geffen School of Medicine found that surgeries performed predominantly on older adults, such as cataract and heart surgery, will have the highest increase in demand and that there will be a shortage by the year 2020.

Provider consolidations, a result of the movement to HMOs in the 1990s, are another cost driver. HMOs succeeded in using their leverage to negotiate significantly reduced prices from providers. To counter these efforts of the HMOs, providers joined forces to reestablish pricing power. The upsurge in the influence of the HMOs in the 1990s had significantly reduced provider profits. But as providers grew, merged, and eventually bought out, competition, local purchasing power was centralized. With the pricing power restored to providers, prices soon went back up.

Consumer demand for hospital services is on the rise, and, as consumer demand increases, the price for services will also generally increase. In basic economic terms an increase in demand, leaving supply constant, will cause the price to rise. In the short term, supply remains relatively fixed because new facilities cannot be built overnight. Therefore, as demand continues to rise, the price will also increase. Since hospitals account for almost 31 percent of health care

costs, any increases in costs due to demand will have a significant impact on overall health care cost increases. Some studies estimate that increased demand is adding 2 percent annually to healthcare costs, representing $10 billion of the increase in health premiums.[26]

Hospitals are also expanding and upgrading their **facilities** at costs in the billions of dollars. An increasing number of outpatient facilities, too, are being built. While the total number of hospitals has decreased by more than 4 percent between 1997 and 2000, there have been double-digit percentage increases occurred in the number of outpatient centers.[27]

►Physicians

A correlation exists between significant increases in physician costs and specialist care. Specialist physicians' charges are much greater than those for primary care physicians – more than two times as great in the year 2000, for example. Much of this price disparity stems in large part from the difference between the salaries of specialist physicians and primary care physicians. In the Midwest, for example, the median salary for specialist physicians is $289,949 compared to a primary care median salary of $148,910.[28] It is important to realize that specialist physicians are paid differently because they do different things, and this relationship is affected by the incentives in our current system which rewards operations, procedures and technology.

Another factor involved with increasing physician care costs is the growing popularity of lawsuits against medical practitioners. While not a major problem in Wisconsin, the costs associated with lawsuits and litigation has multiple effects, including potential insurance rate increases that will yield an increase in the cost of providing health care to consumers.

► Prescription Drugs

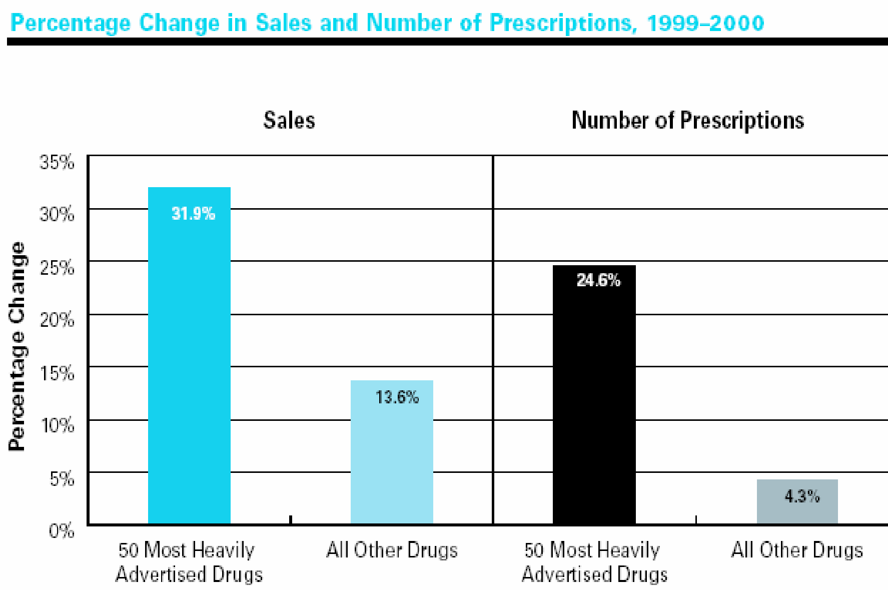
Spending on prescription drugs, while a smaller portion of the total health care cost bill, is **the** fastest growing component of the health care system. In 1993, for example, the average number of prescriptions per capita in the U. S. was 7.8. By 2001 that number had jumped to

[26] PriceWaterhouseCoopers. "The Factors Fueling Rising Healthcare Costs." April, 2002. Pg. 8.
[27] Blue Cross Blue Shield Association. "Medical Cost Reference Guide." June, 2002. Pg. 23.
[28] Bruce A. Johnson, "Trends in Physician Compensation" *Hospital Physician*, Jan. 2003.

10.9.[29] This increased utilization of prescription drugs can be attributed to a number of factors, including the prominence of direct-to-consumer advertising. Once upon a time, drug companies targeted their advertising campaigns toward the intermediary (physician) as opposed to targeting the end-user (consumer). Not any more – spending on direct-to-consumer advertising increased by 212 percent between 1996 and 2000, totaling over $2.5 billion spent on direct-to-consumer advertising in 2000. [30] And even though promotional ads to professionals also increased during this time, it did not increase at nearly the same rate as direct-to-consumer advertising.

Moreover, the most heavily advertised drugs are the newer and "name brand" drugs that tend to be more expensive. A substantial disparity exists between the utilization of the most heavily advertised drugs and all other drugs. As **Figure 13** demonstrates, there is a large percent increase in the utilization of the 50 most heavily advertised drugs, especially when compared to all other drugs.

Figure 13: Percentage Change in Sales & #s of Prescriptions, 1999-2000

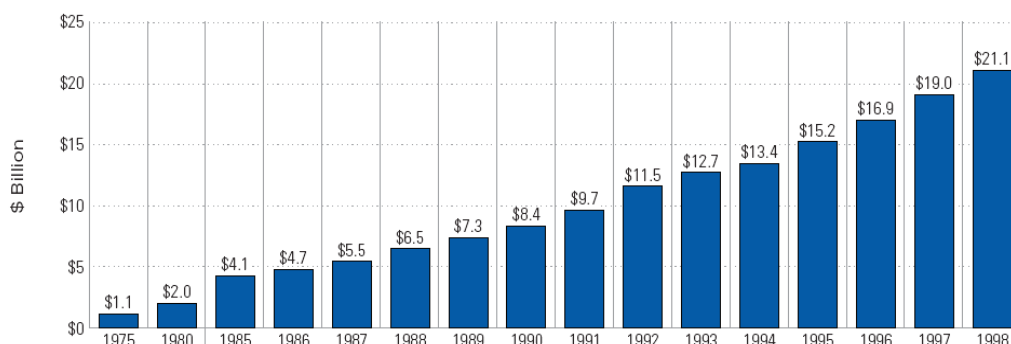


Another reason for increasing utilization is that drug companies pour large amounts of capital into their Research and Development departments in order to keep new and better drugs

[29] Blue Cross Blue Shield Association. "Medical Cost Reference Guide." June, 2002. Pg. 35.

on the market, for which they charge higher prices. The amount of money that flows to this type of R&D, as shown in Figure 14, has grown consistently, and rapidly, since 1975. So, too, have the average number of new drugs approved for sale by the U.S. Food and Drug Administration per year – up nearly two times since the early 1980s, from 19 to 38 per year.[31]

Figure 14: R&D Expenditures for prescriptions pharmaceuticals 1975-1998



notes
Five-year intervals from 1975–1985; and 1-year intervals thereafter.
R&D expenditures for prescription pharmaceuticals only. Includes total expenditures (within the U.S. and abroad) by U.S.-owned research-based pharmaceutical companies ("major pharmaceutical firms"). Since 1990, foreign expenditures comprised approximately 19% of total R&D expenditures.

source
Pharmaceutical Research and Manufacturers of America, *PhRMA Annual Survey*, 2000, published on the PhRMA web site: www.phrma.org, May 1, 2000.

►Technology

According to the Centers for Medicare and Medicare Services, technology, in the form of new machinery, new types of drugs, new procedures or other cutting-edge innovations, drives the lion's share of the cost increases in the health care industry today . While these advances improve our quality of life, and can even extend life, as Figure 15 illustrates, these advances come with a big price tag. Moreover, improvements in technology also create an excess capacity in the system, and the market encourages providers to use the new technology often since there are no additional variable costs, at times even before medical studies have confirmed whether these innovations are shown to improve care outcomes.

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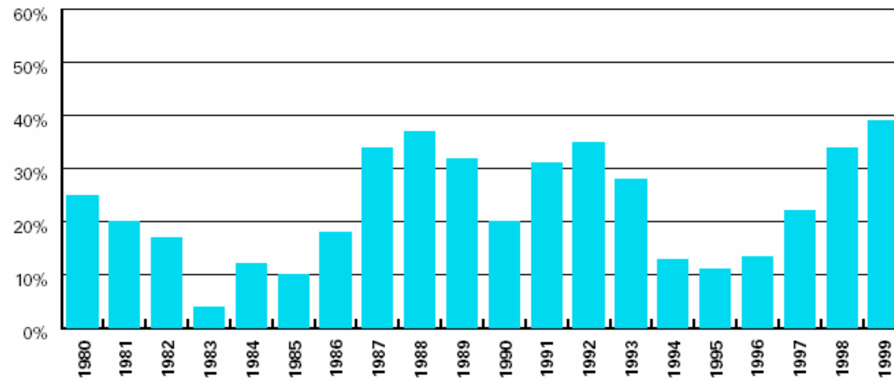
[30] Meredith B. Rosenthal, et al. "Promotion of Prescription Drugs To Consumers," *New England Journal of Medicine*, Vol 346, No. 7. February 14, 2002, Pg. 498.
[31] The Kaiser Family Foundation, "Prescription Drug Trends: A Chartbook," July 2000, Pg. 49.

Figure 15: Estimated Percentage Contribution of Technology to Growth in Personal Healthcare Spending 1980-1999



Since many of these new technologies are making some medical procedures cheaper, safer and less invasive, more and more people are electing to undergo a procedure that utilizes the new technology, even f there may be little reason for them to do so. Such a result is termed "excessive utilization."

Technological advancement also may lead to a situation in which there is a duplication of procedures using similar medical technologies on an incremental basis, also resulting in little or no additional benefit.[32] Much like with prescription drugs, there is sometimes reluctance among consumers to use lower-cost alternatives to high-cost procedures.

Finally, computer technology, while substantially benefiting the efficiency of most other sectors of society, appears not to be as well integrated in all health care facilities. Without sufficient computer technology to link patient records and best treatment methods, not to mention keeping its staff updated on new technologies and procedures, mistakes will be made and inefficiencies will occur. Nationwide, there is a 55 percent compliance with best medical

[32] Blue Cross Blue Shield Association. "Medical Cost Reference Guide." June, 2002, Pg. 47.
[33] Halvorson, George C. and George J. Isham, *Epidemic of* Care, Jossey-Bass, 2003, Pg. 27.

science as a direct consequence of **not** having computers used as physician tools.[33] Given these compliance numbers, one can also assume there is a great deal of variation in the treatment of the same illness from caregiver to caregiver. Getting all health care operations computerized could go a long way toward increasing the quality of care provided to each patient, as well as reducing health care costs, although it would require a significant upfront investment of resources – costs that will need to be borne by both purchasers and providers.

►Systemic

There were a number of cost drivers that did not fall discreetly into a particular category or else were pervasive enough to be included in all of the other categories. We referred to these as "systemic" cost drivers, and they include demographics, poor lifestyle choices, medical errors, consumer insulation from costs and a misalignment of incentives.

Population **demographics**, namely the reality of an increasingly large number of aging "baby boomers," is a systemic driver of increasing health care costs. The U.S. Census Bureau estimates that Wisconsin's over-65 population will increase 70 percent to 1.2 million by 2025. As the number of senior citizens increases, so too will the number of visits to specialist physicians because seniors are likely to make twice as many ambulatory care visits per capita as the rest of the population,[34] and a large number of those visits are to more expensive specialist physicians. The end results will be an increase in health care costs and spending. (*Note: There are some studies, including one conducted by the Center for Studying Health System Change, which suggest that increases in spending by age are not large enough, and the U.S. population is not aging quickly enough, to qualify age a major cost driver.*[35]*)*

Another systemic cost driver are the **lifestyle choices** being made by the citizens of Wisconsin, choices that can cause health problems that require medical care. Examples of these poor lifestyle choices include smoking, eating, drinking and a lack of exercise, habits that usually lead to bad health and, eventually, to having to access health care services (see Section VI below for a more detailed discussion of obesity).

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[34] Blue Cross Blue Shield Association. "Medical Cost Reference Guide." June, 2002. Pg. 28
[35] Wisconsin Public Health & Health Policy Institute. "State Policy Options: Health Costs and Financing." 2002. Pg. 13.

Another cost driver in the health care industry are the costs associated with the number of **medical errors** present in the current system. A study done by the Midwestern Business Group on Health quantified the cost of there types of quality/safety problems – over-use (i.e., services provided when they are not needed); under-use(i.e., failure to provide a service when needed); and mis-use. Their study estimated that 30% of all healthcare dollars are spent on inappropriate care[36] while the authors of *Epidemic of Care: A Call for a Safer, Better and More Accountable Health Care* argue that the current American system only provides "best care" 55% of the time.[37]

Errors cannot be halted solely through a set of guidelines or laws that require providers to stop performing wrong-site surgeries or to simply quit making mistakes. Other factors have an impact on the occurrence of medical errors. For example, in a recent study done by the Joint Commission on Accreditation of Healthcare Organizations, the involvement of multiple surgeons, the performance of several procedures in one surgery, and the pressure from hospital administrators to finish surgeries quickly were all cited as factors contributing to medical mistakes.[38] Thus, any efforts to reduce medical errors that cost the system millions of dollars annually will require a much more systematic approach. Getting all stakeholders to agree on such a way to "reform" this type of system, however, is easier said than done.

With so much of the health care bill being paid by insurance or government, the consumer has little incentive to shop around for the best price, to avoid unnecessary care or to make improvements in his or her lifestyle. In effect, the consumer (patient), who pays relatively little for the cost of his/her health care, is **insulated** from the costs incurred in the administration of health care. As **Figure 16** demonstrates, the consumer pays **for only about 15 percent of the actual health care bill.** If consumers were able to become more aware of costs and actively sought out alternative care, then perhaps the strain on employers and the government could be relieved slightly.

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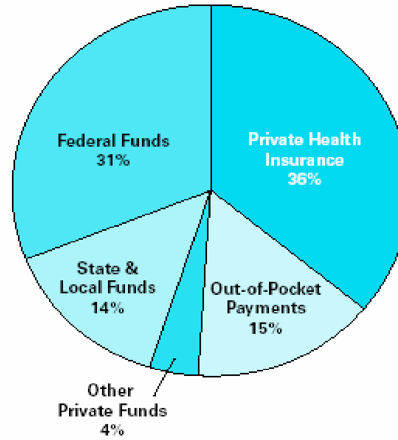
[36] Midwestern Business Group on Health, *Reducing the Costs of Poor Quality Healthcare Through Responsible Purchasing Leadership (*Chicago: Midwest Business Group on Health, June 2002).
[37] Halvorson and Isham, p. 32
[38] Joint Commission on Accreditation of Healthcare Organizations, *Sentinel Event Alert,* Dec. 5, 2001. [http://www.jcaho.org/about+us/news+letters/sentinel+event+alert/print/sea_24.htm].

Figure 16

Distribution of Funding Sources for Health Services and Supplies Expenditures, 2001



Source: Centers for Medicare and Medicaid Services, 2003d

Because the majority of health care consumers are insulated from the costs of the health care they are receiving, a "**misalignment of incentives**" arises (see Section VII below). In most sectors of the economy, a consumer usually has some idea of the quality of a product or service they are purchasing. This is not always the case with the health care system where there is a lack of disclosure of information regarding quality, price and value. The best providers of the highest quality care are not always distinguishable from the providers who do not provide high quality care. If consumers had access to information regarding the quality and efficiency of hospitals, physicians and other provider organizations, coupled with meaningful financial incentives, they would, hopefully, choose high-performing providers, thereby creating a powerful incentive for other providers to seek to improve.

In other words, there is a considerable disconnect between consumers and providers regarding quality, price and value. Providers are not properly incented to provide the best, reasonable health care, and consumers have little incentive to look after their own health. The current system also fails to reward the healthy lifestyle choices made by some consumers or discourage the unhealthy lifestyle choices of others. So, much like the case with incentives for providers, consumers in the health care marketplace are not motivated to improve their lifestyle.

Identifying the factors that are driving up health care costs at ever increasing rates is the first step in developing a plan to try to "reel in" the costs of care. Hopefully, our assessment of the costs of care and the factors driving these costs upward is a starting point for change.

VI. Why Has the Problem Defied Solution?

Health care reform has been high on the national agenda since the late 1980s. From magazine ads and journal articles to academic analyses and television shows, this inherently complex issue has permeated American popular culture. But even with our heightened awareness, there appears to be no comprehensive solution is sight.
In addition to the challenges presented by the cost drivers (see previous section), there are other barriers to change, including:

- Competing political interests;
- Fundamental differences in the priorities of stakeholders;
- Disagreements between the impacts of price and volume;
- The uneven distribution of costs;
- A fragmented healthcare delivery system;
- Lack of accurate national comparative data for quality improvement benchmarking

Each of these contributes to the complexity of the 21st century health care cost crisis. Moreover, and perhaps most significantly, attempts at health care cost containment and reforming the health care system are simultaneously a political, financial, social and ethical dilemma.

►Ethical considerations

History tells the story of the evolution of health care in society. From "medicine men" and tribal priests appointed to save as many lives as possible to ensure the survival of a clan to the first public health movement that arose from a deep concern for personal hygiene and communicable diseases, we have watched countless groups attempt to address a societal need—sustainable health. Contemporary culture has rationalized the provision of health care (to varying degrees) as a type of societal responsibility. However, as the cost of health care

continues to accelerate, some have begun to question the overall system and whose responsibility it is to provide sustainable health to all citizens.

As one of the few industrialized countries in the world that does **not** offer its residents access to a universal healthcare system, the United States is confronting a plethora of moral and ethical concerns in deciding how to care for the ill, injured, aging and needy members of our society. Concerns abound, including questions concerning whether health care is a right or a privilege, if all treatments are justified regardless of cost or stage of life, and whether our health care system should be driven by people or profits.

There are other perplexing issues involved in the health care crisis as well. As people who pride themselves on "rugged individualism" and the freedom to choose what is best and/or what is desirable, ours is a society that has a high tolerance for individual choices—even when those choices may be harmful or destructive in the long run. The choices to smoke, drink, and overeat (to name a few) may have some societal stigmas, but as a society we tolerate bad choices in the name of freedom and liberty.

One striking example of how health care costs increase as a result of behavior-related disease is the case of obesity in Wisconsin. Increasingly, sedentary lifestyles and poor dietary choices are among the leading factors that have spawned an "epidemic" of obesity, prompting it to be cited as one of the leading preventable causes of morbidity and mortality in the United States today.[39] The risks for developing adverse medical conditions such as cancer, sleep apnea, hypertension, high cholesterol, diabetes, stroke, heart disease, and heart failure are significantly increased in persons who are clinically overweight.[40] But, regardless of the known dangers of obesity, the obesity epidemic is continuing to intensify and spread, both in the United States and in Wisconsin (Figures 17 and 18).

[39] Austin, D., R.S. Newsom. "An Ounce of Prevention: What Can Policymakers Do About the Obesity Epidemic?" *Wisconsin Public Health and Health Policy Institute.* Issue Brief, 4(5): August 2003.
[40] National Institutes of Health (1998). Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults.

Figure 17: Adult Obesity Trends: 1985 and 2000

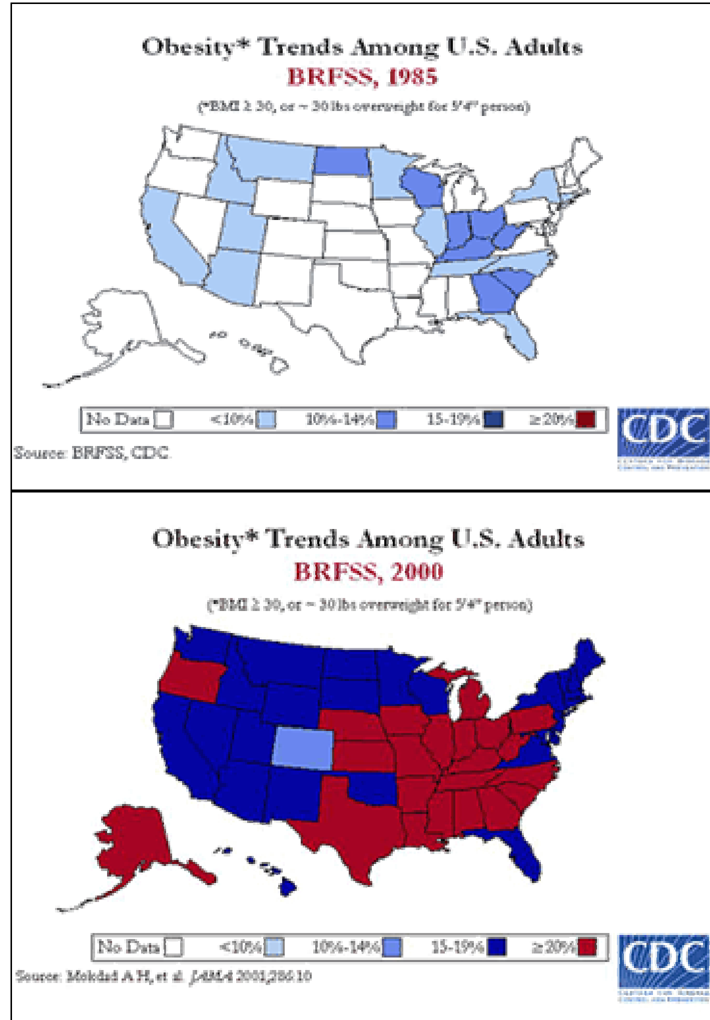
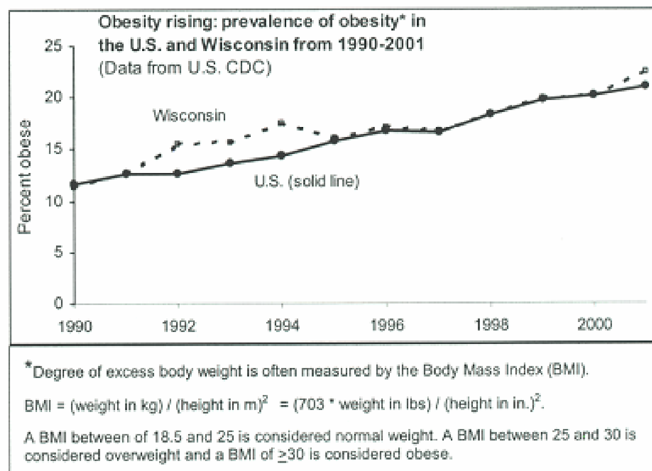


Figure 18: Obesity in the U.S. and Wisconsin (1990-2001)



A report published by the Center for Disease Control stated that as of 2001, 59 percent of Wisconsin's adult population and 15 percent of youth between the ages of 6-19 were considered overweight or obese.[41] In addition to the significant health risks that overweight citizens represent, there are also substantial financial and social costs to be borne by the rest of society. It is estimated that between 5.5 and 7 percent of national health care expenditures are used to treat problems associated with obesity.[42] The U. S. Department of Health and Human Services placed the cost of overweight and obese Americans at 300,000 deaths annually and **$117 billion.**[43] In Wisconsin, obesity-related costs were approximately **$1.4 billion**.[44]

Some would argue that the government should have a place in monitoring bad choices and behaviors, such as those related to the onset of obesity, in order to control costs. However, our American "rugged individualist" ideals lead us to believe that it is our right to choose whether or not we want good health and longer lives. Thus, we are faced with a conundrum wherein health care costs are quickly rising due to behavior-related diseases that our society refuses to overstep because of the boundaries of individual choice.

►Competing Interests

Another barrier to solving the health care cost crisis is the competing interests of all those involved in the current system. Our health care workgroup, for example, has individuals representing physicians, insurance companies, HMOs, health systems, small business, large business, the self-employed, pharmaceutical companies, hospitals, manufacturers, labor, nurses, county associations, nursing homes and government, just to name a few. In representing a particular constituency and its members, each of these representatives brings his/her constituency's ideas about their goals, priorities, economics, and politics of health care reform to the table. These representatives are debating what should be covered, who should be covered, how to pay for medical services and what type of reform will best serve the interests of all stakeholders and create a more efficient and effective healthcare delivery system.

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[41] Austin, D., R.S. Newsom.
[42] Thompson, D., A.M. Wolf (2001). Obesity Review 2(3): 189-97.
[43] Zernke, K. "Fight Against Fat Shifts to the Workplace," *New York Times*, 10/12/03
[44] Austin, D., R.S. Newsom.

In addition to the constraints posed by constituency representation and best interests, there are differing opinions about the most feasible and effective policy options. Some tend to favor the idea of more government responsibility through increased regulation in the health care industry. Others believe that the rules of market competition with little or no government intervention is the best way to encourage quality, efficiency and, ultimately, cost containment. There are also opposing viewpoints in terms of the scope of reform. While some believe that it is more effective to take incremental steps toward reform, others believe that the only way to effectively foster change is through **comprehensive** reform of the entire health care system. Such strongly divergent viewpoints make it increasingly difficult to come to any workable consensus on how to best address health care costs.

►Distribution of Costs

In looking for solutions to the health care crisis, attention must also be given to the cost distribution of health care and insurance premiums. It is important to remember that as health care costs and insurance premiums increase at nearly exponential rates (13.7%[45] and 13.9%,[46] respectively), the costs are unevenly distributed throughout the population. Though there may be groups in which all members pay a similar premium, each individual utilizes a different quantity of care. For example, in the average year, nearly 80 percent of the population incurs little or no healthcare costs while approximately **1 percent of the population incurs almost a quarter of total healthcare costs** (Figure 19).

Confounding the problem is the fact that many reform proposals focus on the "low-cost" audience, namely trying to make those who are already the most efficient in using the health care system **even more** efficient. According to Halvorson and Isham, the authors of *Epidemic of Care,* the real focus needs to be on the "high-cost" audience – preventing their disease, avoiding their complications and providing optimal care so that they can get well faster and receive an efficient level of health services. Relying purely on a benefit-cost shift to reduce the overall costs of

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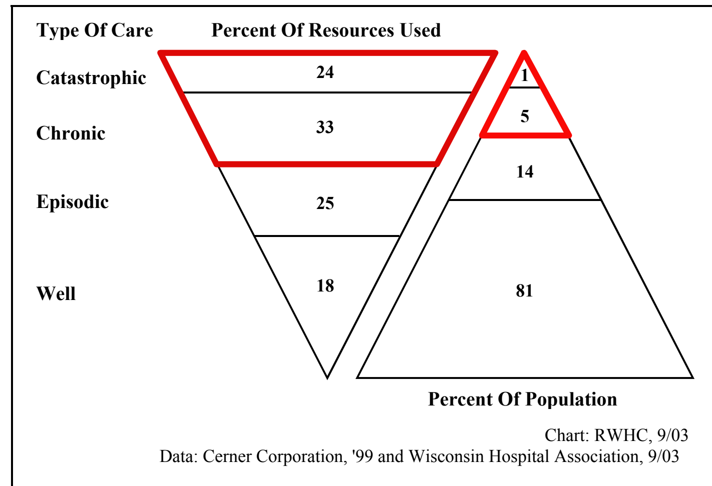
[45] Price Waterhouse Coopers. *The Factors Fueling Rising Healthcare Costs.* Prepared for the American Association of Health Plans, Washington D.C., April 2002, 2.
[46] Health Research and Educational Trust. "Survey Shows Third Consecutive Year of Double-Digit Health Insurance Premium Increases—Up 13.9% From Last Year." News Release, Sept. 9, 2003.

health care might end up making a large percentage of the population unhappy, while still not having the optimal impact on the overall costs of care.[47]

Figure 19: National Health Reform Needs to Follow the Money



Finding a solution that all stakeholders can agree on in terms of "evening out" this cost distribution has proved difficult. Since the majority of health care expenses stem from a relatively small group of people who suffer from severe chronic diseases or illnesses, those wishing to fix the problem might want to focus solely on this group. On the other hand, it may be beneficial to make the 70% of people who are not fully utilizing the system to become more efficient and better users of health care services. For health insurance to be fully functional, there must be a balance between the surplus generated from the healthy population and the losses accrued from the chronically ill or injured. Finding that perfect balance, while simultaneously cutting overall health care costs, is one of the largest obstacles to reforming the health care system in Wisconsin.

►Price versus Volume

Another barrier to finding solutions to rising health care costs is the argument among stakeholders as to whether the cost crisis is due to increased or excessive **utilization** of health services or the result of increasing and excessive cost of health services. Is it volume or price?

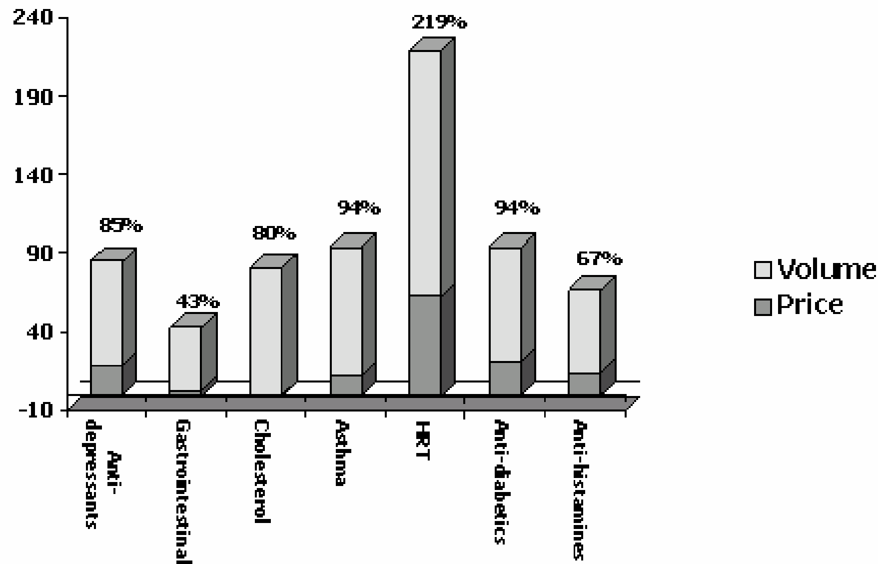
[47] Halvorson and Isham, *Epidemic of Care*

Providers of medical services and pharmaceutical products most often argue that increased utilization and volume are the major drivers in increasing costs. On the other hand, international data comparing the United States to other countries suggest that it is the high prices of health care services that drive lofty cost increases and high base prices of medical care and services. The discrepancy between costs driven by price or volume only breeds more disagreement as to whether policy actions should be taken to directly control and constrain supply, demand or the price of medical services and devices.

It is clear that spending on pharmaceutical products has been rising more rapidly than other healthcare spending. Currently, the perception is that the price of drugs are rising uncontrollably due to high research and development budgets, widespread direct-to-consumer advertising, and quick approvals of new and higher priced drugs.[48] In a recent study published by *Health Affairs,* the data pointed to various "volume factors" that primarily drove the growth in health care cost increases as opposed to "price factors." Volume factors were defined as "those [factors] affecting the intensity of use and the number of users" as opposed to price factors which were defined as "those affecting the price per day of therapy."[49] Of the seven common drugs analyzed in the study, there were substantial spending increases ranging from 43 percent to 219 percent increases over a three-year period.[50] However, when the increase was broken down, it was demonstrated that although the price did rise in nearly every case, the growth in medication *volume* far outweighed the impact of a price increase (Figure 20).

[48] Health Affairs
[49] Ibid.
[50] Ibid.

Figure 20: Drug Spending: Price or Volume?



Source: Health Affairs March/April 2000

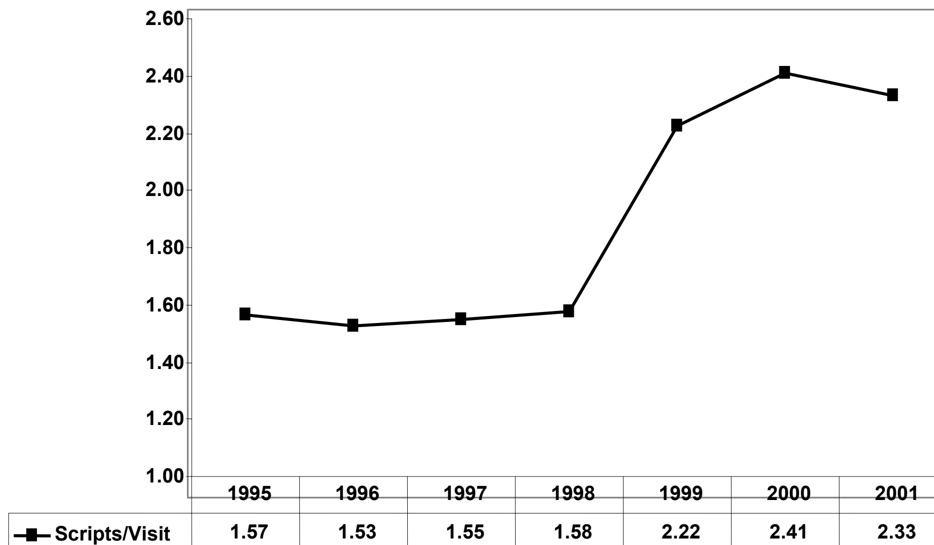
People have consistently used more drugs each year due to a variety of reasons. First, new medical guidelines often call for more aggressive pharmaceutical treatments of disease thanks to new science and technology. Better practice by physicians and the incorporation of evidence-based medicine, practice guidelines, and quality performance measures all have a tendency to increase the number of patients diagnosed with certain conditions treatable by pharmaceutical products.[51] There is also increased patient compliance due to more convenient dosages, increased consumer awareness, and drugs with fewer side effects. Lastly, there is more prevalent off-label use of drugs due to a heightened consumer awareness of the drugs that are available. Overall, pointing to volume as a driver implies specific policy actions quite contrary to those suggested to control and constrain prices.

An argument in favor of increased volume is also presented in a fall 2002 study "Wisconsin Healthcare Cost Trends," published in the by the Wisconsin Hospital Association. It points to increased utilization of health care services as the major culprit behind rising health

[51] Health Affairs, 232

insurance premiums in Wisconsin, arguing that two-thirds of the increases in health care premiums in Wisconsin are attributable to increased public demand for medical services.[52] For example, utilization of prescription drugs is measured by the number of drugs prescribed at each physician office visit. From 1994 through 1998, the number of prescriptions was relatively constant at 1.6 prescriptions per visit on average. However, in just three years, by 2001, the number had increased to over 2.4 prescriptions per visit (Figure 21).

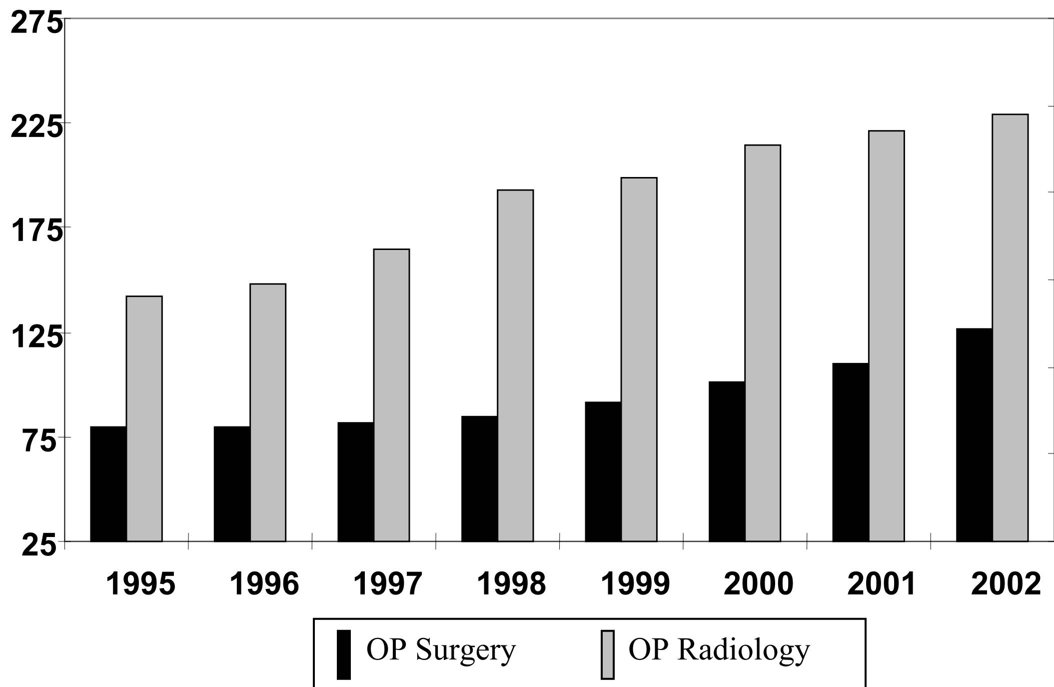
Figure 21: WI Average Prescriptions per Office Visit, 1995-2001



There has also been a shift in Wisconsin toward outpatient services over inpatient services. While the number of inpatient stays has been steadily on the decline, the utilization of outpatient services has dramatically increased. The number of outpatient surgeries per person per year has risen at an average of 20 percent between the years 1995-2002, and outpatient radiology treatments increased at an average rate of 16 percent per year (Figure 22).[53] In summary, the Wisconsin Hospital Association cites increased utilization and volume of health care services as a major cause in rising health care insurance premiums.

[52] www.wha.org
[53] www.wha.org

Figure 22: Outpatient Services in Wisconsin, 1995-2002

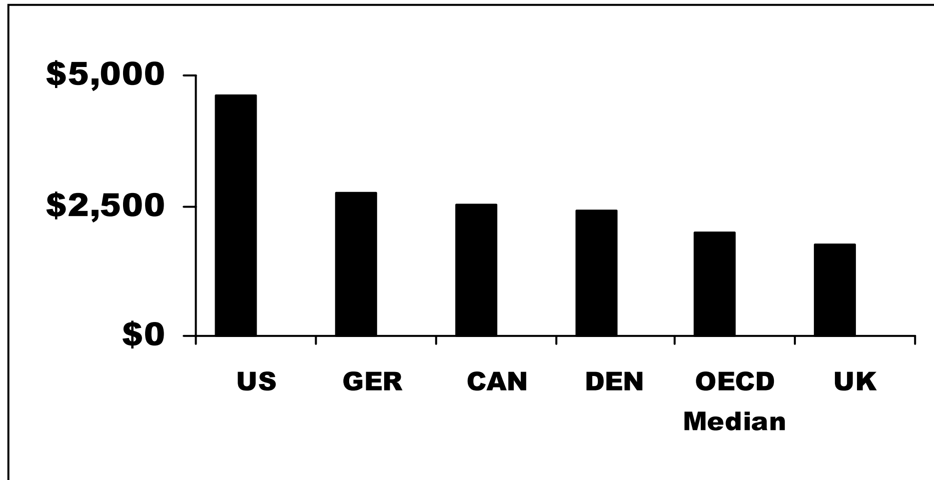


Source: Milliman USA

In contrast to these two studies, international data shows that, when compared to other major countries in the world, price is the major driver in high health care expenditures. In a study done by the Organization for Economic Cooperation and Development (OECD), total health spending is presented and discussed for 30 of its member countries. The data in this study show that in terms of health expenditures, pharmaceutical spending, health system capacity, and medical service use, the United States spends more on health care than any other country.[54] However, despite having the highest health care expenditures, the United States falls below the OECD average on measures of health services use. The study concludes based on the data that the high healthcare expenditures in the United States are due to high prices of medical goods and services, and not high utilization of services (see Figures 23-26.)[55]

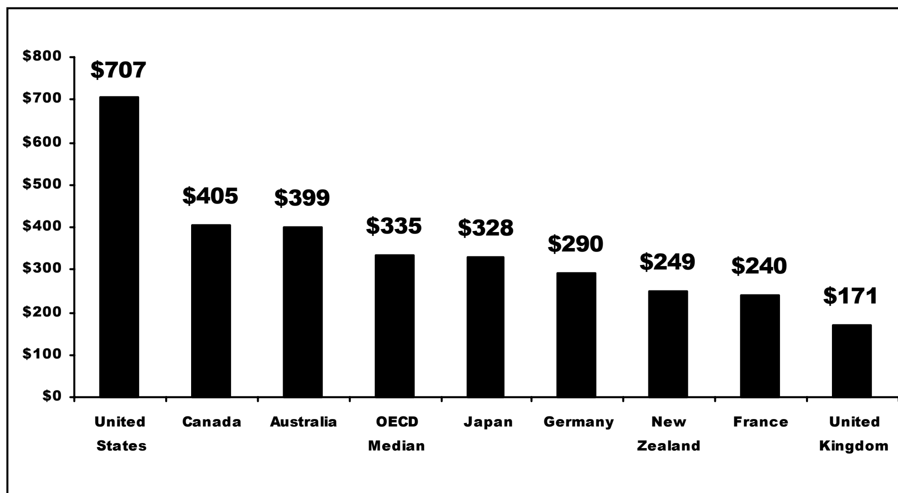
[54] Anderson, et al. "It's the Prices, Stupid: Why The United States is so Different from Other Countries" *Health Affairs* (May/June 2003): p. 89
[55] Ibid., p. 90

Figure 23: Per Capita National Health Expenditures, 2000



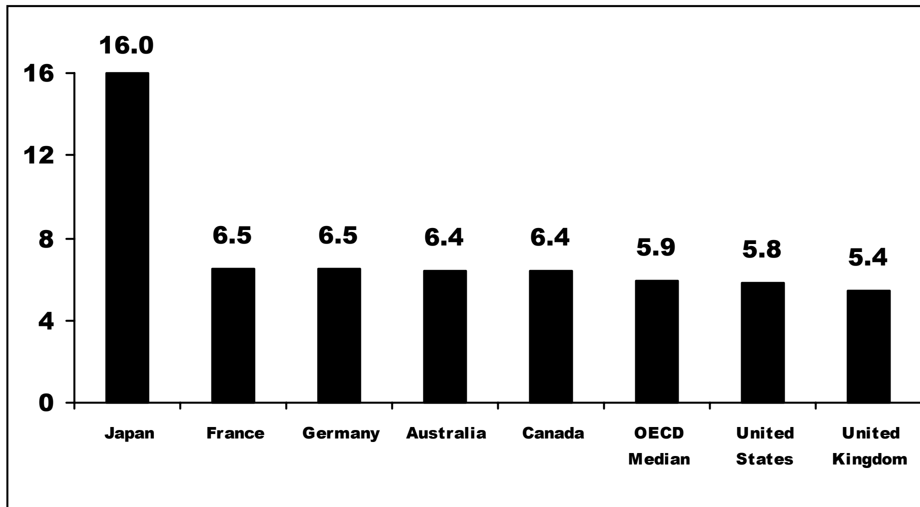
Source: Anderson, et al. "It's the Prices, Stupid: Why The United States is So Difference from Other Countries." Health Affairs (May/June 2003): 89-105

Figure 24: Per Capita Out-of-Pocket Healthcare Spending, 2000



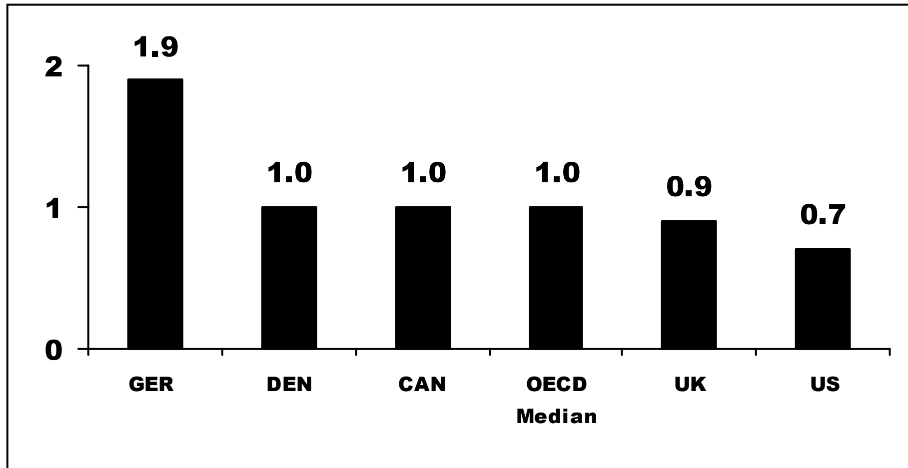
a 1999, b 1998, c 1996
Source: Anderson, et al., Multinational Comparisons of Health Systems Data, 2002.
The Commonwealth Fund, October 2002.

Figure 25: Per Capita Number of Physician Visits, 2000



a 1996, b 2000, c 1999, d 1998
Source: Anderson, et al., Multinational Comparisons of Health Systems Data, 2002.
The Commonwealth Fund, October 2002.

Figure 26: Per Capita Acute Care Hospital Days, 2000



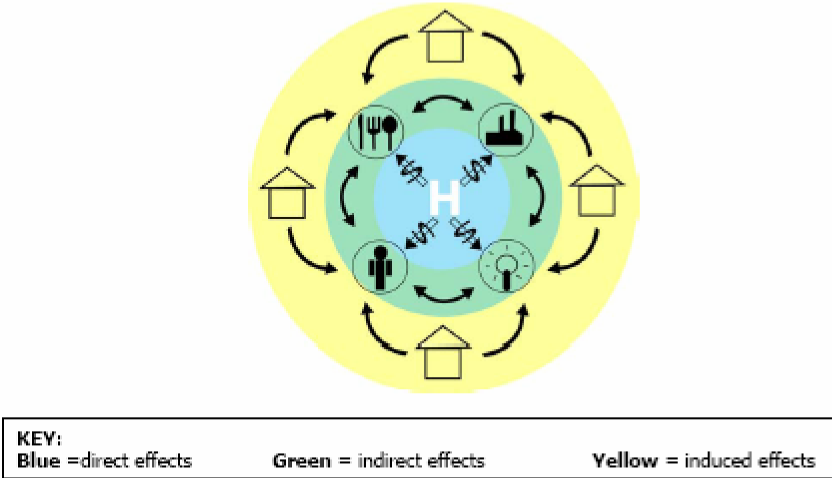
****1999***
Source: Anderson, et al. "It's the Prices, Stupid: Why The United States is So Difference from Other Countries." Health Affairs (May/June 2003): 89-105

Depending on where your sympathies lie – with volume or with price – dramatically affects the types of reform policies you might support. The proposed remedies for cutting prices, therefore, are very different from the proposed remedies to control supply and demand. In itself, this is a huge barrier to finding an agreeable solution to the health care cost crisis.

►A Final Thought: The Economic Impact of the Health Care Industry

Health care facilities within communities bring much more than health and wellness to those communities—the health care industry also brings economic growth in terms of sales, employment, income and tax revenues. Through direct, indirect, and induced effects, a health care system creates and sustains local businesses, creates employment opportunities, attracts new residents and businesses and provides tax revenue.[56]

Figure 27: Community Economic Relationships



The direct effects, including employment, income, and sales provided by the health care industry, are vital determinants in the industry's overall economic impact in a county. However, when considering the indirect and induced effects of the industry, the impact is far more influential. As observed in Figure 27, the direct effects of the health care industry are its purchase of goods and services from the local businesses with which the system operates. The indirect effects are captured in the fact that the local businesses buy/sell to and from each other in order to sustain the goods and services needed by the health care industry. And the induced effects are seen when employees of the health care industry and other local businesses that are linked to the health care industry purchase goods and services within the local community (Figure 28).[57]

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[56] Wisconsin Office of Rural Health. "Economic Impact of Health Care in Dodge County, 2003."
[57] Wisconsin Office of Rural Health. "Economic Impact of Health Care in Dodge County, 2003."

Figure 28: Dodge County Economic Base, 2000

	Industry Sales	Employment	Total Income
	$	number of jobs	$
HEALTH CARE	227,667,482	4,040	145,572,809
Agriculture	260,345,797	3,328	42,537,208
Mining	8,906,836	60	5,592,619
Construction	508,288,366	3,980	213,574,304
Manufacturing	2,659,782,091	13,558	865,720,788
TCPU	203,539,433	1,717	98,763,279
Trade	358,003,589	8,192	249,537,408
FIRE	357,967,131	2,270	248,971,703
Services	261,001,988	6,371	138,543,564
Government	250,178,536	4,946	215,114,560
Total	5,095,681,250	48,462	2,223,928,243

Source: Wisconsin Office of Rural Health

The Wisconsin Office of Rural Health claims that these economic impacts are particularly strong in rural areas, since generally a larger percentage of the population is employed in the health care sector than in urban areas.[58] In order to better understand the economic impacts of the health care industry in Wisconsin, let's look at the case of a predominantly rural area, Dodge County.

Located in Southeast Wisconsin and home to approximately 86,000 residents, Dodge County is a relatively rural area (with the exception of Beaver Dam—its major population center). The county boasts a 3.2 percent unemployment rate and has an annual average income of $27,940. The largest industries in Dodge County include fabricated metal products, industrial machinery and equipment, and health services, which employs 9 percent of the workforce.[59] With three major hospital providers, the health care industry in Dodge County is vital to the health and well being of the residents, and to the economic sustainability and development of the community.

Broadly speaking, the "health care industry" in Dodge County includes doctors and dentists, private and county-owned nursing homes, private and county-owned hospitals, local

[58] Wisconsin Office of Rural Health. "Economic Impact of Health Care in Dodge County, 2003."
[59] Wisconsin Office of Rural Health. County Profile: Dodge County. Available at http://www.worh.org/pdf_etc/CoProfiles.pdf#nameddest=Dodge.

public health departments and other medical services.[60] The direct effects of this local health care industry are significant – of the 48,462 full and part-time jobs, 4040 (8.3%) are in health care. Health care also generated $145.6 million in annual income (6.5% of the $2.2 billion in total income for the county) and $227.7 million in industry sales ($5.1 billion in total revenue was collected from the sales of services and goods within Dodge County). Figure 28 compares these health care totals to the other leading industries in the county.

The popular thought is that every health care dollar spent in a rural community, like Dodge County, is recycled through that community at a rate near one and a half times.[61] The series of spending that occurs throughout the economy as a result of spending in one sector is often referred to as the multiplier effect. In Dodge County, the sales, income, and employment impacts on the economy have all been measured by calculating an Implicit Multiplier, which is the ratio between actual sales, employment, or income from one industry and the sum of its direct, indirect, and induced effects (total impact) on the rest of the economy.[62] An examination of the Implicit Multiplier helps us conclude that in Dodge County (see Figure 29), as in many rural counties in Wisconsin, the health care industry plays a vital role in the growth and development of the local economy.

Figure 29: Economic Impact Assessment

Health Impact	Industry Sales	Employment	Total Income
	$	number of jobs	$
Direct	227,667,482	4,040	145,572,809
Indirect	28,613,770	409	17,335,650
Induced	49,429,540	813	37,464,697
Total	305,710,792	5,262	200,373,156
Implicit Multiplier (Total/Direct)	1.343	1.303	1.376
Percent of County Total (Total/County Total)	6.0%	10.9%	9.0%

[60] Wisconsin Office of Rural Health. "Economic Impact of Health Care in Dodge County, 2003."

[61] Flanders, Gretchen. "Rural Health Care: Good for the Economy?"
[62] Wisconsin Office of Rural Health. "Economic Impact of Health Care in Dodge County, 2003."

The total **industry sales impact** of health care in Dodge County is **$ 305.7 million.**

- The health care industry provides approximately $ 227.7 million directly in annual industry sales in Dodge County.
- Approximately $ 78 million in additional industry sales in Dodge County is supported by the health care industry through the multiplier effect.

The total **employment impact** of the health care industry in Dodge County is **5,262 jobs.**

- There are approximately 4,040 actual jobs in the health care industry in Dodge County.
- Approximately 1,222 additional jobs are supported in Dodge County by the health care industry through the multiplier effect.

The total **income impact** of the health care industry in Dodge County is **$ 200.4 million.**

- The health care industry provides approximately $ 145.6 million in income annually in Dodge County.
- Approximately $ 54.8 million in additional income in Dodge County is supported by the health care industry through the multiplier effect.

Source: Wisconsin Office of Rural Health

Based on this data, it is obvious that the health care industry has a significant impact on the economic well being and potential for growth in many communities. Like Dodge County, other counties throughout Wisconsin depend on the health care industry to promote and sustain local economic growth. Thus, as we consider strategies to contain costs and proposals to reform the current health care system, we must remain cognizant of both the direct and indirect effects on economic security (via employment and income) generated by the health care sector. The goal should be to balance this economic engine with the need to provide quality, access and affordability of necessary medical services.

VII. Movement Toward Consensus

Armed with all this information, and more, the Health Care Workgroup broke into several subcommittees in an effort to focus attention on specific agenda items and to try to clarify what could be done, by whom, about what and when. However, given the exigencies of time, competing interests and the magnitude of the challenge, the sub-committees were not able to make as much progress, as more time would have allowed, nor coalesce around a handful of well-articulated solutions.

Still, thanks to the efforts of both the Aligning Incentives and Thinking out of the Box subcommittees, several thoughtful strategies for addressing health care in both the long and short-term surfaced. We are especially grateful to Chris Queram (Incentives) and Robert Phillips, M. D. (Box) for their leadership on these respective subcommittees.

→ *Short-term Solutions: Aligning Incentives*

> *"The incentive system must align with the (health care) organization's goals and its patients' best interests. For example, if the organization's goal is to save money (as opposed to maximizing revenue) but its incentive plan rewards the physicians who bill the most, the goal and the incentive plan compete.* ***Aligning incentives*** *is like ensuring that everyone in a boat is rowing in the same direction: If it happens, you get where you want to go; if not, you go in circles, if you go anywhere at all."*
>
> - Kent J. Moore, *Family Practice Management*, Vol. 6, No. 6, June 1999

> Background

There appears to be an emerging national consensus on the need to better align consumer incentives/payment to performance as a mechanism to establish an enduring "business case" for quality in health care. Such an effort involves (but is not limited to) the following prerequisites:

- **Transparency –** In the traditional use of the term, something which is “transparent” is “easily understood; clear; open; frank”… (*Webster’s New World Dictionary, Second College Edition*). For purposes of this paper, transparency is defined as the public disclosure of information about the performance of the health care system, both for organizations (e.g., hospitals, medical clinics, nursing homes) and individual professionals (e.g., physicians, nurse practitioners, physician assistants).
- **Rewarding Quality** – link consumer incentives/payment to performance, e.g., measures of quality.
- **Engaging Consumers –** build a more “consumer-centered” health care dynamic.

The “Aligning Incentives” subcommittee's broad purpose was to address the “misalignment” of incentives that typifies the state of affairs in today’s health care system. By focusing on transparency, rewarding quality and consumer engagement, we believe that there may be some near term relief to the health care cost crisis. We concentrated our activities on recommendations and action steps that could possibly be achieved within the next two-three years.

> Recommendations

- Articulate a clear and unifying Wisconsin vision and statement of purpose to serve as a guide for the myriad of new initiatives relating to quality measurement and reporting.
- Adopt a targeted and concise set of performance measures which can be reported in a consistent manner, thereby enhancing consumer engagement and easing the burden of reporting for hospitals and physicians
- Streamline the collection and assessment of the public reporting of standard measures of health care costs, utilization, outcomes and medical errors.
- Link payment to performance
- Encourage public/private sector collaboration on health care purchasing initiatives
- Establish information technology as an enabler of change
- Undertake a broad-based and comprehensive educational initiative (led by the University of Wisconsin System) to prepare Wisconsin consumers for assuming more responsibility for health care decision-making

> Rationale

The subcommittee used as reference a variety of recent, relevant studies, including:

- Two Institute of Medicine publications, *Crossing a Quality Chasm: A New Health System for the 21st Century* (2001) and *Leadership by Example* (2003).
- *Value Purchasers in Health Care* (2001)
- National Quality Measurement Reporting System (NQMRS) from the Strategic Framework Board (2003)
- *Epidemic of Care* (2003)

With those studies serving as guidance, the “Aligning Incentives” subcommittee examined its options. At its foundation, our recommendations focus on raising the performance of health care organizations through the public reporting of information on the cost and quality of health care services.. We believe that this approach will foster and accelerate the adoption of best practices as well as educate and engage the consumer.

Nevertheless, we remain mindful of the challenges that persist, among them:

- That the call for increased transparency is not an end in itself-- while there is evidence to suggest that public reporting will motivate providers to improve, the act of publishing data alone may not be sufficient to drive long-term, systemic change;
- That measuring for improvement versus measuring for selection is not mutually exclusive; indeed, they may vary by community or situation and may exist together as complementary aims.
- That the use of performance data for selection of providers may create a mix of both intended (improved quality) and unintended (i.e., potential for decreased access to both basic and specialty services) consequences
- That decision-making/support tools for consumers are in a state of infancy and that consumers have not been adequately prepared or supported in the new responsibilities they are expected to assume
- That the accuracy, consistency and comparability of reporting data is essential

- That under the leadership of the UW System, Wisconsin should develop and aggressively communicate a "health literacy" program designed to educate residents on the basics of health insurance/benefits, health care performance measures/quality indicators, self-care, and personal health decision-making

> Characteristics

We are hopeful that some of our recommendations can be implemented in the near term. This "new and improved" 21st century health care system will be characterized by:

1. **Transparency of information**
2. **Rewarding of quality**
3. **Engagement of consumers**

There are key roles for all stakeholders, and there are new opportunities for others, including educators, government and public health entities. Moreover, there is a need for information technology to become part of the glue that will enable the widespread availability of information for both external reporting and internal quality improvement. A myriad of financing mechanisms should be evaluated to generate the funds necessary to create the IT infrastructure to support improvement.

Finally, and perhaps most critically, in approaching the new "consumerism" in health care, Wisconsin employers and state government must recognize that **there are no simple solutions to the issue of rising health care costs**. At the core, purchasers must begin to treat health care as a strategic business issue and manage it as aggressively as any other strategic priority facing their business. And even though we are asking the residents of Wisconsin to assume more responsibility for health care decision-making in the coming years, we are not suggesting that we leave them feeling isolated, unsupported, uneducated and victimized. In fact, bringing them into the center of the health care decision-making process may be one of the best steps we can take.

→ *Longer-term Solutions: System Redesign for Value Purchasing*

> *"The health care system of the 21st century should maximize the health and functioning of both individual patients and communities. To accomplish this goal, the system should balance and integrate needs for personal health care with broader community-wide initiatives that target the entire population. The health care system must have well-defined processes for making the best use of limited resources."*
>
> \- *Fostering Rapid Advances In Health Care: Learning From System Demonstrations*, Institute of Medicine of the National Academies, November 2002

> Background

Given the fact that health care today functions as "non-system," one that is disconnected, uncoordinated and ill-positioned to serve society in a safe, timely, patient-centered, effective, efficient or equitable manner, we envision a health care system for the 21st century that maximizes the health and functioning of both individual patients and communities. To accomplish this goal, such a system should balance and integrate needs for personal health care with broader community-wide initiatives that target the entire population. However, a common vision for a 21st century Wisconsin health care system has yet to emerge.

The "Thinking Out of the Box" subcommittee's broad purpose was "to propose a 21st century health care system redesign based upon the Institute of Medicine's models of integrated health care systems incorporating preventive, acute, chronic and palliative care of a population fully connected by information systems committed to evidence-based medicine practices, evaluated by periodic validated outcome measurements for performance evaluation, and financial remuneration." This group was encouraged to be visionary, creative and limitless in its plans for this new system focusing on patients, providers, systems and processes.

> **Recommendations**

- The costs for information technology infrastructure be shared among purchasers, government, providers and the public;
- Evidence-based clinical practice guidelines be incorporated into daily practice to avoid historic wide variation in practice and resulting increased costs by overuse of services;
- Payers, purchasers, insurance, government **align incentives** to pay for performance, with the results being better care and motivation to continuously improve care;
- Schools of medicine produce a health work force trained in scientific-based clinical practice, team-centered care design and state-of-the-art medical computer technology;
- All aspects of the health care system – hospitals, provider groups and established integrated health care systems – be integrated to provide the safest, effective, patient-centered, timely, efficient, and equitable health care for our state and for our nation.

> **Rationale**

The Subcommittee used as reference a number of items from the Institute of Medicine (IOM). The Institute of Medicine was founded in 1973 as a branch of the National Academy of Sciences, chartered by Congress, to advise government on "health of the public" issues. In its 1999 publication, *To Err is Human: Building a Safer Health System,* the IOM reported on medication errors and safety issues, and called for health care system/process changes to prevent future life-threatening events. Then in 2001, the Institute of Medicine issued a landmark report on health care quality in the United States, *Crossing a Quality Chasm: A New Health System for the 21st Century,* which identified the inadequacies of our current system and called for fundamental redesign based on consistent, high-quality, scientifically-based health care which would be available to all with the patient at the center of the treatment circle.

With those studies serving as guidance, the "Thinking Out of the Box" subcommittee proposed redesigning a health care system for the 21st Century based on the Institute of Medicine's six characteristics. Such a system would be:

- **Safe** - avoiding injuries to patients from care intended to help them;
- **Effective** - care based on scientific knowledge, avoiding those services of little benefit;
- **Patient-centered** - respectful of, and responsive to, patient preferences;

- **Timely** - reducing harmful waits and unnecessary delays;
- **Efficient** - avoiding waste of resources and effort;
- **Equitable** - care that does not vary in quality due to race, gender or socioeconomic status.

In addition, the projected 21st century health care system would adhere to the IOM's 10 rules for redesign:

1. Continuous healing relationships
2. Customized care to patients
3. Patient as center of control
4. Shared knowledge with free flow of information
5. Evidence-based decision making
6. Safety as a priority
7. Patient-centered transparency including safety, evidence-based guided treatment and patient satisfaction
8. Anticipation of needs
9. Continuous decrease in waste
10. Cooperation among clinicians

Next, we assessed this projected 21st century health care system from the perspective of both patient and provider.

Patient	Provider
At the center of care – engaged in active information exchange and shared decision-making with their provider	“The right provider for the right patient at the right time” – new categories of providers (i.e., care coordinators, community health advocates, etc.) who are trained and incorporated into newly-designed chronic disease care management teams for the purpose of maximizing access and care delivery
Responsible for adopting healthy lifestyles (i.e., exercising regularly, achieving acceptable weight, not smoking, not using alcohol to excess, etc.)	Accountable for safety, quality outcomes, evidenced-based medical practice and costs of care
Knowledgeable about the costs of care – becoming a “smart shopper” of health care services and understanding of the need to financially share in the costs of chronic disease state management.	Infrastructure to support clinical decision-making, protocol design and appropriate medical supervision within chronic disease care management teams that provide standardized care for the 15 chronic conditions identified by the Institute of Medicine *
Well-informed about their own health or chronic health conditions and participate in self-care.	Trained and educated “next generation of physicians” focusing on team-centered, evidence-based, outcome-guided practice, utilizing the benefits of advances in information technology.

** The list includes cancer, diabetes, emphysema, high cholesterol, HIV/AIDS, heart disease, stroke, arthritis, asthma, Alzheimer's and other dementias, depression and anxiety disorders*

> Characteristics

The 21st century health care system redesign will be composed of entities which are characterized by:

- Information technology capabilities that continuously collect and measure health outcomes; provide real-time, best-practices updates for clinical decision making and patient safety (physician order entry, drug interaction and allergy software protection); and shares health information (by means of electronic medical record or patient portable personal health information smartcards) within a subsystem and/or among multiple subsystems.

- Internet utilization that makes general health information available; uses e-mail for prescription refills, to ask questions of providers, set up appointments, and accesses personal health information 24-hours a day, 7-days a week.
- Clinical research in, and application of, genomics and pharmacogenomics to the practice of medicine;
- The provision of primary care with coordinated access to the full continuum of outpatient, hospital and rehabilitation and specialty care.
- Processes will focus on preventive, acute, chronic and palliative care;
- Standardized and validated health outcomes will be based on measures which are applied fairly, risk or severity adjusted, and recognize patient behavioral factors, i.e., compliance;
- Incentives will be properly aligned to pay for performance;
- Administrative operations will be streamlined, centralized and/or standardized to avoid duplication, redundancy and unnecessary costs.
- Payment systems will be reconfigured by purchasers, insurers and government to pay for population health management, chronic disease state management and care coordination. Traditional point of service reimbursement based on physician/patient episode of care will be changed to reflect the new models of care. Payment methods will incent providers and systems to implement the redesign and pay for high quality care.

VIII. Conclusion

There exists a plethora of excuses and explanations to why the emerging health care cost crisis has long defied solution. However, differences notwithstanding, the Health Care Workgroup has uniformly agreed that the cost of health care and health insurance is a problem bordering on crisis both nationally and here in Wisconsin. We also agree that the current growth rate of health care costs is increasing at an unsustainable rate. We have identified the major cost drivers behind each of the most threatening components of health care services. And, despite all of the described roadblocks, we are committed to trying to overcome the hurdles and barriers as we identify workable solutions around which a consensus can be built to improve the cost, quality, and access of health care in the state of Wisconsin.

Our paper encourages everyone who has a stake in the health care cost crisis – and that includes EVERYONE – to join with us in bringing attention, energy and answers to the current conundrum. The ideas discussed in this paper could be the basis for focused discussion of a painful crisis that threatens our state's future. Wisconsin is a great state with a long tradition of innovative government, positive reform and "out of the box" thinking. It will require this, and more, to stem the tide of increasing health care costs in a way that does not harm quality or access.

The ideas and analysis presented here are intended to help us maintain our grand traditions and forge a consensus that can get things done.

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Wellness Template
By Bill Herman, Vice President, Human Resources, Highsmith Inc., Fort Atkinson, WI.

(NOTE: Mr. Herman presented the Highsmith Wellness Program to the workgroup. Highsmith has about 250 employees and Mr. Herman pointed out that the program has been very successful in reducing costs and is designed for moderate-sized companies like his.)

> Background

Most employers consider health insurance a sound and necessary investment to attract, retain and provide for a productive workforce. Given the magnitude of employer's investment in health insurance it makes sense to leverage that return on that investment. In short, a company's productivity depends on employee health.

Worksites where most adults typically spend half or more of their waking hours can have a powerful impact on individual health. Many studies have documented that employees who take advantage of clinical preventive services have lower absenteeism, higher productivity and a stronger organizational commitment.

Health promotion is an investment in human capital. Employees are more likely to be on the job and performing well when they are in optimal physical and psychological health. Studies have also demonstrated that health promotion programs can and do reduce medical expenditures resulting in direct cost savings.

There are a number of common elements inherent in successful health promotion initiatives. Companies that have been successful have built wellness programs that are results-oriented. Results-oriented programs are those programs that are thoroughly researched, thoughtfully designed, and carefully executed. They are focused not on simply offering a "program of the month," but on impacting the organization's bottom line through improved employee health.

David Hunnicutt of The Wellness Councils of America (www.welcoa.org) suggests the following seven critical benchmarks for worksite wellness success.

1. **Concentrating on Senior Level Support**
   As a program is being built, it's important to understand that senior level support is critical to the success of any worksite health initiative. It's the senior level executives who control the budgets, the organizational agenda, and all of the communication channels. Because of these realities, succeeding without senior level support is virtually impossible. Knowing this, the crucial question becomes, "How does one actually secure support from senior level executives?" Although there are a number of potential strategies, perhaps the most effective route is to link the health promotion initiative to established business priorities. By taking this approach, health promotion will be seen as an important tool in realizing the business mission.

2. **Creating Cohesive Wellness Teams**
   Because the majority of organizations have become extremely specialized, most decisions are now made in teams. In light of this, to ensure that the health promotion initiative is embraced by all of the major organizational constituents, it is imperative to involve key players throughout the company. Included in this mix should be the appropriate representatives from management, human resources, safety, MIS, etc. By taking the team approach, responsibilities of promoting health will be uniformly and strategically disseminated throughout the organization. By creating a broad-based wellness team, a fresh flow of ideas is also assured.

3. **Collecting Data to Drive Health Efforts**
   While collecting data may seem like an obvious step for many practitioners, it is important to understand that, often, a major disconnect occurs in this area. For example, it is not uncommon for an organization to secure senior level support and establish a cohesive team, but instead of then gathering data to obtain a clear picture of organizational needs and employee interests, many organizations immediately begin offering activities. Oftentimes, this maneuver is a fatal one. In order to sustain a results-oriented approach, an organization must work to implement programs with purpose—not simply offer random activities.

4. **Crafting an Operating Plan**

   In most business settings, the annual operating plan is the vehicle that articulates the organization's strategic direction. Moreover, it is this document against which all progress is ultimately measured.

   Successful wellness teams always create an annual operating plan. An important piece in ultimately evaluating wellness efforts at year's end, the operating plan should be a written document that includes measurable detailed goals and objectives. An operating plan also proves to be quite valuable when attrition within the wellness team occurs. The operating plan allows new team members to step in and be effective players right away.

5. **Choosing Appropriate Interventions**
   Once senior level support has been attained, a team has been assembled, data has been gathered, and an operating plan has been written, it's time to start implementing programs. But before doing so, it's important to determine what works and what doesn't when it comes to changing behavior.

   America's Healthiest Companies commonly select the right balance between intensity and duration when choosing behavior change programs. Getting results means not only choosing the right interventions, but also structuring them correctly. What components should the program offer? Tailored messaging? Personal counseling? Pharmaceutical therapy?

   Successful wellness initiatives also consider program length as an important part of the puzzle. How long should a program last? Six weeks? Twelve weeks? Getting results

means spending some time exploring what works and what doesn't when it comes to changing behaviors.

6. **Creating Supportive Environments**
   Supportive environments significantly increase the likelihood that positive changes in health behavior will take place. This is an important benchmark that is all too often overlooked. Fortunately, there are organizations that are doing some amazing things when it comes to creating supportive environments. Consider the multitudes that have implemented smoke-free environments. Think of those who are providing low-fat alternatives in the cafeteria and vending machines. It's no surprise that people working in environments conducive to positive health choices become healthier.

7. **Consistently Evaluating Outcomes**
   The final step to building results-oriented worksite wellness programs is the notion of consistently evaluating outcomes. If clear goals and measurable objectives have already been formulated, much of the work of evaluation has already been done. For those practitioners who have concentrated on senior level support, created a team, collected data, crafted an operating plan, chosen appropriate interventions, and created a supportive environment, evaluation can actually be the best part of the process.

   The most successful programs focus on evaluating participation rates, changes in knowledge, attitudes and behaviors, return on investment, etc. It is important to remember that evaluation revolves around the original goals and objectives set forth in an organization's operating plan. Following the process is key.

Those who implement the seven critical benchmarks of worksite wellness success increase their chances of improving employee health and productivity as well as positively impacting their organization's bottom line.

Whether an employer decides to hire a health promotion manager, use current staff, or contract with a vendor to design and implement a health promotion program, thinking through the implementation process is extremely important. It is essential if employees are to realize the health and financial rewards of health promotion activities.

There are resources available to assist employers in their wellness efforts. One of the best is The Wellness Councils of America (www.welcoa.org). This non-profit organization is dedicated to promoting healthier lifestyles especially through health promotion initiatives at the worksite.

Healthy employees—and those with healthy families—are likely to incur lower medical costs and be more productive. Employers can leverage their investment in health insurance by actively promoting and encouraging health lifestyle choices. It makes good business sense to do so.