



agog dinner & discussion

## **New Directions in Health Care Delivery and Cost Containment**

On September 2, Dr. Bill & Nell Simkoff hosted the last dinner in the 2010 agog discussion series. Moderated by conversation leaders Lea Anne Doolittle, Senior Vice President at NW Natural Gas Company and Jack Friedman, CEO of Providence Health Plans, guests explored the efficacy of publicly financed health coverage and ways to make the health care system more sustainable.

Is health care a common good, or a right to purchase based on income? Public education is an example of the common good: An answer to the first waves of immigration and means to assimilate people from various nations. A couple centuries ago, America faced the same issues that health care is now. It is perhaps the greatest unifying force of our day.

The group generally agreed that the Health Care Reform legislation is a step towards reform (one person said, “This is evolutionary, not revolutionary”) with positives being:

- A chance for us to improve our system
- A way to develop sound data systems, e.g. electronic data records
- Teeth to kick out those companies who don’t participate in requirements, as the system would lose funding if it did not make quality improvements
- Pilot programs of worth that may evolve from this step forward

Several guests thought that the Kitzhaber plan, Archimedes, is what will make this work with the focus on prevention, cost containment, etc.

Obstacles to progress stemming from work on health reform to date:

- Much rides on who is in power in 2014 and thereafter when some of more radical aspects are enacted including Exchanges. Employers might choose move away from providing benefits to paying employees to go to the Exchange.
- The problem of covering health care for all is still not addressed nor the vehicle to pay for it
- The question of “Is health care a right or not?” is really up in the air in our country
- Unsure if reform will address the issue of insured asking for (and sometimes demanding) services that are not clinically indicated (ex. – cataract surgery before optimal time for that procedure)

- How reform will affect reimbursement rates
- How and when will things change and how this really gets paid for is in question

America spends 17.5% of the national GDP on health care, far more than any other industrialized nation. Much of these funds are spent on end-of-life medical expenses. In one of the required readings for this discussion the paper, *Letting Go*, by acclaimed public health writer Dr. Atul Gawande states, “Twenty-five per cent of all Medicare spending is for the five per cent of patients who are in their final year of life, and most of that money goes for care in their last couple of months which is of little apparent benefit... The trouble is that we’ve built our medical system and culture around the long tail [of the possibility of circumventing death]. We’ve created a multitrillion-dollar edifice for dispensing the medical equivalent of lottery tickets—and have only the rudiments of a system to prepare patients for the near-certainty that those tickets will not win. Hope is not a plan, but hope is our plan.”

While most people (and health care providers) believe that every citizen is entitled to essential health services, explaining to a patient that a procedure is not cost effective is trekking in difficult ethical and moral territory. Should a 93 year old be receiving publicly financed bypass surgery to the tune of \$62,000? And, would a surgery like this really improve this person’s quality of life, or really make them any better? The emotional return on investment may be high, but the public can lose lots of money - money that could be spent on education or another public benefit. Is the public doing a disservice to themselves?

The group had a passionate discussion about dying, in particular, physician comfort with the process of dying. There was discussion regarding financial incentives for doctors to offer treatment when it may not be clinically indicated. It was pointed out that oncologists in particular have financial incentives to use chemotherapy when it may not produce substantial results. There was agreement that many doctors aren’t in a position to easily discuss death with their patients. This is, in part, due to the Hippocratic Oath, but also due to lack of training in the area. The skills of social workers, nurses and psychologists may be helpful to physicians. A team approach would be optimal. Dr. Friedman pointed out that Providence is considering instituting longer patient/family visits for discussions about end of life care, with team input prior to the discussion. Another complicating factor is the trend towards having hospitalists, physicians who take on patients during hospitalization. In these situations, primary care physicians are often alienated from their patients during phases of acute care. It is precisely that time period when many patients and their families

### *Thinking outside the box*

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Guests noted an upsetting paradox. Walking into a local public school and a hospital are two very different experiences. The hospital looks like a five-star hotel.

While a hospital should be clean and functional, the oriental carpets and fancy furnishings are offensive. The focus is on filling hospital beds and increasing the amount of black on the books.

Schools used to be monuments. What message are we sending our children by ignoring infrastructure?

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make important decisions about length and extent of treatment desired. If primary care had a role at that time, the benefit of the long-term relationship with the patient could be maximized.

A recent Aetna study was cited that indicated that terminal patients who were given a choice of hospice (palliative care) versus curative, those who chose palliative improved their longevity by one month over those who chose curative. This brings up a lot of questions about our values and efforts to cure advanced illness situations. The study revealed that palliative care expenses were one-third less than curative care expenses.

Medicaid and the Oregon Health Plan are publicly financed medical care programs. Many doctors appreciate the transparency of the Oregon Health Plan, which clearly defines what services and procedures are covered, and which aren't. It doesn't matter who the paying entity is: the system is designed to reward doctors/hospitals for doing more, not necessarily the right thing.

Currently, primary care doctors are rated based on clinical, performance and efficiency measures. Efforts toward rewarding the doctor for doing the right thing are being impeded.

The Oregon Health Authority and the Oregon Health Policy Board are currently developing a plan for comprehensive health reform. The role of the OHA is to help the state lower health care costs, help create better quality for all residents and assemble a health plan so everyone can get the health coverage they need. The [OHA](#) is creating a tiered, value-based benefit package and is currently conducting focus groups involving consumers, providers, and insurers to help determine whether such a package is implementable and marketable.

### **Taking responsibility for health care costs**

Who is responsible for managing health care costs? The insurance companies? Doctors? Individuals? Employers? The government? Health care reform brings new people into the 'medically insured' pool. Approximately 17% of the US population – nearly 1 in 5 Americans – do not have health insurance. The social function of insurance is designed so that the working young and healthy subsidizes it for those who have been previously denied, have preexisting conditions or are too sick. For it to work, it is essential that the young and healthy contribute to the pool. Diabetes and obesity are at epidemic proportions, contributing greatly to health care costs. Citizens and public health organizations and others are working to improve the quality of food and influence policy to eliminate poor agricultural subsidies that contribute to the junk in junk food. Several guests thought subsidies for Big Pharm were asinine.

### **Educating the public**

Within the group, there was the sense that people are generally uneducated about health care. In order to improve our system, taxes would need to increase – and this is not generally accepted by the majority. We discussed the fact that “the greatest generation” more readily increases taxes to care for themselves and the next generation than the baby boomer generation does.

Many guests felt that apathy is an issue – that many people use health resources use what is best for them at the moment – and don't think about the impact on societal cost, or equity.

Employers such as NW Natural encourage their employees to take charge of their own health and engage in preventative care. Ms. Doolittle shared cost concerns from the employer perspective. It is important to analyze how well people are taking care of themselves, and how well they understand their own health, and how well we have done educating people about their health and how to stay healthy. A primary care doctor shared that of the people he sees who are near obese or obese, one third of his patients listen and act on his recommendations. The other two-thirds show little or no change at their yearly visits, despite the time he takes to explain about the consequences of their current life-choices such as diabetes and obesity, performing BMIs (body mass indexes), and the need for exercise and good nutrition.

Several factors drive health care costs up:

- Behavioral issues and lifestyle choices creating health challenges (both individual and socially driven)
- Increased sedation, less exercise
- Overabundance of and easy, cheap access to processed and fast foods; expensive healthy foods.
- Coverage for retired employees
- Overuse of the emergency department
- Shortage of primary care physicians resulting in not being able to see a doctor in a timely manner

Our society has become one driven by immediate rewards and results, and long term benefits have seemed to fall to the wayside. Change – both personal and societal – takes time. The tobacco cessation project took over 10 years and has seen promising results. Perhaps we could grab some take home lessons.

### **Incentivize healthy habits vs. punishing unhealthy ones**

Encouraging people to take charge of their own health is vital, as is setting up systems in which they have the opportunity to do so. Incentivizing health rather than punishing people for their choices may be the road to take. Ms. Doolittle has been instrumental in inspiring employees to participate in healthy activities and gain control of their own health, such as annual health risk assessments in the work place, exercise/healthy living programs like Health Miles where employees are incented to be active, and incentives for weight loss and smoking cessation. Assessments give people helpful information about their physical condition, and give NW Natural data to see how their incentive programs are working and to modify health benefit design.

Ms. Doolittle noted that over the last 7 years, health care costs have inflated by an average of 12%, whereas pay increased only 3%. NW Natural currently pays \$5.90 per hour per employee on health care benefits alone. Employer health care costs are a huge challenge in this country, and employers are likely to go down in one of two paths ): 1) redesign their plans or emphasis wellness to decrease costs or 2) Get out of the health care system altogether and have employees use the exchange (in 2014) to buy their own health care. If employers continue to provide benefits at today's level, they are likely to be subject to a 40% excise tax beginning in 2018.

Some guests commented on the amount of funding employers could offer and the role of the employer in covering costs of health care. If all employers pay a set rate per year, it would be better for parity. In theory, if all employers pay in, overall health coverage costs should come down.

Alternative care providers could be part of the solution to improving health when appropriately coupled with standard health care. They alleviate the burden on primary care physicians, address the whole body in addition to the current problem, and tend to give patients just what they want: time and attention. One person speculated that if alternative care providers are included in the health insurance program, rates will likely go up. Ms. Doolittle mentioned that many plans already include alternative care benefits and it has not increased rates and in fact might diminish rates as the cost of coverage is significantly less than standard health care.

Metropolitan Family Service wellness programs were discussed. The successful (but unfortunately defunded) Promotore program provided health coaching in partnership with Providence that addressed non-insured diabetes management without insulin and in turn prevented ER visits and more serious health decline. Six MFS community school programs have established community gardens so students learn where food comes from. The gardens and the bounty they produce are used to supplement school lunches and/or used as classroom enrichment. A number of school districts are making improvements to school provided food and increasing the number of gardens.

### **Summary and ideas for change**

- Acknowledge that complex issues take time and commitment to change
- Qualified support for the current health care reform legislation
- Choose and model a healthy lifestyle
- Support local and national health initiatives that increase the use and availability of unprocessed, healthy foods in our schools and neighborhood grocery stores
- Advocate for safe neighborhoods, walkways, bike paths and open areas that encourage physical exercise
- Support domestic situations where parents have limited time and resources to prepare good food
- Offer health incentives in your workplace or encourage your workplace to do so

The mission of Metropolitan Family Service is to strengthen families and individuals while enhancing their participation in community life. Organized by MFS, **A Gathering of Good (agog)** is a series of community events promoting discussion, civic engagement and social change. In addition to exploring important social issues as a community, **agog dinners & discussions** raise public awareness of MFS's effective programming for children, families, and older adults. MFS is celebrating 60 years of community service in 2010.



Metropolitan  
Family Service

*Because together, we can do more.*