Business and Public Policy Round Table
May 4, 2011
University Club of St. Paul

"Cutting the Cost of Health Care"

Introductory presenters: Former U.S. Senator David Durenberger, Chair, National Institute of Health Policy; State Senator John Marty

Chair, facilitator and rapporteur: Steve Young, Global Executive Director, Caux Round Table

Participants: Kay Baker; Thomas Farnham; Sharon Rose Goossen; Bob Junghans; Michael LaBrosse; Jeanette Leehr; John Mauriel; Tammy McGee; Deborah Montgomery; Dick Primuth; John Salchert

Conclusions:

Cost control drives our health care system, not the search for health and wellness.

America is in crisis – a financial crisis – because we can't pay our debts. Reducing health care costs is needed to pare down our national debt, even more so when our public debt will only grow as Baby Boomers retire and drive up the costs of providing for their health care.

To the extent health care is paid for by employers and citizens directly, it diverts money from other uses.

Health care has already become 17.3 % of GDP and, if Medicare expenses grow as expected, that percentage will become unaffordable, driving America into bankruptcy.

Health care now costs us $2.5 trillion a year, or $8,000 per person, which is $32,000 for a family of four. In Minnesota, by 2017, health care will cost $55 billion – more than the general budget.

Money spent on health care is not available to fund education, national defense, renewal of our roads and bridges, public safety, or paying down our debt.

The solution is to build a different system; one that does not cost so much. In doing so, it is important to remember that access to health care is also an ethical issue with differing impacts on the rich and the poor. The poor and the disadvantaged don't care about policy debates. They simply fall through the cracks. Until the country treats health care as a moral issue, it will fester. Our country is not there yet. There are so many social issues to overcome.

The new system would seek to prevent, rather than to cure. It would intervene before the fact, not afterwards. It would seek wellness of the person up front, rather than paying for professional interventions on the back end. It would get ahead of the cost curve by keeping people well and healthy. Sick people run up bills; healthy people don't cost us anything.

Keeping people well costs money, but much less than caring for them after they are sick.

Building a less costly system of keeping us healthy, in the first place, will be a journey, not a destination. It will happen, regardless of public policy efforts to expand coverage and to save money by changing what we pay for. It is important to acknowledge that some of ours leaders have advocated for focusing organizational or systems policy around health and health care improvement. But competition among care providers or private insurance companies won't get the job done unless public policy focuses on ends – wellness – not the means – who pays how much for what procedure or medicine.

The current system has perverse incentives:

Some examples cited of being penny foolish and pound wise: St Mary's Hospital in Duluth runs a heart failure program for those who have suffered from a heart incident to monitor their conditions. It has resulted in an 85% reduction in re-hospitalizations and 50% reductions in cost due to tertiary prevention and follow up care.

Health care doesn't pay for nutrition, which keeps people healthy, or for healing touch sessions, or many services provided by chiropractors. The Penny George Center was noted as an example of successful wellness care.

Diet-induced illnesses are not addressed by health care providers who show up after unhealthy consequences have arisen. Improving diets to reduce obesity and diabetes would dramatically cut health care costs.

We need to attack the problem on a number of fronts. We have subcontracted our food system to the food companies, so we need to look at the practices of the food industry, as well as the health care industry. It is an integrated system. We can't change one element without changing the other.

How to share savings from wellness programs is not resolved, so one has an incentive to reduce costs that today, constitute their income because one person's cost is another person's gain. Marketing, especially of drugs and medical devices and redundant practices to forestall malpractice litigation, also are cost escalators provided by the current system.

Our current system of providing after-the-fact health remediation has burned out its leaders in hospitals, insurance companies, politics and public administration. The voices of leadership have become silent. Corporate interest and lobbyists seem to drive our national agenda.

We are in fiscal crisis, are paralyzed and don't seem to know the way out. Our politics is like ping pong – the ball goes back and forth, back and forth. There is no forward motion towards the goal of wellness.

Individual leadership is also important. We have too much of "me," not enough of "we." Business schools need to do a better job of focusing on various dimensions of leadership, including the ethics of leadership development.

Solutions will likely come from those outside of the political system, as politicians are too busy worrying about their own backs. Those who toil and lead in community development can play a key role, community by community, block by block.

It would be wise to price health care insurance for quality and coverage. Incentives for personal responsibility would reduce costs and increase health happiness – paying people to do right, not expensive professionals to fix what has gone wrong.

Change in the larger culture would have to occur before a focus on promoting wellness, good diets and personal responsibility would take place. A cheaper system looks beyond doctors and hospitals. A range of instructors in living wisely are needed. In Brooklyn Center, public schools superintendent Keith Lester has brought wellness care into his district. Where are the school nurses? What happened to home economics classes?

Participants differed on the advantages of having a single payer system versus the current multifaceted insurance system. The current system responds to market innovations, while a single payer structure would achieve more effective coordination of all providers. Views also differed as to the likelihood that innovative technologies, such as consolidated medical records, can help contain costs significantly.