



Health Care Roundtable: Area Execs Prescribe Care

August 1, 2009

As reported in the pages of *In Business* magazine.

The political theater unfolding in Washington, D.C., where (as of this writing) the fate of the first major health care overhaul in 45 years appeared to be unraveling amid public plan panic and anger over broken tax promises, is growing more dramatic by the day.

Amid the intensifying debate, IB convened a panel of experts from the health care field to discuss their industry, pending reform, and its likely impact on businesses and the economy.

Most of our experts doubted a problem so complex could be resolved by August, the Congress' self-imposed deadline, believing instead there will be some kind of framework for the reform that eventually will take place. Sure enough, even President Barack Obama appeared to back off the stated goal of having bills pass through the Congress by the August recess.

If the federal government was interested in truly effective reform, some of our experts noted, they would make a case study of Wisconsin and other Midwestern states that have achieved higher quality and lower cost with business models that emphasize primary care (and correspondingly de-emphasize special care, even though that's what young doctors are gravitating to), practice preventive health education, and understand that health care is a shared responsibility between doctor, patient, insurer, and other stakeholders.

That turned the discussion into less of a diatribe on Washington-style reform and more of a frank talk about what the industry and health care consumers can do to solve the problem without Pelosi, Reid, Baucus, et al. As it turns out, there is quite a bit that can be done without the "help" of the government.

As panelist Kathryn Otto noted: "Think about the different areas in which health care reform can take place — the public policy, the health care delivery system itself, and the culture change. We can all do something, and it's all within our own power. And we are uniquely positioned to make a difference."

While not all health care reform needs to be driven by the national Legislature, the most sweeping health care system changes in more than a generation are in the offing. Will they really constitute true reform that delivers on President Obama's pledge to expand coverage, wring out costs over the long haul, and do so without adding to the deficit and the national debt?

That sounds like a tall order, but as our panelists point out, there is a lot that can be done by health care practitioners and consumers alike. Read on as our experts share their insights.

Our Expert Panel

Dr. Frank Byrne, President, St. Mary's Hospital

Serving South Central Wisconsin since 1912, St. Mary's Hospital offers a wide variety of health and wellness services, inpatient and outpatient treatment, and diagnostic services in primary care and most specialties. The SSM campus includes Adult Day Health Center and surgery centers.

Dr. Craig Samitt, President/CEO, Dean Health Systems

Dean Health System is a for-profit, multi-specialty integrated health care delivery system based in Madison. DHS is the holding corporation that oversees the various organizational entities which provide health services, insurance products, and ancillary services to patients and others.

Chris Queram, Pres./CEO, Wisconsin Collaborative for Healthcare Quality

Queram heads a voluntary consortium of hospitals, medical groups, health plans, and health systems from across Wisconsin working together for about seven years to improve the quality and the cost effectiveness of health care in the state.

Steve Martenet, Plan Pres., Anthem Blue Cross and Blue Shield in Wis.

In 1940, six Milwaukee hospitals jointly offered hospital coverage. This group became Blue Cross of Wisconsin. In 1980, it merged with Surgical Care Blue Shield. Today, Anthem Blue Cross and Blue Shield offers health, dental, and term life coverage to businesses, families, and individuals.

Kathryn Otto, Director of Healthcare Initiatives, Thrive

Thrive, the economic development enterprise for the 8-county Madison Region, represents Southwest Wisconsin (Columbia, Dane, Dodge, Green, Iowa, Jefferson, Sauk, and Rock counties). Thrive wants to grow the economy of the region in ways that preserve and enhance the quality of life.

Jim Woodward, President/CEO, Meriter

Meriter is a south-central Wisconsin health care system with 3,200 employees. Meriter Hospital, a 448-bed, not-for-profit community hospital, offers a wide-ranging scope of medical and surgical services. It is a major teaching affiliate of the UW, and the fifth largest hospital in Wisconsin.

The Discussion

Legislated Reform: Opportunity or Misdirection?

JODY GLYNN PATRICK [IB]: Let's open the discussion with a crystal ball: What do you see coming, Frank, perhaps as soon as August as Congress moves toward deadlines for reform?

BYRNE: I would be surprised if something is done definitively by August, but I think everybody agrees that payment reform is essential to reforming health care. We welcome the opportunity to move to that more sensible environment because, frankly, we are part of an accountable care organization and integrated delivery network now in partnership with our physicians at Dean. We've been accepting bundled payments for over 15 years through our own insurance vehicle, with very low administrative costs. We've been working hard also to lower costs independent of anything else; that's going to be essential under any reform scenario — efficiency, and providing the right care in the right location is going to be the best thing.

And the last thing I would say to open is that we are well positioned with the integrated delivery networks throughout the state of Wisconsin, and especially here in Madison — well positioned to create the future of health care, one that makes a lot more sense.

IB: Thank you. Jim, how are hospitals faring under the present payer system and with the present allotments for fees, etc.?

WOODWARD: I would define it as a system which we have adapted to, but if you look at the impact of the economy — which has really pulled the scab off a number of areas in health care that had been weak for some time — these set of circumstances are really hurting a lot of health care organizations. Bad debt is up 20%; charity care is up an equivalent amount.

We are all, as integrated delivery systems, trying to take cost out of the system. At Meriter, we're taking about \$4 to \$5 million out per year. You run up against a wall, though, where you can't do any more without dramatically changing your core business or letting programs go, which hurts the community, etc.

There's a survival mentality in health care that physicians and hospitals have been under for probably at least a decade. We've adapted to changes that have been coming. My concern is that what we're facing now is being forced.

I think this August deadline is not achievable, to come out of it with anything really realistic. It's probably achievable to come out with a series of blueprints. Let's pick and choose what might work, cost it out, see what the impact would be, and study it for a period of time.

My concern is that the energy behind it right now is to come up with a bill that's passed that can begin to be implemented quickly. From that standpoint, there are a lot of stakeholders jockeying for position right now. Some are going to be in, some out.

Large employers have been, generally as a group, opposed to paying in to any kind of pool to help small employers. Wal-Mart broke from the pack recently. The insurance industry too, and the AMA and others. But I think you're going to see some splitting off within those groups.

So I think that as health care institutions, we have been able to maintain operations. I wouldn't say there's been a large expansion of programs and services.

We've been trying to reduce costs, make ourselves more efficient in preparation for what's coming down the road, not knowing what that is.

IB: Craig, how is this impacting the services Dean Health Systems provides?

SAMITT: We talk about health care reform and the notion of a cost conundrum; actually, there are many conundrums — cost, quality, and also clinician conundrums. On the provider side, physicians sense they're on a treadmill with the way that incentives currently work; [our present] system rewards "more"; it doesn't reward "better."

Our reimbursement methodology for doctors is to pay for more procedures or to pay for more visits, and frankly, it doesn't pay for some of the value-added services that physicians should provide, focusing on wellness or prevention or population health. So the phenomenon we find is that doctors are working harder and harder and harder, generating more and more services — not necessarily generating higher quality care — and being paid less and less and less per service, which is not sustainable.

The lack of alignment of incentives within the various parts of the health care industry is really driving us over the edge. And so, from a reform perspective, we would embrace it. We think something has to change. I agree that I don't believe the problem is going to be solved in August. I think it's going to be Phase I of a multi-phase process. We'll have a framework, make a dent in the uninsured, a dent in the cost conundrum, a dent in alignment of incentives, but the reality is that there are so many stakeholders resisting any change... that changes are going to need to happen little by little, year after year, until we get to where we need to be within the next few years.

WOODWARD: Would you agree, Craig and Frank, as two physicians in the room, that as a society, we have to be comfortable, each one of us, with a lot of exceptions being made? For any kind of health care reform to be successful, we're going to have to give up access to some degree in terms of certain tests?

You know, we may not have the luxury of speedy access, of certain things we've enjoyed as a society. Right now, when you need health care, you go out and you get health care, for the most part. But do you think that's going to change under any kind of national health care system?

Less is More

SAMITT: I actually think the current American paradigm is that "more is better." That's the paradigm we have to break. More hospitalizations are not better; infections occur in hospitals. More surgeries are not better; there are complications to surgery. More testing is not better; there's radiation exposure from extensive testing.

I think Americans feel that more care equals better care; there are numerous examples that less care, in many cases, equals better care. We will need to live with less, but without it compromising quality. I think it will enhance quality.

WOODWARD: I would agree.

BYRNE: I agree that there's a better "less" out there for all of us, Jim. And your comment is valid that — for those of us who are insured — if we need something, we go out and get it. But there's an increasing number of people who don't have insurance, who don't have that access, and their access to care is the emergency room at 11 o'clock Sunday night, and that increases cost.

One of the things that we haven't touched on — you asked for the physician perspective — is what we really need access to is primary care. That's got to be a fundamental fix. Whatever is done with the system has got to make it attractive to be in primary care, because that's what we need. Look at what happened in Massachusetts; they passed coverage for everybody. Guess what? A lot of people are still getting their primary care in the emergency room at 11 o'clock Sunday night because there weren't enough primary care providers to take care of everybody.

We're in a better situation here, whether it's through our St. Mary's/Dean ventures or the work that your organization is doing, the Family Medicine Residency where two-thirds of the residents graduate and stay in the service area. But we've got to provide better access to primary care for everybody.

WOODWARD: I heard an interesting, sobering statistic recently for patients who have a medical home [an alliance with a primary care physician] versus patients who don't. The cost of care for patients who don't is 33% higher. That's a huge opportunity. That's an area to be focused on and drilled into. We know that's a problem, access to physicians and how patients are seeking alternative care.

SAMITT: We received a July communication that Medicare is looking to reset reimbursement with a bit less to specialists and a bit more to primary care. I think primary care physicians will readily say that their respect, recognition, and reward has really diminished over the years [yet] primary care is vital to really focus on the total patient and overall population management. We don't do that well in a fragmented system where a patient will jump from specialist to specialist.

MARTENET: Is it a fair statement to say that better quality, higher-quality medicine costs less? [All three physicians "absolutely" agree.]

IB: You're a stakeholder, Steve, with Blue Cross Blue Shield. What are your cautions, hopes, and fears?

MARTENET: I really endorse the idea of addressing this issue. It's 16% of the economy. It directly affects businesses and the quality of peoples' lives, and I think everything said today is spot-on with what the issues are.

I think of health care costs as the air in a balloon. Initially, what I thought coming out of Washington would be "Let's have a thoughtful discussion and debate around what's driving the health care costs." Eighty-seven percent of the premium dollar collected goes to paying hospitals and physicians and ancillary providers. So I was hopeful that the discussion would be how we manage that 87% of the spend.

The debate's gone to insurance reform, as if correcting that will correct the cost issue. Look at the system we have today: About half of what providers get is through public programs — Medicare and Medicaid. And you see what's happening with that. So the government does have a single-payer system [that is] not addressing cost issues.

Our role as a private sector is to make sure we're providing full disclosure, so we can arm our consumers' members to behave like consumers and choose the highest quality, highest value type of care for them. It's to create plan designs that really benefit our members if they go to higher-quality type of providers, get the care, and make sure the incentives are in line.

So I think [it's about] working with our hospitals and physicians to make sure that we're aligning the incentives to fairly compensate for a higher quality care and [the] primary care physician's role.

So it's to help create a marketplace for services and making sure that as a payer, we're paying for higher-quality type of care in the right setting at the right time.

IB: Chris, what does all this means to you, coming from a quality and transparency movement?

QUERAM: There are a number of important themes that have emerged already that resonate very directly with the core mission and the core value proposition of the Collaborative. Some of the most seminal and significant health services research over the last 20 years has been done by physician researchers at Dartmouth who have highlighted very profound and very significant differences in the quality and the cost of care on a geographic basis across the country. Recently, in conjunction with President Obama's visit to Green Bay, there was a lot of interest in how various regions in Wisconsin compare to other high-cost regions around the country. The quality is higher and the cost is much lower than is true in other parts of the U.S.

Central to health reform concepts is getting a handle on this regional variation and looking to promote some of the concepts, structures, processes, and systems in place in the upper Midwest — Wisconsin, Minnesota, and Iowa — shown to impact quality and cost in a very significant way, and spread those throughout other parts of the country.

I would be quick to add that we have significant challenges in doing that. One is a public perception that more is better, and that there is a tendency to associate positive feelings and attributes toward health care institutions that cost more — or interventions that cost more — because that is perceived as being a Lexus, Cadillac, or Mercedes level of quality. And I think the evidence would suggest that that's not the case.

The other area important to emphasize is that of comparative effectiveness. One of the most critical elements of what's being considered in the health reform proposals is the idea that we have much to learn in terms of how to inform the practice, the organization, and the delivery of health care based on rigorous and objective evaluations of what works. Right now, we don't have a good sense of whether it's

medications or treatments or interventions — or even some of the delivery system reforms that characterize much of how health care is delivered in this state and this region of the country — how that compares from an evidence standpoint to alternatives.

Transformative EMRs

IB: Could being more reflective with the use of electronic medical records, where we might identify the group aggregates we need to study, reveal the locations and impacts of best practices?

QUERAM: I think without question health information technology and electronic records have tremendous potential to be a positive part of the transformation that we're talking about here. And again, Wisconsin tends to be far ahead of other parts of the country in the adoption of health information technology.

At the same time, I do think that we have to be realistic in how quickly we expect to see some of the returns on the investment and health information technology because much of the country, and even parts of the state, are lagging behind in their adoption and their implementation of HIT. It will, in theory, simplify the process of extracting information for purposes of quality and cost measurement, and it will bring better information to point-of-care or point-of-delivery decisions that physicians and other caregivers need to make on a moment-in-time basis. But I think we're a ways away from realizing the promise of that vision.

SAMITT: I think that we have a lot of things going for us, including the incredible penetration of electronic health records already in the state. And Steve talks about the alignment of incentives: Wisconsin, more than many states, already has tremendous alignment between payers, providers, and hospitals. But I'd be curious to hear the rest of the group's perspective on what makes Wisconsin better, because it clearly, by all means of measurement, is evident that we provide better care at lower cost.

QUERAM: I would say there are two things. One, a culture of group practice in terms of physician organization and delivery of care. The statistics may be a little bit off, but I think close to 50% of the physicians in this state practice in 20 organized multi-specialty group practices, which is quite different from many other parts of the country. And evidence has been shown over the years that organized group practices tend to have a higher quality and cost-effectiveness of care than disaggregated models of practice.

The other is — Frank and Craig are examples of this — physician leaders in this state have embraced health care transformation at a much earlier rate I think than is true in other parts of the country. It might be a reflection of the culture of group practice that creates a little different accountable care organization and accountable care philosophy. But I think that's a critical part of it as well.

BYRNE: I would agree we have a heritage of integrated systems in this state. Virtually every part of the state, except for eastern Wisconsin, is pretty well covered. And now there are things being done over there — hospitals, physicians, having a payment mechanism to allow being an accountable care organization,

where you can accept a payment from a family and say, we'll help you manage your health. That's important.

There also is I think a sense of stewardship here. In the Madison area, the health care community has worked hard to be responsible stewards of the resources entrusted to them by the community. We don't have a lot of resource destructive competition. We have a much higher degree of collaboration and avoiding redundancy that you can see in other markets. Those are important factors as well.

IB: Kathryn, you host meetings all over the region with Thrive. What is your view?

OTTO: I take a business perspective of health care as a competitive advantage, looking at costs and quality and access. National discussions seem to be focused on the rate of the uninsured, and the cost of private insurance. While they're interrelated, they're not the same, and neither one really gets at the underlying issue important to the business owner — that private insurance is expensive because health care is expensive, and because of the cost-shifting from the governmental programs and from the uninsured.

There's some value in reform in some individual markets, but the pieces that address more the cost of the health care that's being delivered can be most transformative. One of the areas that jumps out is support for health and wellness. We need to get a better handle on our own health and how we interact with the health care delivery system itself. Let's reduce the number of people who develop diabetes, for example. Let's get at the underlying health as opposed to, "We have excellent quality treatment when there is a disease or an issue." Let's keep people from even getting to that point.

Yes, We Should Take it Personally

MARTENENT: One thing not talked about yet is personal responsibility. So 70% of health care costs are tied to chronic conditions like diabetes and asthma. What are individuals doing to make sure they're educated in what that chronic disease is, what they can do to help manage that, being adherent to the medical protocol, the therapies? I would imagine you see a lot of patients who aren't adhering to the therapies and they end up in the emergency room.

Is that an employer responsibility or is that an individual responsibility? Regarding my auto insurance, I know if I have five tickets and have been in a few accidents, it's going to cost me more. We've kind of insulated the [health insurance] member from the consequences of their behavior because of the way we finance it.

And I'm not to say that's to move away from the group insurance concept or get the employer out of it, because we've seen that where the employer is more involved and has a top-down approach — where CEOs are leading the charge — they end up having better results on their health care plan. And they educate their employees more about the costs.

For a lot of employees, it can be as simple as having them understand this is a benefit that we pay for as an employer. This is how much it's costing us. These are

the things that you can do to help take some of the costs out to moderate the premium increases, and things of that nature.

But I think that's the other piece that needs to be talked about: What's the individual's responsibility to choosing the right providers, making sure they're getting into treatment protocols, doing what they can do to live healthier lives so they don't end up in a catastrophic-type situation?

IB: Does the shift toward higher co-pays or higher premiums make a more responsible employee — or does it further reduce access?

BYRNE; It depends on your income level.

OTTO: There can be very intelligently structured benefit designs that support those people who do have specific disease states, making sure that they don't have the barriers to getting the care within the health care delivery system, but also understanding that's not the only touch-point for what impacts their health.

One of the things that I wanted to jump back to — a few people pulled out the "integrated delivery system model." Let's be explicit about what that means. Correct me if you want to use different phrasing, but the provider-owned health plan is not the only model out there [though it's] very, very strong in the Madison region.

We have five very strong health plans structured under this way; the entities who deliver the care are also the owners of the health plan itself.

And while that integration or alignment leads to some of the better quality outcomes and costs for this region, it also is a unique opportunity for us collectively as a region to start to shift things and to do things differently. But we need to be a little bit explicit about what that model is.

SAMITT: And I would tag onto the notion of alignment. We use the expression "shift of responsibility" and I would argue that it's not a shift we want. It's an expansion of everyone's responsibility.

Let's take diabetes and cardiovascular care as a great example. Are patients themselves responsible for preventing diabetes? Many are not. Are employers responsible for preventing their employees from having diabetes? I would argue not. [Though] look at what employers serve for snacks. Are physicians responsible for preventing diabetes or cardiovascular disease?

I would argue no, not in many groups. [Though] physicians tend to be more rewarded for the complications of diabetes than for the prevention of diabetes. And hospitals are rewarded for hospitalization of diabetics rather than avoiding hospitalizations for diabetics or avoiding re-admission.

What we need is a system where we all become responsible, and there's an alignment of interests to prevent disease rather than treat it, just treat it.

BYRNE: When I was practicing pulmonary medicine, I was actually reducing the billable services by teaching asthmatic patients how to manage their own disease,

which is a good thing. It's been shown that by educating asthmatics, you could reduce their days lost from work and school, and their overall health expenses by 40% — beginning tomorrow morning — with good education.

We also know that people who don't have insurance, or the people with poor coverage seek care later and they have worse outcomes, so their high blood pressure isn't as well controlled and they have more strokes and heart attacks. Their diabetes isn't as well controlled; they have more blindness, kidney failure, and amputations.

We don't know for sure what happens in the co-pay/deductible situation other than the fact that we do know that people at lower income levels, as their employer raises their cost, tend to drop the coverage. And that leads them to be uninsured, and we know what happens there.

One of the things that some creative companies are doing is to provide greater subsidies to lower-compensated employees to make sure that they stay insured.

Also, there are some pilots, including one we're doing with the Dean Health Plan, to waive the co-pays for diabetes supplies [resulting in better] compliance rates.

Sharing Reform

WOODWARD: I think we need to go back to a comment Steve made. When we start talking about shared responsibility, in order for any kind of health care reform to be successful, it's going to be completely a shared responsibility.

I'm at the table not only as a health care provider, but also as an employer of 3,200 employees. And we see our health care costs going up, and having to ask the employees to share more of the premium, etc. And we do have the benefit of also being the insurer and understanding some of the demographic information we see.

So if the airline industry can charge an obese patient a higher premium for their seat, is it not fair to assume that patients or health plan enrollees who still smoke or are morbidly obese have behaviors counterproductive to controlling costs and also to their health care? Should they pay a higher premium? That's a question a lot of previous health care debates have really tried to sidestep.

Frank makes a good point that the flip side of that is, you price them out of the market to the point where they drop everything, and then are you creating a worse situation. So I don't think we have, as a society, an answer to that yet.

But I think that we have, as insurance companies, tried the carrot approach of wellness programs and providing free benefits to many enrollees in health plans to encourage better care management. But the stick approach hasn't really been used that much. I don't know if, as a society, we're ready to do that yet.

IB: How much longer, then, would small businesses continue to participate as an insurance provider without hiring bans — real or implicit — for who would raise their premiums? I foresee discrimination cases, particularly in Madison. What is the employers' role in this? What do you think it should be?

WOODWARD: I think if you look at some states — Maine, Massachusetts — going back to this whole concept of medical home, is there a base or a core benefit that small employers should be offering? Then have some kind of [individual] opportunity to buy up from there, based upon what your specific health care issues are.

I think that's been shown to have some traction. But again, if you don't have that primary care physician coordinating your specific health care overall, the cost is going to be substantially higher. Is that where we should focus small employers? And then maybe the federal government needs to have this pool for the more extreme or more complicated health care conditions. Lots of issues with that too.

QUERAM: My sense is that one of the key lessons that we've learned from the last attempt at comprehensive health reform is that we should not jettison a system that is, for better or for worse, working for a significant percentage of the population. And I am not hearing anything certainly from large, multi-state, national employers that suggest that they're looking immediately for an exit strategy from offering a health insurance benefit.

I will acknowledge that the comparisons between a large, multi-state, national employer and a small, local employer are very different. And the solutions that have to be developed to address the differences in those demographics have to be equally creative; that's one of the emerging themes of health reform.

The insurance industry has stepped forward and they've talked about eliminating the ban on pre-existing conditions. There's been some suggestion about comprehensive rating reform to lean more toward a community rate as opposed to an experience rate. Whether that's done at a national level or a local level is yet another question.

And then there's the third rail of health reform — the public plan. The possibility of some type of alternative mechanism that would make it available for individuals people who work in small companies, to have access to a basic benefit package at an affordable price. There are some interesting, creative ways to structure those.

But whether we're talking about restoring the primacy of primary care or making it more attractive, or the concept of shared responsibility in terms of all stakeholders, one of the realities in this attempt at health reform is an acknowledgement that we have enough money in the system. There should be no more new money invested. If anything, we have a challenge to constrain costs.

All of the great ideas that have surfaced here come at some expense. In order for us to make primary care attractive, almost by definition, we make specialty care less attractive to medical students and residents; that gets into very difficult issues of income re-distribution.

Are we ready as a society to risk rate premiums and create an incentive through financial pricing of an insurance product for people engaging in lifestyles and making personal choices that we know are contributing to health care costs, to make them pay for that? That's likely to be an important part of the equation. My personal definition of a successful outcome of health reform is that everybody feels

a little bit of associated discomfort and pain. Otherwise, I think we're likely not to have a series of changes that will be sustainable.

Front-End Alignment

SAMITT: Going back to the employer-based system, and then the notion of a public plan option, I think efforts to change both are really misdirected. I don't believe they will contribute to a fix to the real underlying problem, which is that we need to provide better value in health care.

We should be focusing our efforts on aligning all the various elements of the system, and rewarding those who provide better care more efficiently. There are other efforts that can really remove the barriers to better care at a lower cost, and that's where we really should be focusing our efforts. Sure, we could change the employer-based system. Is it ideal? Probably not. A public plan option has a whole other array of complexities, including the government playing a more significant role in health care delivery or health care insurance.

But I would argue to let insurers, hospitals, and physicians compete for consumers based upon their demonstrated ability to provide better care more efficiently. And I think that there are many obstacles to that happening, and that's where we should focus our efforts.

IB: Is one barrier the mindset that better care might mean I get the tests I want from the doctor that I want, when I want it? The perception of what "good care" is.

BYRNE: There's no question. Often, I'd have to do Health Economics 101 conversations with my patients. "Come on, doc, why are you giving me that \$7 antibiotic for my bronchitis? Why can't I have that \$56 antibiotic I got when I went to Urgent Care? I got insurance." And then you'd explain that the difference is money their employer is not spending on their salary, benefits, new product development, marketing, research, and things of that nature. So they are paying for it either way, and the \$7 antibiotic will work just fine, thank you very much.

SAMITT: And we may see an alignment of interests or change in benefits. We've already seen that with tiered co-pays for pharmacy benefits, with consumers paying more out-of-pocket for a brand drug.

But, you know, the airline business is considering charging more for an exit row seat or an aisle seat. So it's not unheard of to think that if you want a sort of high-demand appointment spot with a doctor, it could be a higher out-of-pocket expense than a less desirable appointment time; that it's not equal. And so, we may very well see a change in benefits and interests that achieve more alignment.

OTTO: I'm hearing that health care reform is not all encapsulated within legislation. There's definitely a role for public policy, a role for the health care delivery system to make internal changes, and a role for a culture change in personal accountability.

IB: And who spearheads that last point? We can look around the table and see who would be working together on everything else. What is the role of business in that?

Does it start with employers? Is it the doctor with the patient? Is it the health insurance company with the provider? Who changes attitude?

SAMITT: I would argue that health care reform is happening from two different directions. There are all the discussions about external health care reform that's being legislated. But I would argue there's a tremendous amount of health care reform that is happening from within — that hospitals, payers, physicians are becoming closer and more aligned and integrated. You know, the employer community is focusing more on wellness. There is discussion about alignment of patient interests.

And so, even in the absence of external legislation, we're already beginning to see improvement of quality and greater efficiency in Wisconsin. And it's not long before all of Wisconsin needs to look like that. If many markets within Wisconsin are better care at a lower cost... but there are some communities that are not. For them to effectively compete, they're going to also need to be better care at lower cost.

And then, once Wisconsin has better care at lower cost, other states are also going to need to improve their performance to effectively be able to compete. So I think it's happening from two different directions simultaneously.

MARTENET: I like Craig's comment about expansion of responsibilities. It's a shared responsibility. And I think it's a cultural change; the employer's role is to support everything we talked about. I know there are access issues and they want to provide all their employees the optimal access. But, when making purchasing decisions, drive those decisions toward higher quality, more efficient, lower cost of care. [The employer's] responsibility is making sure there's a workplace environment that supports everything we've talked about — whether it's increased transparency, more full disclosure, [and] screening to try to identify that person who's diabetic. So if they do discover somebody, we can get them in the system, get the appropriate care, and they can begin managing that.

BYRNE: Again, we haven't resolved your question about the small employer, which is the most difficult space to be in right now economically, because they don't have access perhaps to the more preferred insurance programs and pricing that a large employer would get. It's really bringing them to their knees in terms of their ability to retain employees and to offer health benefits at all. And some of the things that have happened as a result of health care costs [have become the] excuse to off-shore manufacturing and things of that nature.

So we all have to work together on this. I don't think the employer has the ultimate responsibility for managing my health. I have the ultimate responsibility for doing that, and I need to be a more informed purchaser of health care services. Thanks to WCHQ, I can do that, and thanks to the WHA's price-point and check-point for hospital costs and quality.

As a practicing physician, the most frustrating type of patient I found to deal with was the passive patient who felt that their health was my problem. The most satisfying patients I worked with were ones that saw this as a collaborative team effort — that we were going to work together to make them the healthiest and

most productive they could be. And again, asthmatics who took control of their own disease, patients with chronic obstructive lung disease who stopped smoking, went through pulmonary rehab, [and] took their medications properly were much happier and had better health status.

So, as Steve says, we all have to work together. We are positioned here in this community and in this state to do that. That is our culture, our heritage. I've been in meetings where we've made progress by getting together and talking about some of the statewide health initiatives and sharing health information. We've had meetings in this state that you couldn't get the people in other states in the room without security being present.

We can create the future, and I'm optimistic. If you look at the different pockets around the state, the Madison market costs 20% less per employee for health care than it does in other areas of the state.

Putting Consumers in the Loop

IB: How do we become an informed consumer? And what are my options? Let's say a friend told me that a PET scan was a "must" for her from her doctor, and my doctor is saying he doesn't like to use them for diagnostic purposes. Agreeing not to have cookie cutter tests — is that the sign of a smart consumer? How am I to know when I'm an informed consumer? That I'm smart about health care?

BYRNE: There are plenty of good resources out there. We [health care providers] took ourselves out of the loop 10 years ago by being stingy with information rather than sharing it more broadly, but we've clearly gotten over that. So we have provided our quality information publicly. Granted, there's a lot of stuff that's not accurate on the Internet, and health care is one of the main things that people go to the Internet for, but there are trusted resources you can use from your health care providers.

There are trusted resources for support groups. There is advocacy, for people with specific disease processes, whether it's cancer or cystic fibrosis or diabetes; there are trusted resources out there through the national health care organizations and advocacy groups, and things of that nature.

And your health is a dialogue. It's my job, if you come into my office, as a physician, I don't mind trying to convince you that the \$7 antibiotic is fine, and that you don't need a PET scan. I don't mind that at all.

If you're receiving health care from a provider who takes offense with that... I'm so old that there was all print in the old days, and somebody — usually a woman — would come in with an article from *Prevention* magazine and we'd sit down and read it together. That was the 1980s. If I liked the article, I might copy it and give it to other patients, and share it with them. And they say, "Well, I go to another doctor and they won't engage in this dialogue with me." Well maybe you're not with the right provider.

SAMITT: I think this will require a cultural change in the provider community as well. You know, the frank reality is [that] it's easier for the doctor to order a PET scan than it is to explain to the patient why a PET scan wouldn't be a first choice.

It's easier to say, "Yes, I'll replace your knee" or "I'll replace your hip" because you're having some pain when you play golf, than it is to describe the potential complications of an early joint replacement when you're young, and the benefit of medical management for awhile.

So I think culturally, for both patients and doctors, we need to focus on shared decision-making and recognize the value in better communication, better time to describe the ramifications of clinical decision-making.

It's certainly where we're going at Dean. And I think that all integrated delivery networks, to some degree, are really looking at the importance of better communication with patients and better shared decision-making. It's inevitably the way of the future for us.

QUERAM: I want to weigh in from a slightly different perspective. The Collaborative has had the great privilege of being involved in several national projects that are sponsored either by the government or by major funders.

And the whole notion of "consumer engagement" is salient to all of these projects that we've been involved with.

And while I agree with Frank, and Craig made some very important points, I would say that we've just scratched the surface in terms of making information available in a way that people can feel comfortable using it. And I would also agree that there is a huge cultural shift that needs to take place because we have created a mystique or an aura around medicine that my parents certainly reflect. I think, for many people in this country, you never question your physician or you never question your provider.

So I do think that not only is it a matter of making information available, but it's going through very important educational efforts with individuals, whether it's through the workforce or through other means, to get them to feel comfortable asking for information, having their choices listened to and respected. It's a [new] notion that people are in a position to have more control or more influence over the course of how their condition or their procedure is managed.

IB: What about the physician's view of their roles, and the traditional systems in place? One of my past primary care providers walked in, looked at his watch and said, "Sorry, I'm late. I'm double-booked all day. So what exactly is your problem today?" And there is this sense that you've got two minutes.

How can we develop engaged consumers if you still have models in place that reinforce physicians for the number of patients seen in the shortest time? Is there progress on that, or is the physician still expected to see x-amount of patients in a day?

SAMITT: It goes back to what I said earlier that physicians feel that they're on a treadmill. And we have to stop this notion that more visits, more services, more surgeries, more procedures is better care, because it's not.

I would rather our physicians take all of the time the patient needs to get all of their issues addressed so that they don't need to come back multiple times or see multiple providers for those services. I'd rather have a single visit where a patient can get the full scope of services that they need.

Likewise, there are many patients who come to the doctor that don't need to come to the doctor. We need better communication, better resources, so that patients can get care through other means, self-care, home care. Often, patients will be referred to a specialist, and by the time they arrive in the specialist's office, their clinical condition is resolved.

So we need to really remove the waste from the health care delivery business, and there's a lot of it.

IB: It goes all directions. I was scheduled to see a specialist as an ongoing care program, and told the nurse that I also needed a prescription for a bee sting kit, which this doctor routinely gave me annually. The nurse was very clear that I should not be asking him for that; I should make an appointment with a primary care physician, another appointment, another doctor.

At what expense? My need of the kit is fully documented and it's not a new discovery. Who is the controller of costs here? And my time is valuable, too — why should I have to schedule yet another appointment when there is no exam involved?

SAMITT: You shouldn't have to.

WOODWARD: That's the simple answer.

IB: This attitude, which is still prevalent, in my opinion, is just adding cost and expense to your own system. The doctor was willing to write it "just this last time" but everyone involved was offended by the request or answer.

WOODWARD: We've created — and I think we're still promulgating — this system of primary and specialist, and there's the shortage of primary care and an overabundance of specialists.

And if you talk to UW, no one is electing to go into general surgery. They're all electing sub-specialties within surgery. Nobody's electing, that comes out with internal medicine, to stay in general internal medicine. They're going into medical sub-specialties because the reimbursement is better, the pay is better, etc., etc., and it's probably more interesting for many physicians.

BYRNE: The opportunity to pay back your overwhelming amount of education.

WOODWARD: Student loans, right.

BYRNE: Neither program in the state has sent an internal medicine resident into general medicine practice in over four years now, right?

WOODWARD: Yeah, I think it has been.

SAMITT: And what's ironic about that is the statistic that Jim gave earlier, which is that the care is often more efficient and of higher quality when it is provided by a generalist, as opposed to a fragmented system of care that involves many different physicians.

BYRNE: Some of us, and each organization represented in the room, can talk about what they're doing. We believe that so strongly that we're substantially subsidizing the development of primary care because we know that's essential for creating the future that we all want for the people in the communities we serve.

So whether it's our St. Mary's/Dean Venture, regional primary care practice — whether it's the sponsorship of the UW Department of Family Medicine — we believe in doing those things. We've just got to get to it, because we believe there's going to be a system that will make more sense in the future.

IB: Give us the nurse practitioners for bee sting kits. Hallelujah!

BYRNE: No question about it. When you talk about primary care, we're not just talking about physicians. There are also other great providers. My wife, for example, was just raving about the visit she just had with a nurse practitioner for routine things.

MARTENET: I think you've heard a lot [that speaks] to your question. There's not an easy, quick fix, but we've got to start somewhere. And I think it starts with active participation in the delivery and the care that you receive.

We're fortunate in Wisconsin. I mean, we've got one of the lowest uninsured rates in the country, 10%. That's too high. I think we should commend the governor for some of what they've done with expanding Medicaid to cover more folks.

When you break down that uninsurance, the small [employer] group is probably under 15 [employees] where it's most acute. And those folks just aren't struggling with paying the health insurance, but really just staying in business in general, and all the issues that come with that.

As a trade association in conjunction with everybody here, we've talked about possible solutions and thoughts around what we can do to at least drive a more affordable product so more of them can offer insurance. But I think at the end of the day, if you look at the uninsured rate, about half of it would be folks who truly can't afford insurance and don't qualify for public plans. A quarter of it are folks who qualify for public plans but don't take advantage of it. And then probably a quarter of it are folks who can afford it, but they just choose not to do it.

So what do you do to get to those folks? Lower income folks shouldn't contribute the same amount as the executives within the company. And so, I think there are some things that employers can do immediately to try to expand that. But at the

end of the day, it comes to affordability and what are we going to do collectively, as an industry, to insure or to deliver on high-quality affordable type of care.

Because I think what I heard today is: There's enough money in the system. It's how we're spending the money that's the issue. And if we can spend it more wisely, can we get more people covered? Then that leads to good things for society in general.

And in Closing...

IB: Thank you all. I'd now entertain any closing comments, because we've been in a free-flowing conversation to this point in time, but each of you likely has a point in mind you'd like to drive home for our readership. Craig?

SAMITT: I'll start. Touching on many of the comments that have been made today, I actually think that Wisconsin has a tremendous opportunity to set an example for the rest of the country. I think there are many elements of the way many of our organizations, and many of our communities, are already practicing, which is forward thinking and compatible with what many of us feel health care reform should look like — better integration, better quality, better efficiency, better employer and consumer engagement.

Now, we have a long way to go, but I would argue, when we look at many of our communities in Wisconsin, we're well ahead of where many other markets are.

OTTO: I'm going to echo some of Craig's comments.

I think the topic can feel very, very overwhelming. I think it can make us feel rather powerless. But I think, especially with what we have within this region, within this state, it can actually be very empowering. Think about the different areas in which health care reform can take place — the public policy, the health care delivery system itself, and the culture change. We can all do something. It's all within our own power. And we are uniquely positioned to make a difference.

WOODWARD: I would piggyback on that, as we're going around the table, and just say that I do think, and I have felt for a long time, that the likelihood for a successful outcome for health care reform is going to be more likely to occur more successfully in a shorter period of time at the state level than at the federal level.

And I would hope that the federal government, in pursuing very aggressively — which I think does need to be done — an approach to health care reform, would study some of the state efforts; what's worked in Wisconsin, what's worked in other states, what can be learned from that and adapted on more of a federal level.

But health care, I would argue, is the most complex business that exists in the country. What I worry about the most is the proposed pace of change for a multi-faceted problem.

There's a lot to learn from states. There's a lot to learn from other countries. The shared responsibility that we talked about and the success that's occurred in many of the states is there. And I think it's a textbook that's worth reading in the country before some large-scale changes are made that we may have to step away from at

a future point in time, or may end up not providing the benefit that we're looking for in the end.

BYRNE: I'm excited about the future of health care, specifically in our community and our state, because I think we have the pieces in place to do this right, to be the example.

Something has got to happen. The current system is not sustainable; it doesn't make any sense. We have the huge investment in health care in this country, but we don't have the outcomes to show for it — whether it's infant mortality or chronic health status or anything else you want to measure.

And I'm just excited to be here now. There's never been a better time to be in health care, either, as a provider, a physician, a nurse, or as a health leader, because we can do something.

We have to do something. So let's get on with it. It may not be perfect. It definitely won't be perfect, but nobody is lobbying for the status quo. That's the momentum; I think we've passed the tipping point.

Nobody is lobbying for the status quo.

Two reasons health care reform has failed in the past is, number one, everybody's second choice was the status quo. Everybody wanted something different — each of the different interest groups, and even individuals, wanted something different — but their second choice was the status quo. I'm not hearing that now.

Number two, people who had access to health care were not willing to put that at risk to invite everybody in. And I think everybody realizes now with the economy, with the rate at which people have lost their jobs and their health insurance, with the people who are afraid to change jobs because of insurance issues and things of that nature, everybody realizes that what they have is at risk, so we better do something. So let's get on with it.

QUERAM: Jody, I would comment from this perspective. Much of what's been said is important. Not to reiterate, I agree with it.

I recall reading once that there are several different approaches to accomplishing the type of significant change that we've been discussing in this roundtable. We could try a "professional model," where we rely on the industry and its various components to take the leadership and change. We can rely on a "market model" where we rely on the free enterprise system to conceive the strategies and the solutions. Or we can try a "regulatory model."

Or, we can look for the right calibration of all three.

I think, implicit in what's been said here today, is that we need to have elements of all three brought together in a way that's calibrated and synchronized so that we build on what's working effectively in this state and elsewhere in the country — but yet adopt innovation or adopt other changes that will lead to positive, structural change.

I would say that strategically, my concern with what's being discussed at the national level is that we are focusing perhaps too much on coverage expansion and not enough on cost control. And I do think we have to have a significant commitment to cost control.

And from my way of thinking, one of the most critical elements to accomplishing that — and it gets to a lot of what we've talked about here today — is payment reform.

I do think we have to move away from this emphasis on production, this emphasis on services, and create an environment where patients and their practitioners can come together in an environment where they have the time to really work through a particular condition or a treatment and develop the best strategy and solution for its resolution.

But we have much to build on and much to feel very fortunate about here in our state.

MARTENET: I appreciate the opportunity to participate today. I think in Wisconsin, we're uniquely positioned to make some meaningful headway on this topic. I've been in a lot of different meetings with a lot of various stakeholders in it, and at the end of the day I think everybody wants to do what's right for the community, for business — and that's improving quality of care, improving the cost of care, and getting to the affordability of care.

As a society, or as we talk about health care reform, we need to make sure we're focused on what's driving health care costs. The solution to it is not to pass a bill just to pass a bill, but to make some meaningful headway on how you get at costs and quality, and start taking air out of the balloon — or at least not having the air in the balloon increase at the same rate it has been historically.

So I think we have a unique opportunity here in Wisconsin. I think we're doing a lot of the right things, and folks should be encouraged by that.

IB: We appreciate your viewpoints and your willingness to share them with readers. Thank you for your leadership, panel.

Posted on IBMadison.com at <http://ibmadison.com/healthcare?id=194>