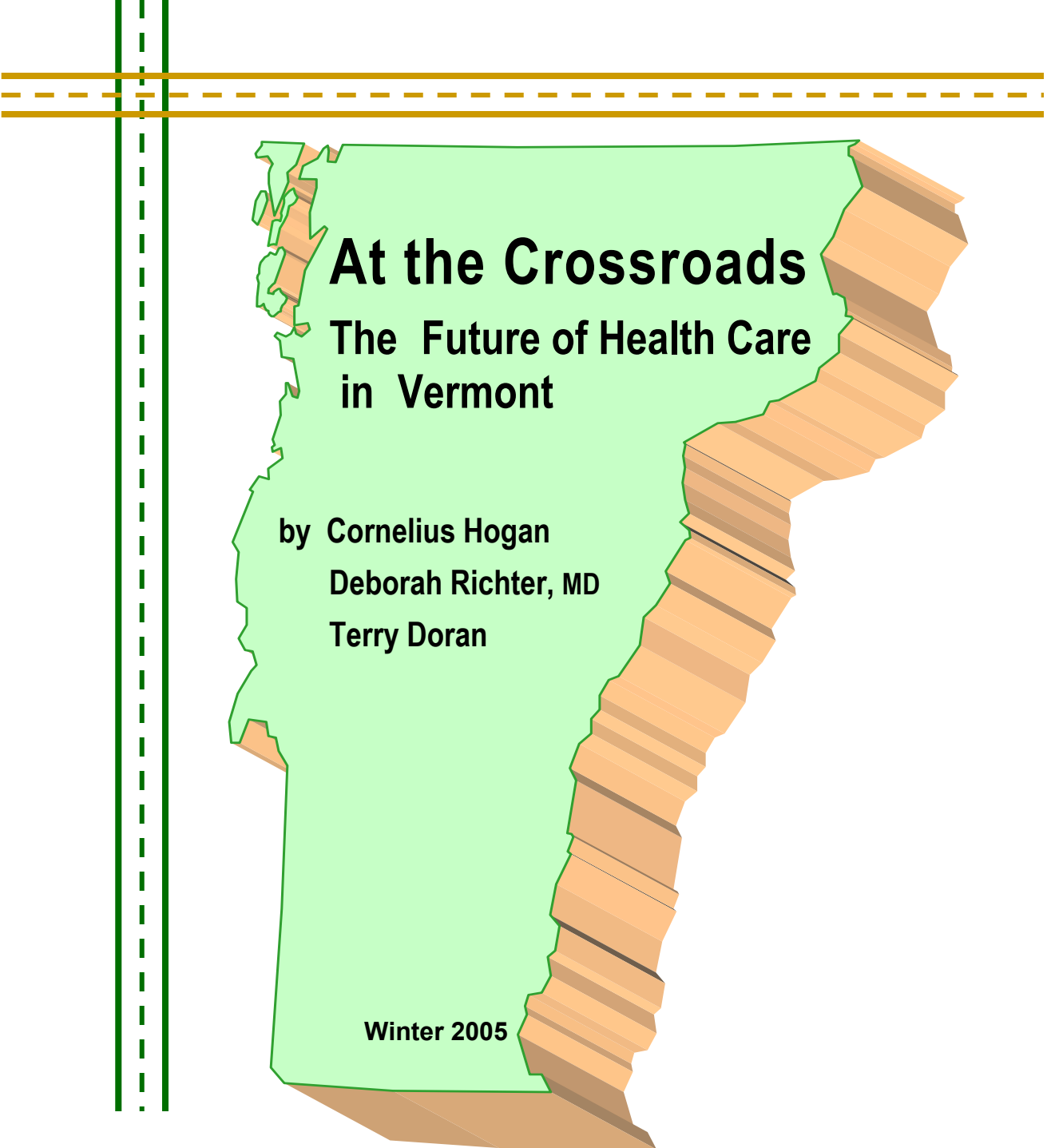




At the Crossroads

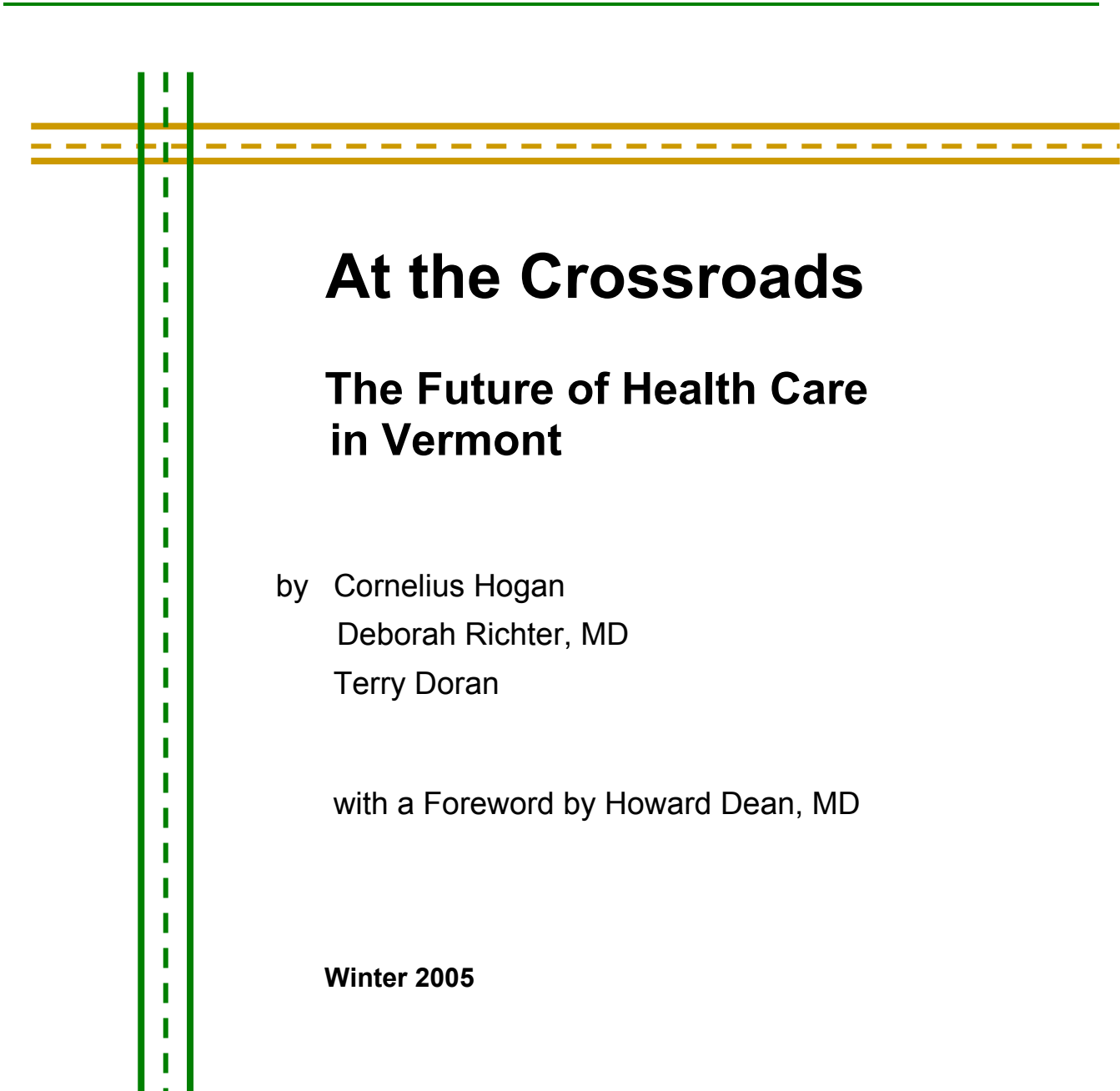
The Future of Health Care in Vermont

**by Cornelius Hogan
Deborah Richter, MD
Terry Doran**

Winter 2005

At the Crossroads: The Future of Health Care in Vermont
by Cornelius Hogan, Deborah Richter, MD, and Terry Doran

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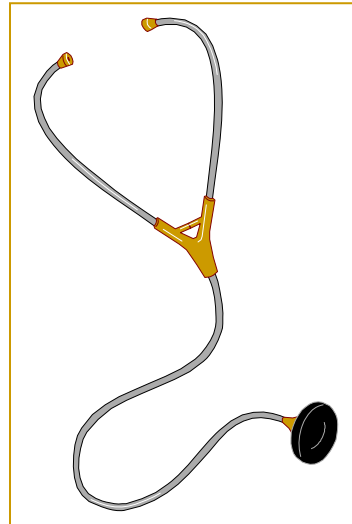
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with a Foreword by Howard Dean, MD

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Dedication



This book is dedicated to the physicians, nurses, and other direct caregivers in Vermont, who deserve a more rational system in which to do their healing.

Foreword



America is well into the sixth decade since Harry Truman made “Universal Health Insurance” part of his platform as President. At the time, most of the world's industrial nations either already had some form of health insurance for all their citizens or were on the way to developing it. Now we are alone among industrial nations in not providing adequate resources for health care and in having an enormous percentage of our population without access to medical services.

The best thing about this book is that it shows the way to make the compromises necessary for reform as well as the rationale.

Vermont is a state with a strong history of social responsibility and frugality. If universal access to health care starts among the states, as Social Security did, Vermont is the most likely state to take the initiative. We have vast experience in consensus building. Vermont is small enough that all the players know each other and so less likely to demonize each other's views.

Con Hogan and Deb Richter are veterans of the health care reform effort in Vermont and elsewhere. Deb is a strong single-payer advocate; Con is an incrementalist. Together, they have laid out a compelling discussion of how much all of us, particularly the business community, have to lose if we continue to fail at reforming our health care system.

Their book proposes some principles and actions for achieving real change in health care for both access and costs. I thank them both for re-igniting a reform effort in which America can no longer afford to fail.

HOWARD DEAN, MD

Preface



Like most problems that reach into every corner of society, health care is complex. All of us, at one time or another, are touched by the need for health care services. In what follows, the authors dispense with looking at the problem from an individual point of view in favor of a more general view. An individual point of view is limited to our personal experience.

Our contention is that for all of us to grasp the problem of health care in its entirety—and visualize solutions—we must set aside for the moment our personal experience. What we are suggesting goes against the grain. To regard health care from our own point of view is only natural. That's because the large majority of us seldom use health care services—maybe once a year, maybe not even that—until something happens to cause our need for medical attention.

When we seldom use health care services, we don't think about them, we don't consider their existence at all. Instead, what we may notice is our Medicare tax or our insurance premium come due or a co-payment. But how do health care services exist from year to year? What makes us so sure they will be there when we need them?

Answers are not forthcoming if we stick to our personal experience. That point of view limits us to something like: my insurance premiums are too high... my health benefits aren't good enough... other people must be using too much health care... physicians must be making too much money... I'm young and healthy so why can't I pay less for insurance... I take care of myself so why are my premiums as high as people who don't... and so on. But that's a litany of complaints not answers.

Over the course of this book, the authors invite readers to set aside their personal point of view for a far more general view. They will find that answers are found in this realm. Yet such a perspective is difficult to attain and hold. Our individual points of view are all too comfortable. What counts

most to us is what affects us. We are asking readers to step beyond their individual points of view and broaden “us” to include all Vermonters.

In brief, we begin by describing what is good about Vermont’s health care services. Then we describe what is going wrong, which is basically all in the fiscal sphere. Using state agency projections and analysis, we outline what can happen to our health care if we stay on the sidelines. After that, we give reasons why reform of something so large and complex is difficult and where opposition arises.

Having done that, we make a more detailed attempt to convert the reader’s perspective to a more general one. We offer this as a practical framework for understanding change in health care. We then outline what we have for health care services at the local, regional, and statewide levels—and beyond.

The argument then arrives at the necessity for a true health care system in Vermont, which does not now exist. Goals are stated, principles are given to guide us toward those goals, and working elements of a system are outlined. Within the confines of these principles, choices are offered. Topics addressed are responsibility, responsiveness, freedom of choice, cost control, budgeting, financing, local input, quality, benefits to Vermonters, benefits to the state, benefits to the economy, benefits to businesses, among other topics.

The authors arrived at a consensus after intense discussion of problems besetting health care in Vermont. Each comes to the problem from a different direction. Agreement on what to do and how has been hard won. All three of us see that finding common ground in a contentious subject is a good sign. This subject is especially prone to unexamined bias and distortion. We found that one of our consuming tasks was to beat back our own biases and glib assumptions in order to clear the ground for real discussion. We think we have done this.

The hope for this book, dedicated to the good people of Vermont, is to serve as a framework for understanding the complexities of health care, for initiating serious discussions of reform among all Vermonters, and for generating a realistic political process toward far-reaching change for the health of us all.



WE ARE:¹

Deborah Richter, MD, is a practicing family physician in Cambridge, Vermont. She first recognized the need for reform many years ago through her experiences with patients and has invested time and energy since to bring about reasonable change.

Cornelius Hogan, from Plainfield, Vermont, is past president of the American Public Welfare Association (now known as the American Public Human Services Administrators). He was Vermont's Department of Human Services Secretary for the 1990s and is currently an international consultant to governments regarding a variety of people-serving and organizational issues.

Terry Doran from Montpelier, Vermont, is a former editor and journalist.

¹ See Appendix A, "*The Authors*," for more biographical information.

Acknowledgments



Many people and organizations in and around Vermont have influenced our thinking over the longer haul and certainly during the formative stage of writing this book.

One of those people is Otto Engelberth, who, through the eyes of a responsible employer, outlined the very real problems of the current health care system in Vermont in a 2004 draft paper, “Fixing Vermont’s Coming Health Insurance Train Wreck.” We also thank Steve Kappel, who was willing to vet our numbers as we constructed a longer-term set of financial targets for Vermont’s health care system. We also applaud the efforts of Coalition 21, sponsored by the Snelling Institute and led by Stephen Morse of the Windham Foundation. Dr. Elliot Fisher has also been an important influence. He and Dr. Jack Wennberg of Dartmouth offered some of the freshest thinking about the regionalization of health care in population planning and the regional differences in practice and cost.

We also thank the many good people on the Vermont scene, who may not agree on how to proceed but have added immensely to the needed discussion about health care in Vermont. These people and organizations include but are not limited to: the chairs of the Health and Welfare Committees of the Vermont Legislature, the Vermont Medical Society, the Ethan Allen Institute, Vermont Health Care for All, the Vermont Hospital Association, Physicians for a National Health Program, and the Vermont Program for Health Care Quality, among many others. These voices have laid the groundwork for this important discussion.

Brief Dialogue on the Book's Conception



CON: From my long-term view of the health care world, I've believed that we could move toward universal health care incrementally. Over the course of the 1990s, Vermont was on that track. I also equated increasing coverage with increasing costs, which was the case over that period. However, when the economy softened, we began to lose serious ground with coverage; the costs continued to skyrocket. I'm now to the point where I'm convinced that universal coverage is the key to long-term cost control.

DR. DEB: I've been at that point of understanding for a long time but for a different reason. I believe this is a moral issue front and center. Initially, I didn't care what it costs. As a physician, I believed we had the moral obligation to provide health care for all our people. The more I looked into it, however, the more clearly I saw our inability to control costs was one of the reasons that people didn't have health coverage, which stemmed from our lack of a health care "system." I also believe that universal health care will greatly simplify nonmedical spending, which will contribute to lowering systemwide costs.

CON: I've also believed that the closer health care became a market enterprise, the more opportunity we would have to control costs. However, events have proven me wrong. The markets that exist are macro or national markets, not micro or local markets. Little competition exists at the local level in Vermont nor, for many reasons, is very likely. In Vermont, people are being driven from comprehensive coverage in rapid fashion. So a universal approach, from my point of view, is a common sense solution.

DR. DEB: Subjecting health care to market forces has never been the way I've thought about health care. Health care is not a good fit for the marketplace for many reasons. But I do believe in a very important kind of competition designed to keep health care quality high.

CON: I continue to believe that individual citizens have the wherewithal to make their own decisions and choices about who they receive health care



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to long-term
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from and under what circumstances. Yet, overall, health care is more like our roads and bridges, representing an infrastructure that cannot be purchased on a pay-as-you-go basis. Once I began to understand that, the idea of everyone paying for health care and its infrastructure became much easier to accept.

DR. DEB: I have also gradually come to the same conclusion. Most people who believe in universal health care think only in terms of coverage for individuals. That is how I used to think about it. But my thinking evolved when I recognized that most of the money spent on health care is for shared services. I found that a better way is to think about a broad base of people paying for the infrastructure of health care and then giving everyone access.

CON: I had also believed those who say that we pay more for our health care because Vermont and the nation have the highest quality health care in the world. However, as a result of my travels, I'm now convinced that the quality of our health care, in some areas, is in question. The price we pay has not resulted in extraordinary quality. This was an eye opener for me.

DR. DEB: In my experience, I have seen a rapid deterioration in the quality of health care over my 18 years as a physician. The Institute of Medicine's report² on medical errors was not a surprise to me. As a family physician, most of my training was in the era before managed care. Managed care has created chaos in the system. As a result, the quality of care has deteriorated to a visible degree. In Vermont, we suffer to a lesser extent, since the quality of care here is pretty high, but the threat of deterioration is real.

CON: What I find fascinating is that two people with backgrounds as different as ours can come to the same point—admittedly for different reasons, but to the same point, nonetheless.

DR. DEB: My hope is that the people and policymakers can also come together. We really don't have a choice but to adopt a universal health care system if we want to keep the wonderful health care we have for ourselves and for others.

² Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, editors, *To Err is Human: Building a Safer Health System*, Committee on Quality of Health Care in America, Institute of Medicine (Washington DC: National Academy Press, 1999).

Introduction



Our nation has a health care crisis—and so does our state. It’s less visible in Vermont, perhaps because historically we have enjoyed excellent health care. Still, dire language is being used for the first time across the United States to describe the seriousness of impending problems with our health care system, if not systematically and comprehensively addressed.³

The crisis in Vermont is largely fiscal. Businesses that provide health benefits to their employees can attest to this as can municipalities, states, and individuals. In the public sphere, the example is the Medicaid program, which has fallen into a \$50 million deficit. No solution is in sight. Access to health care, when examined closely, also shows serious signs of slippage.

Attempts to address these problems, which are fundamental and structural, have failed. Such failures include the Clinton Administration’s grandiose “Jackson Hole” plan but also efforts at the state level. Vermont was one that tried and failed. The simple fact was that the citizen groundswell necessary to confront a problem of this size and complexity had not emerged.

The intractable problems associated with our current system of health care have become increasingly clear. In response, a flurry of good faith solutions were proposed and many adopted. Equally clear by now is that none of these basically incremental attempts have made a lasting difference, particularly for the extraordinary costs of health care.

The State of Vermont has attained more than most states in delivering high-quality health care and in providing access to its people. But like other states, Vermont finds itself in a cost spiral that is beginning to affect both access today and quality tomorrow. Vermont’s small scale permits the possibility of change, whereas the size of other states may make major change virtually impossible.

³ *Lexington (KY) Herald Leader*, September 9, 2004.



Since
our nation's
beginning,
Vermont
has led
the way.



Vermont's health care services are rated highly. Various studies place Vermont among the best half dozen states in our nation for health care quality and access. Yet among Vermonters, health care is the number one social issue in need of remedy.

At first, this fact seems both odd and contradictory. It isn't. Because the dissatisfaction that runs deep among Vermonters is not about the health care itself but about how we pay for it. Attention is riveted by the overall costs and their rapid rise. The harmful effects of such costs have spread widely at personal, social, and economic levels.

Vermont may be in better shape to undertake specific and needed change in order to ensure that all of citizens have access to high-quality health care at more reasonable costs today and more predictable costs over time. In other words, Vermont could be an example and standard for the rest of the nation.

We take the position that the subject of health care has been considered through a faulty framework that simply reinforces the current approaches which are resulting in increasingly intractable problems. We need a new way to look at this complex set of problems. Our hope is that what we have to say begins to meet this need for new thinking.

WHAT WE HAVE

WHAT WE FACE

WHAT CAN HAPPEN

WHY CAN'T WE DO SOMETHING ABOUT IT?

MAYBE WE COULD...IF

BUT ONLY IF

LET'S TAKE ANOTHER LOOK

CAN WE AFFORD IT?

HOW DO WE FIT IN?

WHAT ARE THE BENEFITS?

WHAT ARE THE OBSTACLES TO OVERCOME?

OTHER WORRIES ABOUT CHANGE?

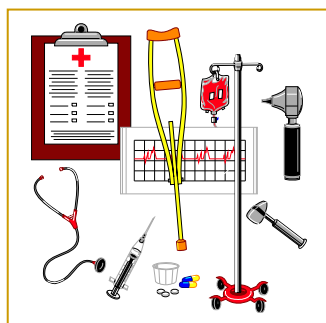
THE BUSINESS CASE

HOW DO WE GET THERE FROM HERE?

HEALTH CARE IS "IN THE PUBLIC INTEREST"

SUMMING UP THE OPPORTUNITY

What We Have



Quality of health care is directly connected to our well-being and life expectancy. No more important aspect in our lives beats being healthy. Being healthy allows us to thrive in our work and with our families. Health allows us to enjoy our physical surroundings and enhances the creativity and energy in our lives.

From a political point of view, Vermont may stand alone. The nation's political climate gives every indication that any near-term comprehensive health care reform at the federal level is not in the cards. Yet Vermont's congressional delegation is independent. Our history of taking on major issues against the prevailing tide is well known. Vermont has a history of doing what it thinks right. We have led the way on a range of issues from our beginnings as a republic.

The potential for an even broader coalition in favor of health care for all Vermonters exists. The formation of Coalition 21 from businesses, providers, payers, and patient-advocacy groups is one example of such leadership. Health care reform is the next issue on which Vermont may well stand alone in the national political scene, because we have many strengths.

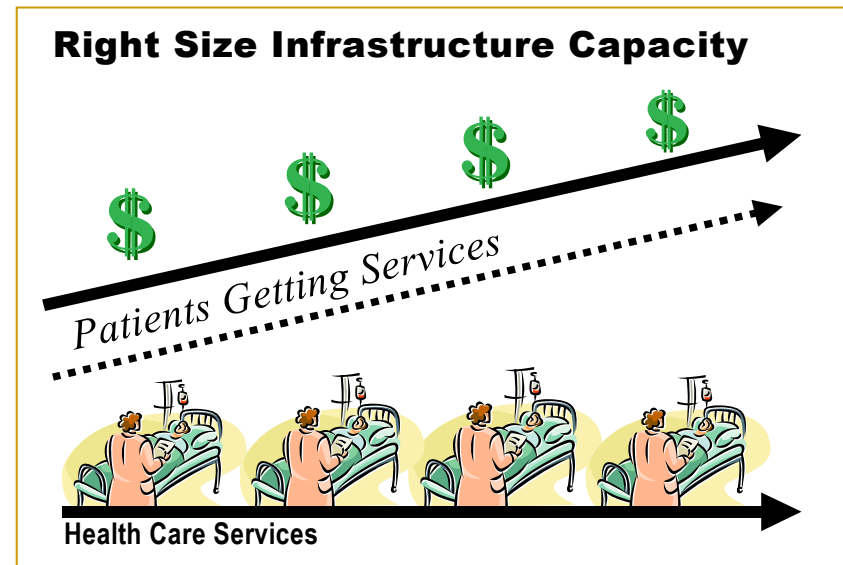
Vermont's Health Care System: A Strong Foundation

If problems weren't starting to impact our state's health care, Vermont could serve as a fine example of how health care can work. The quality of health care in Vermont is strong; access to health services is good; costs have been favorable compared with the national average; and health care capacity closely matches the needs of the population.

Capacity, such as hospitals, physicians' practices, nursing homes, and such, are the services and facilities that constitute Vermont's health care

infrastructure. If this infrastructure or capacity is too large, costs will be unnecessarily high; if too small, not enough health care will be available.

Unlike most other states, Vermont is in the enviable position of having nearly the right size health care infrastructure or capacity. This position means that no drastic changes to health care itself need be envisioned for achieving health care reform. Vermont has a very strong foundation from which to begin a process of major change.



Vermont's Health Care Costs: Favorable

Compared with other states, Vermont's spending on certain health care sectors is moderate. For example, its per capita cost of health care is consistently below the national average. The cost of Medicare in Vermont is also below the national average on a per capita basis. However, Vermont's Medicaid portion of its health care costs are among the highest in the nation. The reciprocal notion here is that, as a result, Vermont insures more of its citizens through Medicaid than most states. Nearly all Vermont children are covered as a result of Medicaid eligibility rules, which allow enrollment of

Managing
capacity is
fundamental
to curbing
costs.

children with family incomes up to \$58,000 for a family of four. For a long time, more than 90 percent of Vermonters were covered for health care, but that percentage is beginning to erode.

Until recently, the average costs of Vermont's hospitals were in the lowest quartile of the nation. That has also begun to change. As hospital costs have risen, Vermont's relative advantage has shrunk. Vermont is now around the national average. Compensation for Vermont physicians, nurses, and other health professionals is lower than the national average—about three-quarters of the average.

When comparing overall health costs in Vermont with those of the nation, its per capita costs for 2004 are estimated at \$5,100⁴ as opposed to the national average of \$6,100.⁵ Overall, Vermont's health care costs are less than elsewhere, which gives Vermont a clear advantage to contemplate change. See Appendix B, "*Vermont's Health Care Spending*," for more figures.)

Vermont's Prevention Record Is Strong

Other favorable conditions contribute to Vermont's advantage. Vermont has accumulated an enviable record of excellent indicators of well-being, such as positive immunization rates of two-year olds and negative pregnancy rates of young teens. Many of these indicators are related to Vermont's relatively sound health care services and policies. See Appendix C, "*Indicators of Prevention in Vermont Over the Last Ten Years*," for indicators that changed for the better as a result of health care.

These positive indicator trends bode well for Vermont's long-term health care outcomes and costs. For example, the significant decline in young teen pregnancy rates not only contributes to fewer burdensome social and economic outcomes but also produces lower social service and health care costs. In a mere six years, between 1991 and 1997, the 35 percent decline in

⁴ Vermont Health Care Expenditure Analysis and Forecast, Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA), 2004.

⁵ Stephen Heffler, Sheila Smith, Sean Keehan, M. Kent Clemens, Mark Zezza, and Christopher Truffer, "Health Spending Projections Through 2013," *Health Affairs*, Project HOPE, Web Exclusives, February 11, 2004, pg. 55.

young teen pregnancies for women aged 15 through 17 resulted in \$9 million in less direct costs to the state.⁶ These dollars, saved on direct health care services for young women and their babies could be spent on other important services or returned to taxpayers as unneeded spending.

Vermont's relatively strong record of prevention also contributes to a foundation for change. However, when looking at national data compared with prevention records in other countries, Vermont's results don't appear so sterling. A comparison of avoidable events in five countries appears below:⁷

Comparison of Quality of Care in Five Countries: Avoidable Events

	AUS	CAN	UK	NZ	US
Suicide, All ages	4th	3rd	Best	Worst	2nd
Suicide, Ages 15-19	3rd	4th	Best	Worst	2nd
Suicide, Ages 20-29	4th	3rd	Best	Worst	2nd
Asthma mortality, Ages 5-39	Best	NA	3rd	Worst	2nd
Pertussis	Worst	3rd	Best	NA	2nd
Hepatitis B	2nd	3rd	Best	2nd	Worst
Smoking rate	2nd	Best	Worst	3rd	Best

NA = data not available

These marginal results can also be seen in international comparisons of “process” indicators, which measure percentages of the population reached

⁶ Con Hogan and David Murphey, *Towards an Economics of Prevention: Illustrations from Vermont's Experience* (Washington DC: The Finance Project, December 2000).

⁷ Peter S. Hussey, Gerard F. Anderson, Robin Osborn, Colin Feek, Vivienne McLaughlin, John Millar, and Arnold Epstein, “How Does the Quality of Care Compare in Five Countries?” *Health Affairs*, Vol. 32, No. 2, May/June 2004, pp. 89-99.

by important screening activity. A comparison of these process indicators in five countries appears in the table below.⁸

Comparison of Quality of Care in Five Countries: Process Indicators

	AUS	CAN	UK	NZ	US
Breast Cancer Screening Rate	Best	2nd	4th	Worst	3rd
Cervical Cancer screening Rate	2nd	4th	Worst	3rd	Best
Influenza Vaccination Rate, age 65	Best	3rd	2nd	Worst	4th
Polio Vaccine Rate, age 2	2nd	4th	Best	Worst	3rd

NA = data not available

Vermont's Health Care Infrastructure: Solid

Vermont's Health Care Administration is part of the state's Department of Banking and Insurance (BISHCA), which annually collects data on health care spending. BISHCA publishes how much is spent on each sector, including Vermont's health care infrastructure. The infrastructure or capacity is defined as the state's hospitals, nursing homes, physicians' practices, and all other medical facilities.

Another agency, the Vermont Program for Quality in Health Care, provides information on the number of Vermont physicians and practitioners. Its

⁸ *Ibid.*

annual report also provides the distribution of physicians across the state in relation to the state's population.

The picture that emerges is that Vermont is well served by its 14 regional hospitals, 3 major academic medical centers,⁹ 44 nursing homes, 1,200 practicing physicians, and other important services staffed by 35,000 health care employees. These facilities, practitioners, and services form an adequate health care infrastructure for Vermonters.¹⁰

By most measures, Vermont stands up well. We have solid and responsive high-quality health care.¹¹

Vermont's Use Trends: Lower than National Average

Vermonters traditionally have demonstrated a frugality in their use of health care services as measured by comparative "utilization" rates. No expectation exists that a "run on the hospital" would result if health access became universal. Still, aspects of use require careful scrutiny

Until recently, Vermont has had a good balance between the amount of infrastructure or capacity and Vermonters' health care needs. This balance has meant that the health care needs of the population have been adequately served, in general. In Vermont, we tend to use health care more appropriately, such as undertaking fewer procedures per capita than in other places.¹²

Vermont's adequate capacity, however, has recently tended toward becoming excess capacity. Because infrastructure constitutes the bulk of health care spending, excess capacity is one of the drivers of higher costs. Good evidence

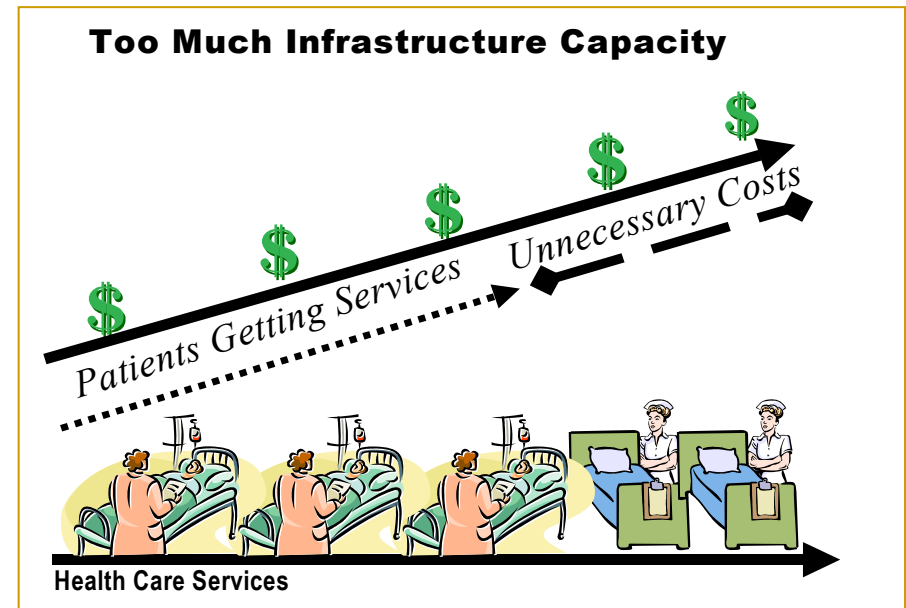
⁹ Fletcher Allen in Burlington, Vermont; Dartmouth Hitchcock in Hanover, New Hampshire; and Albany Medical in Albany, New York.

¹⁰ For an overview, see The Governor's Bipartisan Commission on Health Care Availability and Affordability, Cornelius Hogan, Chair, December 4, 2001, at <http://www.state.vt.us/health/commission>.

¹¹ Stephen F. Jencks, Edwin D. Huff, and Timothy Cuerdon, "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998-99 to 2000-01," *Journal of the American Medical Association*, Vol. 289, No. 3, January 15, 2003, pp. 305-312.

¹² 2003 *The Vermont Health Care Quality Report* (Montpelier VT: Vermont Program for Quality in Health Care, Inc., 2003).

exists that excess capacity is also a driver of utilization.¹³ Another often discussed suspect in over-utilization is malpractice liability, which may very well lead to doctors erring on the side of caution.



These dynamics between health care needs and health care capacity help explain Vermont's relatively low (but rising) levels of use.

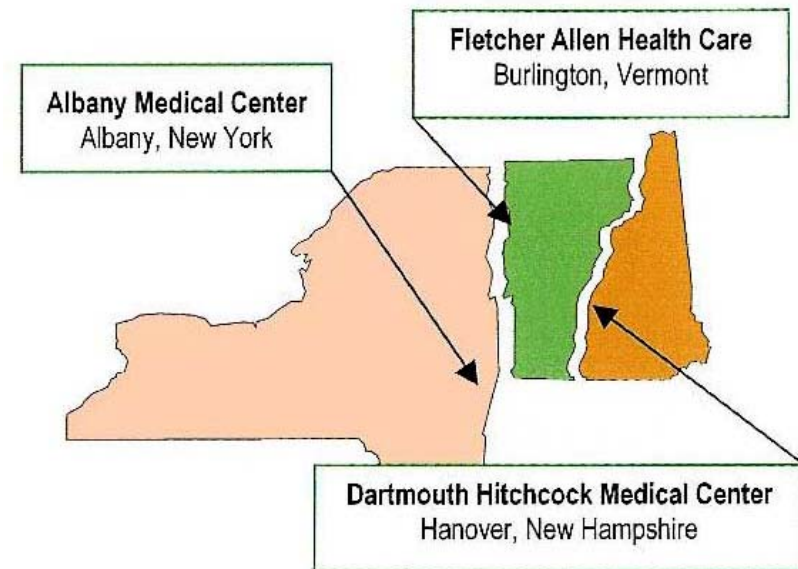
Vermont's Health Care: Relative High Quality

For years, the quality of Vermont's health care has been judged as among the best in the nation. Almost every Vermonter is within 35 minutes of one of our 14 hospitals. About 1,200 physicians practice here. Although their distribution is uneven in some areas, the number is judged as adequate for our

¹³ Elliott S. Fisher, David E. Wennberg, Therese A. Stukel, Daniel J. Gottlieb, F.L. Lucas, and Etoile L. Pinder, "The Implications of Regional Variations in Medicare Spending, Part I: The Content, Quality, and Accessibility of Care," *Annals of Internal Medicine*, Vol. 138, No. 4, February 18, 2003, pp. 273-87.

population. We have nearby access to three excellent, high quality academic medical centers (Fletcher Allen in Burlington, Vermont; Dartmouth Hitchcock in Hanover, New Hampshire; and Albany Medical in Albany, New York).

Vermonters' Regional Access to Academic Medical Centers



Beyond these, the remarkable medical facilities in Greater Boston are available to Vermonters when needed. Another positive factor is that Vermont ranks high among the states in Medicare quality. According to Paul Harrington, Executive Director of the Vermont Medical Society, Vermont's quality ranked second highest in the country.

Still, confidence in Vermont's health care quality needs to be placed in the context of the nation and the western world. Recent studies report that our health care quality is indeed strong—but not in all areas. A recent study¹⁴ measured common health outcomes or process indicators across five nations: Australia, Canada, New Zealand, England, and the United States.

¹⁴ Hussey et al.

Health Care is a Moral and Fiscal Issue

In summary, the United States led or tied for best in only 4 of the 19 indicators that had comparable cross-nation data. Those four best outcome indicators were: breast cancer; measles, smoking, and cervical cancer screening. The United States had the worst outcome record among the measured nations in two of the indicators: kidney transplant survival and hepatitis B outcomes.

At the same time, Australia ranked first in seven of the outcome indicators: including survival rates for cervical cancer, nonHodgkin's lymphoma, breast cancer screening, and flu vaccination rates. Canada led in five of the indicators: including childhood leukemia and kidney or liver transplant survival rates. The UK was best in seven of the indicators: including suicide, pertussis, and hepatitis B vaccination rates.

Such general measures of the health of populations are influenced by many factors, but the results call into question our blind view that the United States has the best health care in the world. Vermont's health care fits somewhere within the framework of the accumulated national data as reported above. We do have excellent health care, but opportunities abound to learn from other countries where health outcomes are better than ours. We cannot be complacent about health care quality.

The necessary perspective here is that, even though we believe Vermont is doing well on quality,¹⁵ the future in this regard is not assured. We have only to look at what is happening across the country, where quality is clearly deteriorating.¹⁶ Vermont cannot stand on the sidelines and still preserve quality health care into the future. We must act now.

Vermont's Medical Ethics: Strong and Positive

Here in Vermont doctors treat first and ask questions about money later. Patients get the care they need regardless of their ability to pay. This strong medical ethic is to the credit of the Vermont medical community. As laudable as this is, the problems remain to be solved. If the charges for

¹⁵ Jencks et al.

¹⁶ Kohn et al.

service are not met, who is to pay them? If patients who cannot pay are too ashamed to seek care, who is to pay when delay in care results in medical complications costing far more? Self-rationing may be laudable in some circumstances, but the eventual costs may be too steep. It's a tangled situation. Yet who would want to condone abandoning our medical ethic. It makes Vermont very special.

While she was practicing in Buffalo, New York, Dr. Richter, one of the authors, had a patient who was suffering from rapidly progressing multiple sclerosis. Dr. Richter had to implore several hospitals and MRI centers to undertake important tests and treatment on the patient's behalf. She was turned down many times but finally one agreed. That would never have happened in Vermont. A strong ethic on behalf of the people we serve is a strength of Vermonters.

Vermont Hospitals: Part of Our Communities

More or less like everywhere else, life in Vermont has turned inward at the expense of group and community life. We have seen this play out in the waning of church and community life, along with the consolidations of our schools, which further blurs the historical and traditional geography of our communities.

One of the remaining centers of gravity in Vermont is our community hospitals, which are more than mere places to be treated and healed. Beyond providing health care, community hospitals are a place where people come together to support and care for each other.

In that galvanizing role, Vermont's community hospitals—and related community-based services provided by physicians, home health agencies, and other local providers of care—need to be at the center of any reconstruction of Vermont's health care sector.

Vermont's health care costs are comparatively lower than other states, health care quality is comparatively high; nearly all Vermont children and most adults have access to health care; we enjoy a well-developed health care

infrastructure and access to intensive care specialists; and we have shown excellent outcomes that result from strong community-based health care.

Still...There Are Serious Problems

Regardless of these obvious positive aspects, health care in Vermont has serious problems because of the lack of an integrated “system.” Some of these problems are quite evident, while others are not so; some are often hidden and masked. Combined and accumulated, these problems represent a serious threat to the future of our health care if not addressed soon.

Vermont is ready and poised for change.

What We Face

Rapidly Rising Costs



Nationally, health care costs are an ever-increasing share of the Gross Domestic Product (GDP). Since 1988, the share of GDP for health care costs increased from 11 percent to 15 percent and is still rising.¹⁷ This rise is a reflection of the sheer size of health care costs combined with steady increases three to four times greater than the Consumer Price Index (CPI).

Internationally, the difference in per capita health care costs for people of the United States versus those of other industrialized nations has reached almost incomprehensible dimensions. Following is a summary of these differences in 2002.¹⁸

Difference in Health Care Costs of Industrialized Nations, per capita

Japan	\$ 2,077	(for 2001)
UK	\$ 2,160	
Sweden	\$ 2,517	
France	\$ 2,736	
Germany	\$ 2,817	
Canada	\$ 2,931	
United States	\$ 5,267	

Yet, the American public has not demanded change. It's incomprehensible.

Even Vermont's less than average costs are steadily rising. In fact, the overall costs of health care in Vermont doubled from \$1.5 billion to over \$3 billion in the last five years. Projected costs five years from now are \$5 billion.

¹⁷ Heffler et al.

¹⁸ *OECD Health Data 2004* (Paris: Organisation for Economic Co-operation and Development, 2004).

The bulk of the burgeoning national debt, which is projected to be around \$53 trillion in 2050,¹⁹ is attributed to a health care system that is out of fiscal control. These debt projections assume that health care costs will continue to rise at a rate at least two times that of other countries. If not addressed, this debt will have a devastating impact on our economy.

One Vermont businessman, Otto Engelberth, who has purchased health insurance for his employees over 30 years, watched the annual costs of health insurance for the families of his employees soar from \$1,500 per year to more than \$9,000 per year today.²⁰

Successive administrations and multiple legislatures make annual attempts to stem this tide—and fail. Still, almost everyone who runs for public office has controlling the costs of health care at the center of a public agenda. Even with many incremental steps to control costs in Medicaid and improve planning and oversight, the results are dismal.

Rising health
care costs
have the same
impact
on the public
as raising taxes.

Increase in Premiums

In a recent study, the U.S. Labor Department summarized the problem at a macro-economic level, reporting that rapidly rising health care costs are taking a toll on an already weakened economy.²¹ The overall conclusion was that health care is now taking away dollars from consumer discretionary spending, which has the same impact on the economy as if taxes were steadily increased. In fact, health care spending as a percentage of average household income now takes a larger bite out of household income than taxes.²²

Further, the Kaiser Family Foundation recently surveyed 3,000 businesses and reported that American consumers are experiencing the fourth straight year of double digit increases in health care premiums. Official data on premium increases are difficult to obtain, but the survey reflects the

¹⁹ “One Nation, Under Debt,” *USA Today*, October 4-5, 2004.

²⁰ Otto Engelberth, “Fixing Vermont’s Coming Health-Insurance Train Wreck,” *Vermont Health Care for All*, March 3, 2004, at www.vthca.org.

²¹ Tom Abate, “Health Care Costs Bruising Economy: Spending Slows: Workers Cut Back to Pay Medical Tab,” *San Francisco Chronicle*, September 10, 2004.

²² *Ibid.*

experience of those in business for a significant period of time. Premium increases are astounding.

Health care coverage provided by the private sector, as opposed to government-sponsored programs, continues to decline. Many small businesses do not provide health insurance. The costs are too high. Small businesses that have provided health insurance to employees are no longer doing so. We know that most of the Vermont workforce is employed by small business. Under current trends, fewer and fewer employees in small business will have comprehensive health insurance. As a result, the number of uninsured will increase even more with all the attendant problems described above.

The same applies to employees in the public sector. For example, about 80 percent of school budgets goes for the salaries of teachers, classroom aides, and administrators. An ever-larger portion, however, is devoted to rapidly rising health care costs for personnel benefit packages, leading to acrimonious negotiations between local school boards and teachers. The latter are worried about losing their hard-won health care benefits; the former are worried about financing their expanding school budgets. Virtually all negotiations get hung up on identifying who is responsible for funding the rising health insurance costs. Inevitably, a falling out occurs between teachers, who feel they have earned their health benefits, and the general public, who see their own health care benefits eroding. The implications are far reaching. Affected is the public's view of school budgets, which have been at the center of Vermont's school financing issue. Health benefit costs are an important "tipping point"²³ in these local dynamics.

A current example of premium increases is Medicare, the universal health care program for over 40 million elderly Americans. As a result of recent congressional action, Medicare recipients are experiencing a 17 percent increase in premiums. That translates nationally into somewhere between \$350 and \$500 billion of premium increases over the next five years. At this rate of change, the average for a Medicare recipient will increase from 25

²³ The accumulation of many small things that add up to being able to break inertia and get things moving. Malcolm Gladwell, *The Tipping Point: How Little Things Can Make a Big Difference* (New York: Little, Brown and Company, March 2000).

percent of household income now to about 35 percent in the year 2025.²⁴

Another example is the plight of retirees. Major corporations are moving to limit premium increases in benefits for their retirees, either by eliminating retirement programs or forcing increased co-pays for health insurance. For example, a 37-year employee of Lucent Technologies retired just three years ago when his share of the health care premium was \$32 a month.²⁵ Today, three years later, his monthly share has reached an astounding \$577 a month. Premium costs to businesses are going up quickly, but they are going up more quickly for employees or retirees. According to the Kaiser Family Foundation, unrelenting premium increases in 2003 compelled 10 percent of large companies to eliminate health benefit plans for retirees. Worse, major companies that have had generous health care benefits, such as Coca Cola, Motorola, and John Deere, are simply no longer offering health care as a benefit in new employee retirement programs.

The rapid rise in private insurance premiums paid by businesses that provide employee health benefits is taking its toll. These costs depress wages and cause other serious problems. Larger companies find revising their health care programs and premiums for retirees a necessity. When as large and respected a company as IBM is forced to change its health care retirement benefits and costs to retirees, the size and scope of the problem becomes clear.

The Rising Uninsured

Mary is a 36-year-old married Vermont woman with two teenage children. She works as a para-educator for one of the local schools. Mary experienced a mass growing in her pelvis for more than eight months. She knew she wasn't pregnant, but she knew this was a serious symptom. Still, she did not seek care until the pain and discomfort became overwhelming. Mary is one of many cases that Dr Richter sees each week in

²⁴ Senate Select Committee on Aging; American Association of Retired Persons, April 1995 and March 1998; and *Health and Aging in the 21st Century*, President's Message from Annual Report (projections to 2025 adjusted to include nursing home costs), (New York: Commonwealth Fund, May 1999).

²⁵ *The Chicago Tribune*, November 21, 2004.



her practice. Many people know they have something serious but are reluctant to seek care due to the costs.²⁰

For many years, Vermont has taken pride as a national leader in health care for its citizens.²¹ In 1989, 91 percent of Vermont's children were covered by health care insurance. By 2000, 96 percent were covered. This coverage was primarily through the Dr. Dynasaur program, which began during the administration of Governor Madeleine Kunin and grew over the years under the General Fund. In the mid-1990s, the Dr. Dynasaur program received an important boost from Governor Dean when monies from the General Fund were matched with Medicaid monies, allowing coverage for even more children. Stipulated income levels for coverage were generous—more than \$50,000 for a family of four, which was a point of some political criticism. The net result, though, is that Vermont regularly ranks number one, two, or three among states in covering children for health care.²⁶

A similar arrangement was constructed for some adults. In the mid-1990s, Vermont expanded coverage for adults beyond traditional Medicaid levels through its Vermont Health Assistance Program.

In 2000, a state study indicated only 43,000 Vermonters still had no health insurance.²⁷ The rate for all citizens, almost 93 percent, put Vermont among the very best in the country. Since then, estimates are less impressive; they indicate significant erosion. The number of uninsured is currently about 63,000.²⁸ In a few years, Vermont went from 93 percent of Vermonters covered to 90 percent, and the number of uninsured appears to be rising rapidly.

²⁰ This story and subsequent ones about Vermont people are true and are meant to put a human face on statistics. The names have been changed to preserve confidentiality.

²¹ David W. Baker, Martin F. Shapiro, and Claudia L. Schur, "Health Insurance and Access to Care for Symptomatic Conditions," *Archives of Internal Medicine*, Vol. 160, No. 9, May 8, 2000, pp. 1269-1274; and *The Social Well-Being of Vermonters: A Report on Outcomes of Vermont's Citizens* (Waterbury VT: Vermont Agency of Human Services, Planning Division, February 2004).

²⁷ Joint Fiscal Office, September 29, 2000.

²⁸ Presentation: "Vermont Health Care Expenditures and Health Insurance Coverage" to Coalition 21, by Dian Kahn, Director, Analysis and Data Management, Vermont Health Care Administration, August 24, 2004.

Not having
health
insurance is
harmful to
one's health.

Profiles of the uninsured are worrying. About 68 percent of the uninsured are families with full-time working heads of household.²⁹ This percentage is enormous and is expected to get worse. For instance, greater numbers of uninsured almost certainly will strain the budgets of the health care infrastructure, such as hospital emergency rooms. The lesson learned is that not having insurance causes people to delay seeking care, which leads to even more serious health care problems. The Catch 22, based on experience in other states, leads to even higher health care costs, which leads to more uninsured, which leads to higher costs.

A real cost of another kind bears on the overall well-being of the uninsured. Anxieties suffered by uninsured workers—as well as the sacrifices made by their families when someone close becomes gravely ill—are terrible mental and financial burdens. Another important dynamic is that the rising number of uninsured, when accumulated, work against the ability to provide comprehensive care. Because of the rising price, people are moving away from comprehensive care toward ways to control their personal costs, such as health savings accounts and catastrophic-only coverage.

Outside of Vermont, the problem is even more severe. The Kaiser Family Foundation recently reported that, over a mere four-year period from 2001 to 2004, at least 5 million fewer jobs provided health care coverage.³⁰

An assuredly odd way to contrast the plight of the uninsured is to know that a number of farm animals in Vermont have comprehensive health insurance. For an anecdote on this, see Appendix D, “*A Horse with Good Health Insurance*.”

Health Consequences of Not Having Insurance

Not having health insurance is harmful to one's health. Statistically, people without health care coverage are 3.6 times more likely to delay seeking care³¹ and more likely to require future hospitalizations. People

²⁹ *Ibid.*

³⁰ *Employer Health Benefits 2004 Annual Survey*, the Kaiser Family Foundation and the Health Research and Educational Trust, September 2004.

without health insurance are two to three times more likely to die than those insured when both are hospitalized for similar illnesses.

Another recent study on the medical impact of not having health insurance concludes:

*uninsured people aged 55 to 64 (the near elderly) have a 43 percent higher adjusted mortality rate than their privately insured counterparts.*³²

Greater likelihood of financial instability is one byproduct of this. Insolvency doesn't take too many health care bills today: "70 percent of the uninsured with medical bills exhausted their savings to pay their medical expenses."³³ Some hospitals place liens on homes of patients unable to pay their health care bills. These people then become burdens on friends and families, thus spreading the financial pain. In fact, 40 percent of all personal bankruptcies are a result of large unpaid medical bills.

These direct outcomes are but a few associated with the medical uncertainties in having no health coverage. The indirect results are to render people financially unproductive and financial burdens to friends, family, and eventually the government. Common sense tells us that people without health insurance are going to have more serious health problems later in life than if they had access to earlier preventive care.

Health consequences of having no insurance have been well studied. Findings by the American College of Physicians show an interconnected nature of physical health and financial health. The consequences of not having health care coverage range from psychological vulnerability to health susceptibility to financial liability. Not having health care coverage, in one way or another, enters into every aspect of our lives.

³¹ *The LaFollette Policy Report* (Robert M. La Follette School of Public Affairs, University of Wisconsin-Madison), Vol. 14, No. 2, Winter 2003-2004.

³² J. Michael McWilliams, Alan M. Zaslavsky, Ellen Meara, and John Z. Ayanian, "Health Insurance Coverage and Mortality Among the Near Elderly," *Health Affairs*, Vol. 23, No. 4, July/August 2004, data supplement.

³³ *LaFollette*.

Something is fundamentally wrong when the financial condition of an individual or family is the primary determinant of receiving high-quality health care.

More Underinsured

Sheila and John are a married Vermont couple. John works as a machinist and brings home \$312 a week. He is insured through his company. Sheila is disabled and cannot work. Both are covered on John's insurance. John suffers from diabetes, high cholesterol, and high blood pressure. His prescriptions total \$500 per month; however, his insurance only covers one-half of his prescription costs. John needs a car because they live in a trailer 35 miles from his work. They haven't paid their rent in nine months, but the landlord has not yet moved to collect. They cannot afford heat or hot water. Their choices are limited. They have been homeless in the past. These are strong, hard-working Vermonters who cannot completely provide for themselves. Their only luxury is a small dog. The day that they inevitably need care will make clear that they are underinsured.³⁴

The underinsured is a different category. The formal definition of underinsured used by most studies is when out-of-pocket health care costs exceed 10 percent of income. The estimate is that 16 percent of Vermonters are underinsured, and the number is growing.³⁵ Currently, this percentage represents about 100,000 Vermonters. Their situation is both a moral and a fiscal issue.

Just how many people are heading toward less coverage to escape the rapidly rising costs of health insurance is difficult to ascertain. But no one questions that many people are turning to higher deductibles to reduce cost increases in their premiums. Others are buying lower-cost catastrophic-only policies for the same reason.

³⁴ As this book goes to press, John was laid off his job and now has no health insurance.

³⁵ Testimony of Gail Shearer, Director, Health Policy Analysis, Washington Office of Consumers Union, on the "Impact of 'Consumer-Driven' Health Care on Consumers," U.S. Congress Joint Economic Committee, February 25, 2004.

Clearly, rapidly rising costs contribute to a dynamic that results in more and more people choosing to take the risk of being underinsured or, in the case of currently healthy young adults, to take the risk of no coverage at all.

Out-of-Control Administrative Costs

Ten years ago, administrative costs were calculated at 24 percent of health care spending.³⁶ Today, a national study puts the administrative share at over 31 percent.³⁷ This rise is remarkable. At 24 percent, Vermont's administrative costs ten years ago were twice what Canada spent on administration. Today, the disparity is even higher.³⁸ Similar comparison figures are not available for other nations as their numbers do not include administrative expenses in hospitals and physicians' practices. Yet, no one familiar with world health systems doubts that other countries' total administrative costs are far lower than ours.

Administrative costs arise in two places: "provider" costs generated within hospitals and physicians' practices; and "payer" costs generated in Medicare, Medicaid, and private insurance companies. Administrative costs in Medicare and Medicaid are comparatively low.

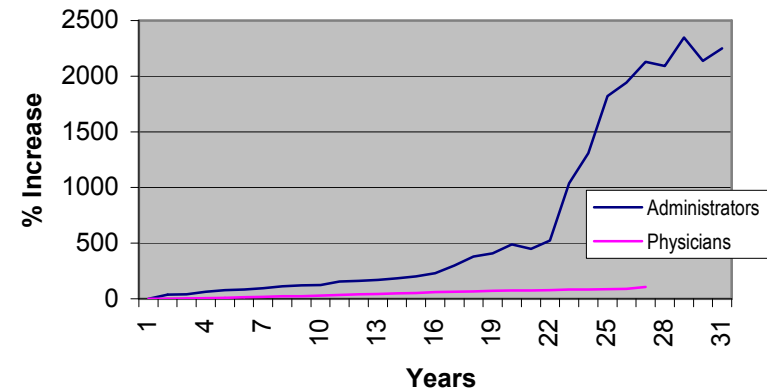
Major businesses succeed or fail in their ability to control overhead costs. Stockholders turn corporations inside out when overhead costs cut into their stock dividends. Government, through the annual appropriations process, is under constant review to squeeze out inefficiencies that can affect our taxes. School budgets are scrutinized with a fine toothcomb to expose inefficiencies in order to keep costs down. Yet, administrative costs of our health care have run amok.

³⁶ Steffie Woolhandler and David U. Himmelstein, "The Deteriorating Administrative Efficiency of the U.S. Health Care System," *New England Journal of Medicine*, Vol. 324, No. 18, May 2, 1991, pp. 1253; and S. Woolhandler, D. Himmelstein, and James P. Lewontin, "Administrative Costs in U.S. Hospitals," *New England Journal of Medicine*, Vol. 329, No. 6, August 5, 1993, pp. 400-03.

³⁷ S. Woolhandler, Terry Campbell, and D.U. Himmelstein, "Costs of Health Care Administration in the United States and Canada," *New England Journal of Medicine*, Vol. 349, No. 8, August 21, 2003, 768-775

³⁸ Woolhandler and Himmelstein, *NEJM*.

Growth of Physicians and Administrators



One reason for rising administrative costs is that no control process exists. There's not even a good way to understand and identify these costs accurately on a local basis. Any current estimates are based on national and international studies of administrative costs. Neither reasons nor evidence support Vermont's administrative costs as being any different than the national experience. To understand their magnitude, current administrative costs in 2003 were reliably estimated to be \$780 million.³⁹ That figure does not include administrative costs of private insurers, which are not available at the state level. Most observers believe that, if these costs were added, the total would be close to \$1 billion. That amount figures between \$1,200 and almost \$1,600 for every Vermonter. By the year 2009, even if no further percentage increases occur, the administrative share of health care spending could very well be a wasteful \$1.5 billion.

Personnel costs are a good way to track and demonstrate this problem. A reliable 1999 estimate put personnel costs assigned to administrative and

³⁹ D.U. Himmelstein, S. Woolhandler, Sidney M. Wolfe, and "Administrative Waste in the U.S. Health Care System in 2003: The Cost to the Nation, the States, and the District of Columbia, with State-Specific Estimates of Potential Savings," *International Journal of Health Services*, Vol. 34, No. 1, 2004, pp. 79-86.

clerical functions at 27 percent of health care spending. In 1969, that figure was 18 percent. Almost all the increase is attributable to the administrative costs of managing health care use at the payer end and chasing the money through complicated billing at the provider end. Another indication is that, since 1970, the number of health care administrators has increased more than 2500 percent, whereas the number of doctors and the number of nurses increased over the same period by 159 percent.⁴⁰

To put the rise in administrative costs into perspective, consider this: if Vermont were to function at the administrative efficiency levels of other countries, our health care spending would be about half a billion dollars less than now.⁴¹ How big is a half a billion dollars? What could we do with half a billion dollars on behalf of the people of Vermont?

The overall health care bill for Vermont in 2004 is \$3.2 billion. That bill is larger than the entire budget for the State of Vermont and three times the total support for our elementary and secondary education. These comparisons give a clue as to what could be accomplished in Vermont with half a billion dollars. Half a billion dollars is four times the cost of paying for every uninsured Vermonter's health care and ten times the current Medicaid shortfall. Spent beyond health care, the possibilities multiply. A half billion dollars used well for a variety of worthy purposes could give information technology in Vermont a needed boost. Our prison system could be uprighted. Programs for children could be greatly enhanced—not to mention tax relief for Vermonters.

Another way to look at half a billion dollars is to imagine just not spending that amount over a ten-year period. The computation is an astounding \$6 billion. This figure alone ought to drive home the idea of just how massive our health care spending really is and how controlling waste can pay immense dividends over time.

⁴⁰ "Analysis of Current Population Survey," Bureau of Labor Statistics (Washington DC: U.S. Department of Labor, 2004).

⁴¹ Woolhandler, Himmelstein, and Wolfe, *IJHS*.

Increasing Concerns About Quality

A 2004 survey reports primary care experiences among adults in Australia, Canada, New Zealand, the United Kingdom, and the United States.⁴² The survey revealed serious concerns about the quality of care in the United States, particularly its extraordinary costs. The survey summary says it better than we could:

Health care spending is not an economic stimulus but a restraint on competition.

Across multiple dimensions of care, the United States stands out for its relatively poor performance. With the exception of preventive measures, the U.S. primary care system ranked either last or significantly lower than the leaders on almost all dimensions of patient-centered care: access, coordination, and physician-patient experiences.

These findings stand in stark contrast to U.S. spending rates that outstrip those of the rest of the world. The performance in other countries indicates that it is possible to do better. However, moving to a higher-performing health care system is likely to require system redesign and innovative policies.

The Impact on Discretionary Income

A recent study shows the cumulative impact on our economy of people who have less and less disposable income.⁴³ In one day, Dr. Richter saw two vivid examples:

- Susan and her husband own a small business. Their monthly health care cost is \$900. To this point, they are healthy. They have two children. Recently, the son wanted to join the school soccer team. The cost included a \$50 fee plus soccer cleats and uniform costs, all of which added up to several hundred dollars. They chose to forego health care coverage, because they couldn't meet the expenses of the children's normal, life-enriching activities. They are trusting they will stay healthy.

⁴² Cathy Schoen, Robin Osborn, Phuong Trang Huynh, Michelle Doty, Karen Davis, Kinga Zapert, and Jordan Peugh, "Primary Care and Health System Performance: Adults' Experiences In Five Countries," Project HOPE, Web Exclusive, *Health Affairs*, October 28, 2004.

⁴³ Abate, *San Francisco Chronicle*.

- George, a semi-skilled worker, is employed and makes \$25,000 a year. His house needs a new roof. His choice came down to a new roof or health care. He chose health care. He still needs a new roof.

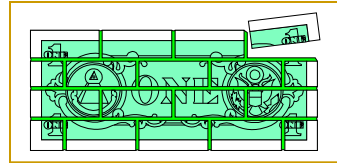
Rising health care costs have far-reaching effects that are sometimes not immediately discernible. We sense their impact on our lives beyond the direct costs of health care. But in what ways? Consider the following: School and municipal budgets bear a direct relationship to health insurance premiums. As premiums go up, budgets go up. In turn, property taxes are pressured upwards.

Businesses that provide us with goods and services are directly affected. As premiums go up, prices are pressured upwards. Health care benefit costs, therefore, act as a hidden tax. For example, the first \$1,200 of the labor needed for each worker to build a car goes to pay for health care benefit costs.⁴⁴

Cumulatively, the indirect effects act as a damper on our economy. Monies that might be spent by consumers are diverted to health care spending, depriving our economy of a vital stimulus. Until recently, a belief widely held was that health care spending served as an economic stimulus, but growing evidence shows the level of spending is now affecting the ability of businesses to compete, certainly on the global front.

A counter view is that we ought to view health care as we might a growing corporation. That is, health care provides jobs and economic vitality. The view is suspect. For one, can health care's growth offset its dampening effects on the economy? For another, in a normal corporate setting, the goods and services produced result in payments that multiply within the economy. In health care, however, the unacknowledged problem is that any multiplication may well be compromised. The fact is that much of the payment comes from taxes, and taxes subtract from potential discretionary spending by consumers.

⁴⁴ Kirstin Downey, "A Heftier Dose To Swallow," *The Washington Post*, March 6, 2004.



Are Functions That Increase Costs Necessary?

Health care in the United States and in Vermont is riddled with functions that incrementally and cumulatively add to costs. Here are some functions that need rigorous review:

- Sales commission costs that in the private sector can add precious percentage points to the cost of health insurance.
- The role of insurance companies in making medical decisions.
- Multiple and redundant utilization review systems.
- Sector fragmentation that limits our ability to implement cost-saving information technology.
- Cost of marketing by payers and providers.
- Administration of eligibility requirements.
- Risk selection and analysis procedures.
- Itemized billing in hospitals.
- Collection agency activity.
- Administrative costs to investigate, prosecute, and defend against system fraud.

Hospital Deaths and Consequences

The Institute of Medicine reports that about 100,000 preventable hospital deaths occur annually in the country. Some of these deaths end up in expensive litigation. Most states have medical liability problems. Fortunately, Vermont is not yet one of those states, but our concern is for the future.

Survival rates in certain medical areas leave much to be desired when comparing the rates in the United States against rates of other prominent countries.⁴⁵ A summary of those rates is found on the next page:⁴⁶

⁴⁵ Hussey et al.

To be sure, the above are national and international assessments. We do not have equivalent data for Vermont. Even though we have high-quality health care here in Vermont, we have the benefit of seeing the future now. To date, we've avoided these problems in Vermont, but they are serious and imminent warnings for us.

Comparison of Quality of Care in Five Countries: Survival Rates

	AUS	CAN	UK	NZ	US
Breast Cancer	2nd	4th	Worst	3rd	Best
Colorectal Cancer	2nd	3rd	Worst	Best	4th
Cervical Cancer	Best	3rd	Worst	4th	2nd
Childhood Leukemia	Worst	Best	3rd	4th	2nd
Kidney Transplant	2nd	Best	3rd	3rd	Worst
Liver Transplant	2nd	Best	Worst	*	3rd
Non-Hodgkin's Lymphoma	Best	4th	Worst	2nd	3rd
AMI, Ages 20-84	Best	Worst	NA	2nd	NA
Stroke, Ages 20-84	2nd	Best	NA	Worst	NA

NA = data not available

Employer/Employee Model Causes Serious Problems

The current employer-based model for providing health care is an accident of history. During World War II, employers faced wage controls. To attract the needed workforce, they began to pay current employees more (within the rules of the wage freeze) AND pay health insurance for new

⁴⁶ *Ibid.*

employees. In effect, a long-term system of paying for workers' health insurance was born of this short-term need. The genesis of how we pay for health care was happenstance.

Over the years, this arrangement has caused a myriad of problems both for the employers and the employees. In our time, these problems are accumulating and ripening. For example, Vermont businesses have been unable to form large enough markets to make a difference in the price of insurance. Businesses (and their employees) view this as a reason for the high prices of their insurance.

Further, choices for employers and employees are narrow due to high health care costs.⁴⁷ Employees have little choice from among few company health care plans and, embedded in this decision, is often no choice of physicians or provider groups. Employees are facing higher cost-sharing with employers concurrent with shrinking choice of plans and providers as well as less coverage.⁴⁸

The costs of health insurance, when averaged over a 25-year period, show an average increase over 10 percent per annum, while the average increase in wages over the same period is less than half that. It's also true that employees at the higher end of the compensation scale do better, in relative terms, than those at the bottom end of the scale. They pay less of their incomes proportionately toward health insurance than do lower income employees.

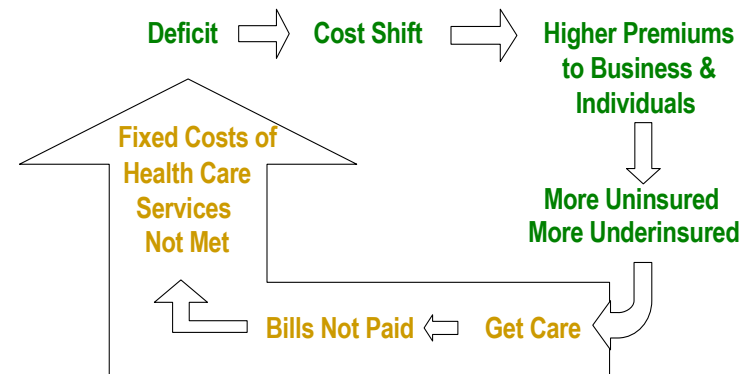
Taken together, these factors have a negative effect on employer/employee relationships. This effect is readily seen on the public side of teacher negotiations. Community after community is inflamed over rising costs of health insurance and efforts by school boards to shift some costs to teachers. That same struggle is being played out in the private sector, though not in the public eye, with consequences to productivity and relationships.

⁴⁷ A.A. Gawande, R. Blendon, M. Brodie, J.M. Benson, L. Levitt, and L. Hugick, "Does Dissatisfaction with Health Plans Stem from Having No Choices?" *Health Affairs*, September/October 1998; Vol. 17, No. 5, pp. 184-194.

⁴⁸ "Small Employers and Health Benefits: Findings from the 2002 Small Employer Health Benefits Survey" (Washington DC: Employee Benefit Research Institute, May 2004).

This kind of long-term, inexorable arithmetic is bringing employers, employees, and the health care system to their knees. Soon, patients and citizens, employers and employees—in essence, the people who pay the bill—will come to the conclusion that a better approach to providing and paying for health care must exist.

Cost Shifting: No End in Sight



The “Cost Shift” Has Reached a Dangerous Point

The term “cost shift” has received considerable public and political attention in Vermont recently. Most of that attention has related to the Medicaid program, where the idea of cost shift is quickly grasped. Simply put, costs shift from those who cannot pay to those who can. The Medicaid cost shift is the sum of the underpayment by the federal government to Vermont and Vermont’s underpayment to those health care services. Instead of pass the buck, it’s pass the bill.

In an ideal system, those receiving care would pay sums, directly or indirectly, at least equal to the costs of service. In reality, some of those receiving care pay more than the fair cost of service, some pay less, or not at all. Vermont health care is riddled with inequities. Cost shifting is a survival mechanism. When the net loss reaches a critical point, the cost is shifted through the system to those who can make up the difference.

Another kind of cost shift is direct from employer to employee. Employers who wish to provide employees with health benefits are experiencing difficulties because of the double-digit rise in insurance premiums, which itself is a result of cost shifting. To cope with rising costs, employers are shifting a larger percentage of health benefit costs to their employees. In its different forms, the cost shift is:

- exacerbating employer-employee relations,
- raising genuine doubts about the state's Medicaid program,
- eroding our confidence in government,
- saddling the Legislature with an unwelcome problem for which it has no answers,
- eating away at support for Vermont's high standards of medical ethics,
- costing everyone more money than they can afford.

This problem has been going on for years but has finally become unmanageable.

Cost shifting is not confined to health care. It occurs in every economic segment of our society. The University of Vermont shifts a significant portion of its costs to out-of-state students to keep costs down for in-state students. The same shift happens in our property taxes. Taxes for out-of-state owners of Vermont property are now higher than for Vermont residents. As long as more than one payer exists in any system, a cost shift will occur. Businesses use "loss leaders." They sell a product at cost to attract new customers, but prices go up on other products purchased by their regular customers.

However, the idea that some can pay more is a relative concept. Sufficient signs are appearing in health care that cost shifting has just about exhausted itself.

A closer look at cost shifting shows that private payers choose to reimburse health care services at different amounts for the same medical procedures regardless of the cost to the services. Public payers do it, too. Among public payers, Vermont's Medicaid program routinely under-reimburses health care

services. Contributing to this imbalance is the strong medical ethic among Vermont providers. They give free or reduced-cost care to those who are uninsured, underinsured, or cannot pay.

The unintended consequence is that some health care services are placed in financial jeopardy. Here is where the cost shift comes into play. The services move their unmet costs to those who can pay, namely, private insurers. This shift acts as a temporary, and illusory, solution for health care services. Their own finances are put into reasonable order for the time being, but the financial disorder is transferred to the rest of the system. Private insurers convert higher charges into higher premiums, which creates more uninsured and underinsured. Payers, like Medicaid, must then cope with more and more Vermonters qualifying for publicly financed coverage. To do this, Medicaid's available funds are spread over a greater number of enrollees.

Reimbursements drop further. Health care services are back where they started or worse. The temporary relief was only an illusion.

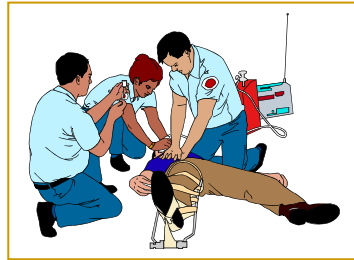
The effects radiate throughout Vermont. Private employers feel the effects as do public employers from the state and municipalities to school districts and individuals. Of course, the system has some flexibility, which over the years has allowed health care services to absorb modest cost short falls. But the time has come when cost short falls are out-running any flexibility. Has the cost shift reached a dangerous point? It would appear so. Every sector in Vermont is experiencing the effects.

What will happen if all of these effects add up to a tipping point? What will happen, for example, if 25 percent of Vermont employers drop employee health benefits? Or if another 25,000 Vermonters become uninsured in the next few years?

The bottom line is that regardless of where cost shifting occurs in the system or its severity, the cumulative impact will always hit the Vermont taxpayer. We ultimately pay the bill. Cost shifts introduce an almost impenetrable barrier to understanding the current financing of the health care system. Because of this complexity, trying to understand who is paying what for what cannot be answered easily. Constant cost shifting has made answering that question almost impossible.

What Can Happen

Why is the Cost Shift Dangerous?



Vermont's cost shift has reached the danger point, because its current size has paralyzed government's ability to deal with it. When governments cannot come up with answers to a problem, a crisis of confidence follows.

In 2004, Medicaid's shortfall was the source of a cost shift around \$50 million, which is only a portion of the shift across Vermont's health care services. Medicaid's problems are publicly visible. Cost shifts between our health care services and private insurers are poorly documented but reliably assumed to be much larger. Whatever the source of the shifts, they eventually show up in higher insurance premiums, higher taxes of some kind, and public indebtedness.

Medicaid is indebted to Vermont's health care services and nursing homes⁴⁹ to the tune of \$50 million, a figure still rising and expected to nearly double within a year or so. The Legislature is looking for answers. How did Medicaid get to this place?

Medicaid is the insurer of last resort. The economics of health care are driving more Vermonters below the eligibility line for Medicaid coverage. We are looking at not only a cost shift but a shift in responsibility. Qualified Vermonters, when they can't get health insurance any other way, fall into the laps of Medicaid or Medicare. No one else but public insurers will take responsibility for them. Currently, Medicaid and Medicare insure more than a third of Vermonters. However, they pay almost 45 percent of total health care costs. By contrast, private insurers insure a little over 58 percent of Vermonters but only 38 percent of total health care costs.⁵⁰

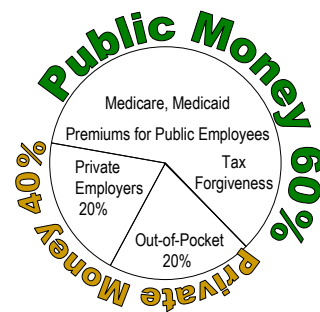
⁴⁹ Medicaid pays 58 percent of the costs of nursing homes. (Medicare contributes 21 percent, out-of-pocket 19 percent, private insurance 2 percent.) *Vermont Health Care Expenditure Analysis and Forecast: Initial Release*, BISHCA, April 2004, pg. 20..

⁵⁰ *Vermont Health Care Expenditure Analysis*. BISHCA, 2002.

Nor is this the whole story. Because so many more Vermonters today qualify for Medicaid, including children, the available Medicaid funds have had to be spread more thinly. More thinly, of course, means that payments to the health care services are less and less adequate and, in turn, health care services wind up shifting the shortfall in payments to those who can pay. Under these circumstances, not surprisingly, health care services are increasingly less confident about Medicaid's ability to pay adequately. Medicaid is a state and federal tax-supported program operated by the state, so its high-profile troubles are creating a serious credibility issue for government.

But is this fair? On the one hand, we ask government to step forward and help those who cannot obtain private insurance. On the other hand, we blame government when its program wobbles under the onslaught of those who qualify. To put it another way, we ask government to take responsibility for a situation over which it has no control. Buried in the high dollar figures of the cost shift is a shift in responsibility.

What can happen is already happening in Vermont. So far, a few health care services have begun to doubt the wisdom of taking on Medicaid patients and are refusing to do so. What can happen did happen in the late-1990s in dental care. Many dentists dropped out of the state program for lack of fair reimbursement. Eventually, only 35 were left serving the entire Medicaid population of about 100,000 people.



The Way We Finance Health Care

How we finance health care is the major source of our problems. No health policy guarantees coverage to all Vermonters (nor all U.S. citizens, for that matter). Therefore, financing by definition must come from multiple sources, which results in fragmentation and inefficiency. The health care sector has become so complicated that massive bureaucracy is required to make it work.

Following are different financing sources for health care in Vermont:

- (1) About 60 percent is funded by taxes and tax forgiveness,⁵¹ which supports public health programs, Medicaid, and Medicare. A significant portion of tax money comes from the federal government as matching funds for Vermont's Medicaid program and the Medicare program for the elderly. For the latter, Vermont pays more out in taxes than it receives in benefits because of Vermont's relatively low Medicare costs.
- (2) Employers also help cover private insurance premiums for health plans for their employees with tax-exempt dollars.
- (3) Premiums are paid to private insurers by individuals who are not part of a larger group.
- (4) Individuals pay direct expenses for health care services outside the bounds of their insurance or as a result of having no insurance.

This mix of payers creates a situation that allows underpayment for services and major inequities among those who are paying the bills. Further, when the fixed costs of the infrastructure aren't fully paid, a deficit results; then everyone in the system tries to offload their financial obligation to someone else. At the heart of the problem is the fact that no payer wants to take responsibility for Vermont's health care services. Instead, the shrinking number of payers systematically try to avoid paying the fixed costs of the services, which at one time or another they'll need.

Today, Who Pays for Our Health Care?

A simple exercise in arithmetic offers a perspective on who pays for health care. The average health care cost per person in Vermont is about \$5,100, which is nearly \$1,000 less per person than the national average. The average lifespan in Vermont is 70 years. So, if we take a very average Vermonter over a very average lifespan, we find that s/he requires \$360,000 (at today's dollars and today's costs) for a lifetime of health care.

Give or take a little, \$5,100 is about the cost of a good private health insurance policy today for an individual. Some people use less than \$1,000

⁵¹ S. Woolhandler and D.U. Himmelstein, "Paying for National Health Insurance –And Not getting It," *Health Affairs*, Vol. 21, No 4, July/August 2002, pp. 88-98.

worth of health care a year; some use much more. The numbers are fairly steady. Around 10 percent of the Vermont population (63,000) is responsible for more than 70 percent of the health care spending; 90 percent (567,000) are responsible for 30 percent of spending. One needs to be careful of wrong conclusions here. One wrong conclusion is thinking you can identify the 10 percent of people who use too much health care. That 10 percent is a statistical category. You can be one of the 90 percent for most of your life, then have a car accident and land immediately in the high-cost 10 percent category.

Averages and statistical categories help our understanding but cannot capture the wildly uneven and unpredictable distribution of illnesses and trauma for individuals. The patterns of incidence are invisible to us at the micro or individual level but become visible at the macro or population level. The macro level is where meaningful patterns of payment emerge.

If we were to hand over \$5,100 to every Vermonter each year to pay for health care, a lot of us would make out fine. But many of us would not. The latter would use the \$5,100 quickly and be in debt up to their ears in no time. Such disbursement would have the effect of putting health care services in debt at the same time.

Where Does the Money Go?

Most of Vermont's \$3.2 billion health care bill in 2004 went to health care services or what we call the health care "infrastructure."⁵² The health care infrastructure accounts for 70 percent of health care spending or more than \$2.2 billion. The remaining \$1 billion went for prescription drugs, medical supplies, government health activities, and some private payer administration.

This breakdown makes health care itself sound expensive. However, the figures conceal another important number: administrative costs.

At the national level, administrative costs for health care are around 31 percent of total spending. This figure covers administrative costs of

⁵² Figures for 2004 are estimates based on the *Vermont Health Care Expenditure Analysis and Forecast*.

One-half of
health care's
administrative
costs are to
chase payments
or deny coverage.

providers, such as hospitals, and public and private insurance payers. The figure for Vermont may be a little less than the national figure but not by a lot. At the state level, administrative costs of private insurance are not available and must be estimated using national figures. The total Vermont figure for administrative costs is somewhere between 26 percent and 30 percent—probably closer to the latter.

Almost certainly, the real figure is between \$800 million and almost \$1 billion. More than half of that figure—between \$560 million and \$700 million—consists of administrative costs tied directly to the way we pay for health care.⁵³ That money is for administrators to chase or deny payments. Health care systems in all other industrialized nations do not incur these costs. They pay for health care with less administrative costs. If we had adopted one or another of their more efficient payment systems in 2004, we could have saved somewhere between \$500 million and \$700 million.

These are big numbers. Reading them, you ask, “Is this OK?” Of course it’s not OK. But we don’t do anything about it. We seem paralyzed. No self-respecting business would tolerate administrative costs in this range. The fact that much of the money spent on administration could be used to make health care accessible to other Vermonters makes it even more distasteful.

How Big is 3.2 Billion Dollars?

We’re used to having big numbers thrown at us these days. Hundreds of dollars have turned to millions and millions have turned to billions. When we talk about our national debt, we are talking trillions of dollars. So how big is \$3.2 billion?

For starters, the \$3.2 billion spent in Vermont for health care is one-third bigger than the entire budget for the State of Vermont. It represents 14 percent of Vermont’s entire economy. It’s enough to buy ten Universities of Vermont. We spend \$350 million on our roads and bridges, which comes to

⁵³ Woolhandler, Himmelstein, and Wolfe, *IJHS*. The 2004 estimate is based on the 2003 figure of \$500 million cited in the study.

only 10 percent of our health care spending. Indeed, \$3.2 billion is more than three times what we spend on elementary and secondary education.

Systematic Gaming of the System

Anything as large and lucrative as health care is ripe for “gaming” the system by both providers and payers. One hears regular reports of Medicare scams across the nation. A series of egregious abuses of health care have occurred at the national level over the last few years. A brief list follows:

Cases of Health Care Fraud/Abuse with Settlement Fees

• Tenet Health Care was involved in a Medicare fraud and patient abuse scheme.	\$683 million
• Smith Kline and Corning Lab were involved in billing fraud.	\$800 million
• Caremark was charged with kickbacks and fraud in its home intravenous business.	\$200 million
• Fresenius/NMC was involved in dialysis fraud.	\$486 million
• Roche & BASF were involved in a price-fixing cartel.	\$725 million
• Beverly Corporation was involved in nursing home fraud.	\$175 million
• Noll Corporation suppressed important research data.	\$135 million
• Abbott Labs produced faulty lab test kits.	\$100 million
• Health South settled a major Medicare fraud case.	\$325 million

These remarkable settlements alone total more than \$4 billion, more than Vermont’s entire health care bill.⁵⁴

⁵⁴ *New York Times*, July 30, 1997; October 10, 1999; November 3, 1999; January 20, 2000; and February 4, 2000; *Modern Healthcare*, March 25, 1996, and March 3, 1997; *The Nation*, April 7, 1997; U.S. Department of Health and Human Services, Inspector General; *CBS 60 Minutes*, December 19, 1999.

Fraud is like an iceberg. Only a small percentage is visible. These fraud cases are only some of the grossest examples of what is detected and prosecuted each year. They are testimony of the ease with which one can “game” the system.

As for Vermont, fortunately, we’ve been spared serious breaches of fraud. But constant vigilance is another cost of keeping a system honest.

The Vermont Medical Society reported⁵⁵ in 2004 that a \$100-million settlement had been reached with major insurers across the country, including Cigna and Aetna. The case involved systematic “improper and illegal” reimbursement methods. Violations included practices known as “bundling, downcoding, recoding, failure to recognize modifiers, and breach of prompt payment laws.” The complexity of health care administration is as an open invitation for fraud and requires additional bureaucracy to police and monitor the system.

Failure of the Political Process to Deal with Problems

Our three most recent governors have tried to deal with the complex and growing problem of health care costs. Governor Richard Snelling employed a “Blue Ribbon Panel” of health care experts to advise him on how to control health care costs to a more “sustainable” level.

Governor Howard Dean, along with a generally sympathetic Legislature, tackled broad-based health care reform in the mid-1990s. The process collapsed, closely following the disintegration of the Clinton plan. Then, in his last year of office, Governor Dean issued an executive order to create the Bipartisan Commission to Control Health Care Costs. The Commission was composed of key legislators and administration officials. Their charter was to find political agreement on the future direction and prospects for Vermont health care. Con Hogan, one of the authors, was the chairperson of that panel. It too failed dismally to reach any meaningful political agreement. The findings were predictably partisan and ideological, splitting between free-market initiatives and government-driven solutions.

⁵⁵ *Green Mountain Physician*, Vermont Medical Society, September/October 2004.

The current Governor James Douglas has also advanced a set of proposed changes to Vermont's health care system. To date, their reception in the Legislature has been lukewarm.

Churchill Hinds, a long-term observer and participant in Vermont health care, has documented over the years the many efforts of the Vermont political process to make a difference. Hinds tells us that, in each biennium, about 100 bills related to health care are introduced into the Vermont Legislature; about 24 pass into law. Further, he notes that over the last 40 years at least 5 different organizational approaches emerged to regulate health care in the state. As Vermont's one time Budget and Finance Director, Hinds identifies more than a dozen government departments and agencies that deal with health care in one way or another. On average, a major study of health care has occurred every four years or so in recent history.

With all this attention, no doubt remains that Vermont has seen important and significant improvements in health care. Improvements in Certificate of Need (CON) control capital expenditures; the current Purchasing Oversight Commission (POC) better tracks health care expenditures and budgets; an insurance mandate was won for mental health; and countless other laws were enacted to improve health care and control costs in Vermont.

Still, with all the hundreds and hundreds of bills passed, Vermont health care remains fragmented, unconnected, and incremental with little visible impact on the extraordinary rise of health care costs. Clearly, we have to consider more comprehensive change in health care if we are to have a visible impact on its costs.

Large Market Trends

Some believe that if we left the fate of health care to open markets somehow things would magically improve. In fact, some important features of marketplace economics need to be at the center of any reconstructed health care system. One of those features is to ensure that all Vermonters have a choice of physicians and other health care providers. Another important feature of market-oriented systems is to empower citizens with the information needed to choose well who provides their health care

and how. Incentives to promote the judicious use of health care could be an important feature of market-oriented systems.

However, other important factors work against creating a market-based system for health care.

In Vermont and elsewhere, a consolidation of previously independent and free-standing units of health care has occurred. The overall effect has been to decrease the number of providers and payers. These mergers and acquisitions include our own Fletcher Allen Health Care. Other kinds of affiliations among health care units include some of Vermont's community hospitals and their affiliations with Dartmouth Hitchcock and Fletcher Allen.

Insurance companies have also been going through a cycle of consolidation. The net result is fewer insurers competing in ever larger and denser markets. One negative result is that more rural and lightly populated areas have fewer potential insurers. Vermont has been directly impacted. Continuing consolidations have resulted in concentrations of money in the health care sector, which leads to a concentration of risk for everyone. For example, Fletcher Allen represents about one-sixth of all health care dollars in Vermont. If Fletcher Allen were to fail financially for some unforeseen reason, the results would be catastrophic.

Vermont health care has little control over some other nonmarket trends that will significantly define what is needed and what is possible in the future. These include the continuing worldwide AIDS epidemic, new forms of deadly viruses, such as SARs, the rising worldwide tide of tuberculosis, and the decreasing effectiveness of our traditional antibiotics against newly resistant bacteria. These trends inevitably go beyond the scope of a health care system for Vermont.

Much rhetoric is expended on moving toward a market-based system of health care, which contains some realities that must be respected. Some of these were well expressed by Vermont businessman Otto Engelberth. His analysis begins with a definition of a free market as:

*One that can regulate itself, in a freely competitive market through the relationship of supply and demand, with a minimum of governmental intervention and regulation.*⁵⁶

He then proceeds to list the characteristics of the current health care system in relationship to this definition. He properly assesses that employees generally do not have free choice of their health care; their employers actually negotiate the package or range of options. He points to Medicaid and Medicare as programs that also offer limited choice for health care consumers. His conclusion is that Vermonters do not have health care that qualifies as a true market.

The Problem Summed Up

First

The problems besetting health care in Vermont can be summed up as follows. ***The problem is gargantuan and to date has overwhelmed efforts to solve it.*** The time has come to recognize that incremental measures are not going to solve it nor significantly improve it. In fact, incremental fixes have had negligible impact on cost control.

Second

Most of our health care dollars are spent on services and facilities whether we use them or not. The way we finance payments to services and facilities is so fragmented and disorderly that it only makes the problems more uncontrollable.

Third

We have no effective means of controlling costs. These costs increases are passed on to each of us from every direction in the form of higher premiums and higher taxes.

Fourth

No one is acting as the responsible agent for health care in Vermont. Without some kind of comprehensive plan with full responsibility for our current and future health care, the problems can only worsen to the point where our economic vitality begins to crumble.

⁵⁶ Otto A. Engelberth, "Market-Based Health Care," an unpublished paper, 2004.

Fifth

Perhaps the biggest problem is that *we think of health care as something to be “consumed” on an individual basis*. In fact, health care needs to be considered as a public good. We will address this important topic at length in another section.

Vermont’s Health Care Sector is Vulnerable

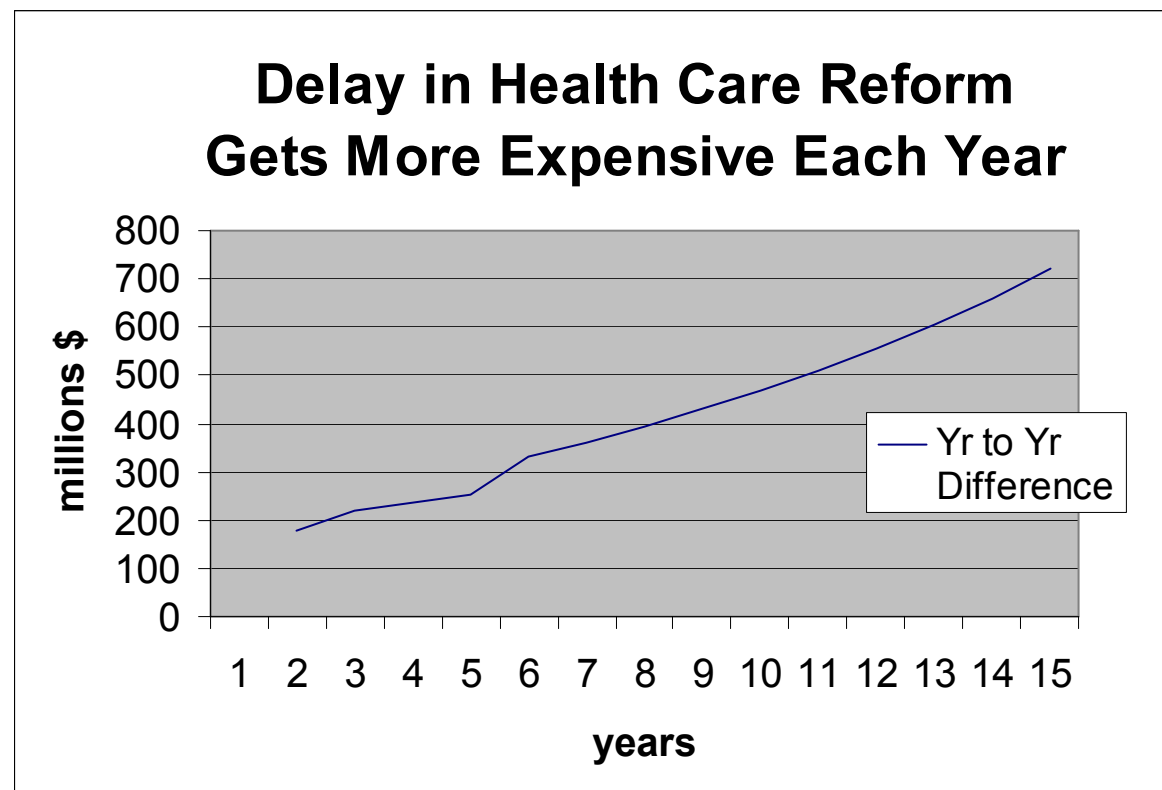
Health care vulnerability is not limited to people. The health care sector itself is vulnerable. A weak economy, for instance, adds significantly to the number of people who cannot afford health insurance. Despite our recovering economy, the number of Vermont uninsured rose by about one-third. In our current economic recovery, Vermont is not experiencing the kind of job growth consistent with past economic recoveries. Evidence reflects that, on average, the kind of job growth we are seeing is not higher-paying jobs with benefits and health coverage as in the older manufacturing-based economy. This difference is cause for real concern. When the economy inevitably weakens again, health care coverage will be even more vulnerable and fewer people will have it.

The cost of health care benefits for employees has emerged as a competitive issue. In a highly competitive marketplace but a weakened economy, an attractive strategy for employers is to have their employees pay an increasing share for health benefits or altogether drop employee health benefits. This situation is true within Vermont and beyond.

Another worry is the disproportionate role that Fletcher Allen Health Care plays in Vermont’s overall health care economy. Fletcher Allen represents about half a billion dollars of health care spending in Vermont or one-sixth of all spending. Its recent ethical and financial lapses caused a crisis of confidence for the public and the State of Vermont. Contributing to the institution’s problems is an eroding capital structure in response to a larger set of financial problems that have beleaguered it for some years. Fletcher Allen is slowly working its way through its problems with signs of slowly recovering its financial health. However, the concern is that something unforeseen may occur to threaten its financial viability, which would affect Vermont’s entire health care system. Such concerns might include any indication that Fletcher Allen is a sub-par hospital, another failure of

oversight by the administration or its board of trustees, or breaking up Fletcher Allen today into unrelated components that could dilute its financial capabilities, and so on. These are speculative scenarios. However, such risks must be considered in assessing the vulnerability of Vermont's health care.

A clear and present vulnerability is the relentless accumulation of cost increases. No mechanism exists anywhere in the system to slow these rapidly rising costs effectively. Vermont health care, like health care in other states, has no way of putting on the brakes. A system that cannot control its financial health is a vulnerable system.



The Road Ahead

Telling the future is beyond us. However, if we look at past trends merging into current trends, we can make intelligent guesses. The following conditions are likely to occur in Vermont's health care system, if current trends continue.

First

We have watched the number of people who are uninsured rise from about 43,000 in 2001 to about 63,000 today. If this trend continues, conceivably over 100,000 Vermonters will be without comprehensive health care coverage in the next five years. This number would represent a dramatic increase in the percentage of uninsured from 8 percent in 2001, to 12 percent today, to 18 percent five years from now.

Second

The number of persons who are underinsured could double over that period. Although this number is speculative, common sense teaches that people will do what they have to do to stay financially solvent. If that means cutting benefits or restricting themselves to catastrophic-only insurance policies at the expense of systematic and periodic care, they will do so. We should note that 80 percent of the population at any one time is healthy and uses very little health care. Unfortunately, this fact acts as an incentive for them to drop or limit coverage in favor of other personal economic needs.

Third

Expectations are that the assault on retiree benefit plans will continue. An increasing number of retirees who believed health benefits awaited them in retirement will be bitterly disappointed. This reality will add to the overall pressure on the health care system.

Fourth

Fewer companies will even offer health care benefits, which poses a particularly difficult problem in Vermont. A great share of Vermont's economy is driven by small businesses that struggle to help employees with health care benefits. Without a way to cover their employees, these small employers become less competitive. We are flirting with serious economic consequences for our state. People want and need health coverage. The workforce will gravitate to businesses that offer it.



Hospitals and other services will resort to extreme measures for collecting money to cover their fixed costs and unpaid bills. We will see a dramatic rise in personal bankruptcies.

These scenarios are grim indeed. But they are not far fetched. In other places in the country, such conditions are becoming reality. Vermont cannot allow its health care to undergo this kind of degradation.

Vermont's Health Care Is Worse Than It Appears

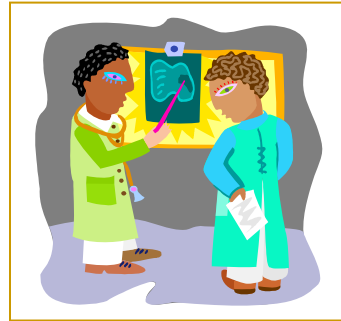
On the surface, Vermont's health care looks in good shape; however, the fiscal picture is not. On closer look, we see ominous signs. Medicaid has plunged into a \$50 million debt and is headed deeper rapidly. Neither employers nor employees feel able to cope with the increased costs of health benefits. School district budgets are in trouble, due primarily to rising health care costs for teachers and other personnel.

The deterioration of the fiscal picture gets most of the public attention. But indications are that health care itself is beginning to suffer in Vermont. Physicians and nurses—the backbone and the spirit of health care—are getting fed up. Rapid unionization of nurses is one indicator of this discomfort. We have no hard evidence in Vermont in the form of studies, but anecdotal evidence is strongly suggestive of a loss of morale among health care professionals. Many people in the profession now recognize that the problems are getting worse and answers are few and far between.

Paradoxically, the good news is that Vermont health care is only lagging behind the times. It hasn't fallen to the level of other states in decline, such as California, which has closed over one-half of its trauma units over the last ten years.⁵⁷ The bad news is that Vermont may soon begin to experience similar problems.

⁵⁷ *Los Angeles Times*, January 24, 2001.

Why Can't We Do Something About It?



The Gargantuan Size of the Problem

The reason why we haven't effectively grappled with this problem is first and foremost its gargantuan size. Its complexity involves interactions of the private sector, government regulation, insurance companies, markets, and citizens.

Some Reform Elements Always Resisted by Someone

Specific elements of reform will always be resisted strongly by those with serious financial interests at stake. Since all health care reforms have the moderation of cost as an objective, some players in the system will lose financially. This factor guarantees serious resistance to change.

A second impediment is an inordinate insistence on creating the perfect system. Perfect, the old saying goes, is the enemy of the good. Any reform proposal is going to have soft spots. Weak points are wise to acknowledge, but goals are unwise to abandon. Canada's much-maligned health care system offers an example. Although serious problems and weaknesses exist, they are correctable. Canada's health care system is open to public assessment and debate. The federal and provincial governments are adjusting the system in response. The point is, Canada has a system, so its dynamics can be fixed. Vermont's health care services fall far short of being a system. What we have in Vermont is not open to assessment or correction. If it were, we wouldn't be writing this book.

Systems as large and complex as health care are subject to events beyond their control and cannot nor will not ever be perfect. This fact is true of every health care system in the world. Our big concern ought to be with what we have now and what is bound to happen if we don't figure out how to change it. That's why we should consider a "design-build" approach.

The design-build concept takes into account that perfect planning for a new structure may not be possible. Events intervene and change specifications. Some construction projects use a process where basic characteristics of the structure are determined, such as size and shape. Then, as construction begins, various teams put together more specific plans for the structure. These ongoing plans are then accommodated in the construction. The process becomes an iterative one. The approach allows successive stages with each stage building on the last and each evaluating and adjusting throughout the process.

Legislature Lacks Sustained Focus or Technical Support

The Vermont Legislature's structure and process go against sustained focus on an issue of the size and importance of health care. Further, the Legislature does not possess the necessary technical support to tackle an issue this big and complex. Furthermore, the Legislature's normal committee process is wide open to distortion of crucial reform elements, especially if the reform threatens powerful special interests as health care does.

The accepted process means that any legislative bill moves from committee to committee with each committee adding, subtracting, changing, or amending the bill until its original purpose is lost from view. In the case of complex issues, such as health care, many legislators are put in the position of taking someone else's word for whether a bill is good or bad and whether it does the job or not. Under these conditions, special interests can far too easily prevail.

Vermont has every reason to be proud of its tradition of a citizen Legislature and its capable, nonpartisan Legislative Council. Even so, the order of magnitude of health care defeats normal understanding. The technical help is not there; when it is there, it does not come from disinterested parties but from providers, payers, and others with obvious financial self-interest.

We're at a Crossroads

Vermont is at a crossroads to future health care policy. Our choices are relatively straightforward.

We can continue to muddle along and let trends have their way with us and let costs spiral out of control. We can allow fewer and fewer people to have health care coverage. In a short period of time, those covered through the private sector will be forced to find alternatives to their current comprehensive coverage. They will turn to higher deductibles, catastrophic-only insurance, and other alternatives like health savings accounts to keep the price of their health care under control. These trends, in turn and over time, will result in a deterioration of preventive opportunities as more and more available dollars go to treating people who are very sick.

These trends are inevitable, if we do not step in and control our own destiny.

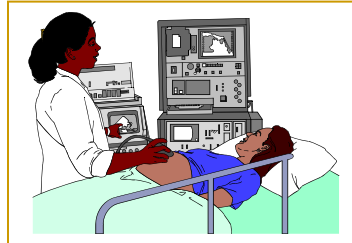
“Define or be defined” is the other choice at the crossroads. We have the ability to alter the future of health care, if we come together and begin to act. The problem is too large and complex to allow these problematic trends to continue. We can maintain and even improve the quality of our health care and begin the difficult process of controlling costs, while still providing coverage for all Vermonters.

Simply by making all Vermont citizens eligible for health care coverage, we open the door to finding ways to streamline financing and to eliminate outsized administrative spending. Health care coverage for all can actually prompt an organized approach to doing more prevention. In doing so, we can lower the massive cost of preventable disease and illness, such as diabetes and heart failure. One thing can lead to another, if we choose the right road

Fortunately, no place in the country offers a better prospect of systematically reforming health care than Vermont.

Maybe We Could ... If

We Understood Better What The Public Wants



Most discussions about a better health care system have been led by those who have a stake in the existing system—primarily, the providers and insurers. A missing but essential constituent is the public itself. Broad-based studies give us a sense of what the public would like to see in our health care system. One set of characteristics and values expressed by the public were taken from a recent CSPAN discussion. Some key words and phrases from that discussion follow:

We need a system that supports people and their communities... Individuals should have information and power to make their own decisions... Patients should be able to choose their providers with few exceptions... We need national standards for health care with more local control and management... Citizens should have clear rights and the health care system clearer responsibilities... Decisionmaking needs to be taken 'out of the beltway' where compromises aren't possible... We need to find agreement on our core values first, then figure out how to meet them... We need new templates that help communities act on behalf of our health.

These publicly held values are striking. They go beyond the current limits of the health care debate; they embrace issues of family and community. The public's view broadens the definition of health care from a narrow view of treating disease to broader views of prevention, community, and lifestyle.

In effect, the eyes of our citizens provide the vision needed to unleash the genius of the American public on behalf of a better and more cost-effective health care system.

We need to be more futuristic in our thinking and get beyond the “prison” of the annual budget. Many communities count on health care for their

economic sustenance. We need a period of two to five years to plot a course to bring us back on track, allowing us the time to chart new goals and principles and transform our health care into an integrated system.

In the words of one commentator, we need to increase the “health span” not just the life span.

We Agreed on the Principles

We need to reach agreement on fundamental principles and goals for Vermont’s health care system.

Think
“health span”
not just
life span.

One of public policy’s afflictions is how regularly and quickly we plunge into details before any agreement on principles. Principles and goals should drive the process. For example, do Vermonters believe that all of us should get the health care we need or not? Do we believe that government has an important role in whatever we create or not? Do we believe that financing such efforts should be fair and equitable or not?

These questions are fundamental for Vermonters to answer. After all, we the people have to pay a good part of health care costs. From these conversations will come a set of basic principles and goals about health care. Such principles will guide our way through difficulties that we are certain to encounter.

Any process of rethinking our troubled health care system should start with a broad effort to gain public consensus on principles and goals for reformed health care in Vermont.

We Focused on the Process of Reform

How reform is undertaken is just as important as the content of the reform itself. Substantial public engagement is necessary in a process whose goal is both large and complex. At some point, health care reform will touch everyone’s life. Policymakers should know that support for change is wide and deep.

The process of change needs to be staged over time. The intricacies of health care reform are so dense and complex that they require time to grasp and implement fully. These stages, however, must represent real strides toward the ultimate goal, not merely tinkering with detail.

As much as possible, the process must be nonpartisan. To assure this, an entity as a guiding authority may be necessary to take a stand somewhat apart from any given administration.

Last, but most important, the Legislature has to find and adopt a decisionmaking process that allows consideration and action on a comprehensive approach to our health care problems.

We Created Better Legislative Decisionmaking

The size and scope of action to be taken on behalf of a better system of health care for Vermonters will require new ways of doing business, particularly in the Vermont Legislature. One candidate for a new way of thinking is what was known in the U.S. Congress as the “base-closing” process. Briefly, this approach asks a legislative body to vote up or down on a whole proposal submitted by an independent authority, following review of the whole by a joint committee of a legislature formed for that specific purpose.

Precedent already exists for this way of doing business. For decades, Congress was asked to streamline our military by closing some military bases. The process was stymied by powerful congressional representatives with strong political interest in keeping them open. Congress was stuck until the idea of an up or down vote was introduced. This practice took individual congressional representatives off the hook as the vote migrated to a level where the interests of the whole were primary. When this provision was finally passed, Congress could begin the serious business of streamlining the military through a ten-year program of base closings.

Similar legislation allowing up or down votes on whole proposals could set the Vermont stage for proposing large-scale changes to health care.

Altering the usual process will not be welcomed by some in the Legislature. Nor are the special interests throughout the health care industry going to be happy. However, if we can marshal the forces to adopt a version of an up-or-down vote on a whole proposal, then individual legislators will find themselves in this position:

The “*Yes*” vote on a health care reform proposal
will affect all Vermonters for the better,
The “*No*” vote brings Vermonters nothing.

The aim of this technique, of course, is to ensure that a whole integrated proposal comes to a vote. Confusing details of small, hodgepodge initiatives, even if good policy on a limited basis, would achieve little cumulatively.

Over the last ten years, hundreds of health care bills have passed in the Vermont Legislature. If we are honest with ourselves, we know their affect on the growth rate of health care costs has been nil. Invariably, the promoters and sponsors of the legislation have advertised the changes as “health care reform.” Given their limited impact, “reform” is a stretch of the imagination.

Could Vermont Systematically Improve Health Care?

The answer to this question is straightforward. Yes, we can. Three key elements are needed to improve Vermont’s health care, plus a working guideline on how to approach the problem.

- We need to construct key principles and goals for an improved system.
- We need to outline key elements of an improvement plan.
- We need to clearly define the roles of all players in the new system.

An important working guideline in tackling this huge problem is to stay with a macro level of planning and get agreement on broad change before plunging into details. Unmanageable detail early in planning will assure that any change process will get stuck and not recover.

However, we must think long-term at this point. We are beyond short-term, incremental, quick fixes.

But Only If....

A Major Perspective Shift is a Good, Needed Start



As we begin to consider health care as a system, we would like readers to take a moment and solve the following arithmetic problem. The rules are simple. Please read the following out loud, then answer the question at the end. You are not allowed to go back and reread the problem after you read the question.

You get on a bus and it leaves the terminal. At the first stop, 4 people get on. At the next stop, 3 more people get on. At the next stop, 2 more people get on and 1 person gets off. At the next stop, 6 people get on and 4 get off. At the next stop, 4 people get on and 8 people get off. How many stops did the bus make (and you are not allowed to go back and count)?

You probably didn't know the answer, because you were solving a different problem. You were trying to determine how many people were on the bus after the last stop. In health care, we're nearly always trying to solve the wrong problem.

The history of bureaucracy is littered with detritus of solving the wrong problem at the wrong level. For example, health care costs are high compared with every nation that makes any pretense of having a health care system. The problem always posed is how to reduce the "use" of health care. That's the wrong problem, rather like counting the people who get on the bus.

Health Care Services: Shared, Not Consumed

To get a clear view of the underlying problem, the one we need to solve, we need a different perspective. A first step is to accept that health care is an essential service. In Vermont, because almost everyone gets the health care they need, health care is a shared service. We take the position that the



distinction between a “*shared service*” and a “*consumed product*” is critical to understanding the fundamental problem.

Looking upon health care as a consumable commodity has proven misleading and confusing. The portion of health care “consumed” is small. Consumables are restricted to prescription drugs and medical supplies (e.g., splints, bandages, wheelchairs, etc.). They comprise only about 16 percent of the costs in running a health care facility, such as a hospital.

Instead, the largest costs of a medical facility are apportioned between fixed costs (overhead items, such as rent, utilities, etc.) and costs that are all-but-fixed (the skilled professional staff). The first amounts to about 32 percent of the total. By far the largest portion—52 percent—is for skilled staff.⁵⁸

We’ve coined the term “all-but-fixed” to cover a category that is routinely misunderstood in health care. Skilled professionals, like those providing health care services, are not easy to find or replace. On an annual budgetary basis, they act as fixed costs. On a longer-term basis, more flexibility emerges. A health care service may discover a pattern, over a year or two, of declining admission rates and find that six nurses are too many and five is sufficient. But for all practical purposes, over the short term (at least a year), skilled staff act as all-but-fixed costs.

While writing this book, Terry Doran, one of the authors, experienced a lesson in fixed costs vs. consumables. He broke his leg running on a treadmill at a Montpelier gym. Five EMTs showed up, two transported him by ambulance to Central Vermont Hospital’s emergency room. An attempt to reduce the fracture failed. The next afternoon, it was surgically set and plated. The following afternoon, he was discharged on crutches. Over the 48 hours there, he “consumed” four meals, surgical bandages, dressings, staples and gloves, the surgical plate, pain medications, anesthesia, a soft cast, and a few other items, such as a disposable toothbrush. He retains the crutches. Over those 48 hours, he also had face-to-face exchanges with 21 health professionals: doctors, nurses, technicians. Another 10 professionals (unseen)

⁵⁸ Rebecca R. Roberts, Paul W. Frutos, Ginevra G. Ciavarella, Leon M. Gussow, Edward K. Mensah, Linda M. Kampe, Helen E. Straus, Gnanaraj Joseph, and Robert J. Rydman, “Distribution of Variable vs. Fixed Costs of Hospital Care,” *Journal of the American Medical Association*, Vol. 281, No. 7, February 17, 1999, pp. 644-649.

were involved: radiologists, lab technicians, and operating room personnel. Roughly 30 health professionals (not counting cleaners, cooks, and administrators) attended to him. The physical capital (ambulance, hospital room, etc.) and the human capital (EMTs, doctors, nurses, technicians) represent fixed costs. The costs of “consumables,” by comparison, are minor.

Over a year’s time then, the majority of costs for health care services—84 percent—are inflexible.⁵⁹ On an annual basis, these costs are unresponsive to whether we use them or not. Only about 16 percent of health care costs are “consumed.” They also vary at any time. So tackling health care costs from “use,” or the consumer end, cannot produce the dramatic reductions that are envisioned. This point is fundamental.

We are not claiming that use plays no part in costs. We are claiming that the preponderant factor in costs is the “capacity” that is in use. In fact, the term “use” is usually used pejoratively to imply “unnecessary use.” Over the long term, “use” is a reflection of “need” within the population served. Need and capacity are closely linked.

When health care services are used, they are not used up. Medical knowledge and skills can be used as much as needed, yet still remain. Most health care is like that. Terms like “use” or “consume” are beside the point. Most costs pay for health professionals to deliver care with a high degree of medical knowledge and skills. Trying to save money by keeping patients out of the hospital is like trying to save money on schools by keeping kids home for the day.

A simple example: consider an MRI scanner. The capital cost is about \$3.5 million, amortized over a period of years. The MRI is staffed by a radiologist and technicians. Those fixed costs are about \$500,000, plus annual amortization. An HMO patient needs an MRI scan.

- (1) Permission from a clerk is required. Permission falls under what we call patient-end control.

⁵⁹ *Ibid.* This study centered on hospitals’ fixed costs. We extrapolated the physicians’ practices and other services; so we expected some variance but not enough to disqualify the point.

- (2) Whether or not the clerk grants permission, the annual fixed costs remain the same. Curbing unnecessary use has little effect on annual fixed costs.
- (3) The fewer patients using the MRI scanner, the higher per patient charge will be to “retire” the annual fixed costs (or, the more patients, the lower the charge per patient). The real effect of such use-or-not-use decisions is to move charges among payers or, if annual fixed costs are not met, to shift them to those who can pay.
- (4) The basic question is not: can we reduce use? But is there enough need in the population to support the annual fixed costs of an MRI service? Or, is this MRI service the right capacity? If it’s more than we need, it’s costing us more than necessary. If it’s less than we need, capital investment in another MRI scanner is necessary.

Excess
capacity,
not use,
is the driver
of health
care costs.

Chipping away at the “use” or patient end won’t alter the MRI’s annual fixed costs or save a lot of money. Another example:

For some years now, the Montpelier School Board has wrestled with a drop in enrollment (“utilization”). At the end of 2004, the board voted to close Main Street Middle School and build a wing on the high school for middle school students (in effect reducing “capacity”). Reducing capacity also means cutting staff. The costs will be publicly financed by city taxpayers and the state. The board’s decision was made in the face of strong opposition from many in the community.⁶⁰

Capacity

Any discussion of costs must begin with capacity. If instead we begin, as managed care did, with “use” or individual utilization, we find that the techniques of cost management can be very expensive. The evidence is also insufficient that managed care reduces total costs. Decreased utilization can save money but only over the long term. The immediate link that we want to investigate is between “costs” and “capacity.” The two are directly related. If one goes up, the other goes up; if one goes down, the other goes down.

⁶⁰ *Times Argus* September 9, 2004, and December 17, 2004.

Costs That Will Go Up & Costs That Will Go Down

↑ UP

- Care for the uninsured
- Care for the underinsured
- Quality control
- Information technology
- Short-term costs for chronic disease

↓ DOWN

- Administration
- Workers compensation
- Secondary illnesses
- Overuse of medical care
- Charity care
- Long-term costs for chronic disease

Costs shift
from those
who cannot pay
to those
who can pay.

What is capacity? Capacity is a measure of how much health care a facility can provide. The determining factors of capacity are the size of the facility itself (fixed costs) and the size of its professional staff (all-but-fixed costs). If health care is costing too much, you have to decrease the fixed and all-but-fixed costs (that is, reduce the capacity). If too little health care available is, you have to increase these costs (that is, increase the capacity). Capacity is critical to understanding health care costs.

Curbing “capacity” saves a lot of money. Capacity is one of the principal drivers of medical care costs. Excess capacity is a driver of unnecessary costs. Capacity is measured across the health care infrastructure. When there’s more capacity (too many staffed beds in a hospital) than need, cost per patient go up.

Imagine that a hospital in Vermont chooses to expand. It builds a new wing and staffs it with doctors and nurses. Setting aside the one-time construction costs, ongoing costs will include the increase in overhead for the new wing and the increase in medical staff. To meet the increase in fixed and all-but-fixed costs, the hospital must have paying patients. If it doesn’t, then it must advertise for them. If it can’t find enough new patients, a couple of choices remain. The hospital could give up the new wing and the new staff OR increase its charges to current patients in order to spread the costs around—the cost shift.

Spreading costs around doesn't mean only to current patients. When charges go up for a large enough group—as this hospital's patients—insurance companies are going to raise rates to offset the new charges. That means premiums for the rest of us go up, whether we go to that hospital or not.

Fletcher Allen is a perfect example in Vermont of having too much capacity. We know this because it is advertising for patients in New York State. If this need isn't met, higher costs will trickle down to all Vermonters. Capacity then is a managed response to population-based planning. Managing capacity is fundamental to curbing costs.

To reduce the rate of rise in future health care costs requires more closely matching the capacity with the population's needs. Other fragmentary approaches may emerge, but they are less efficient and bound to cause unintended consequences.

Health care's
“infrastructure”
is its capacity
measured by
medical
facilities and
services.

Capacity is a reliable guide to important aspects of health care. But where does capacity come from? What guides capacity? The population shares in the health care services, so capacity is measured at the population level.

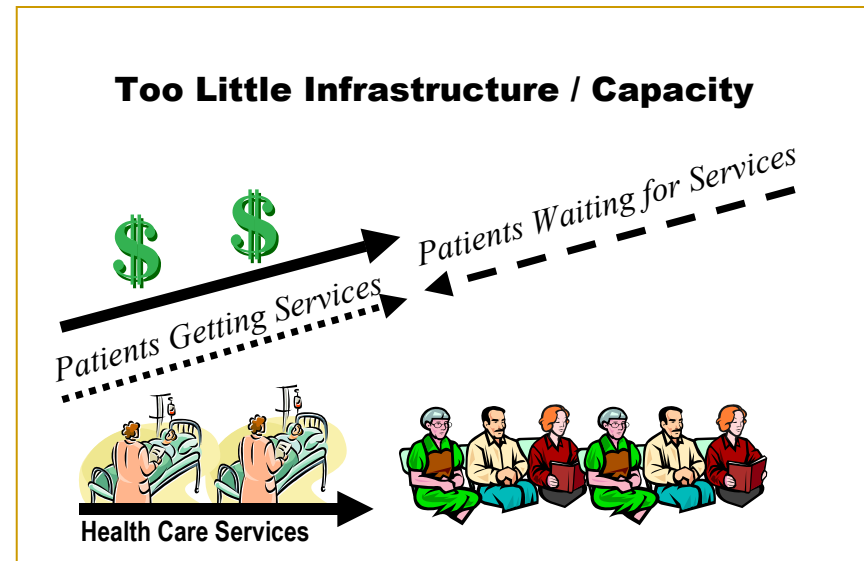
Capacity has been shaped over many years. It continues to evolve and will continue into the future. Capacity, in other words, is a *process*. Capacity is set in motion by the health care needs of all Vermonters. Vermont's health care infrastructure is what it is right now. But the infrastructure's capacity responds to changing needs within the population. The shortage of flu vaccine in 2004 will likely cause a surge of unplanned need, for instance. The infrastructure is probably flexible enough to accommodate this need, but other changes within the Vermont population will require more permanent additions or subtractions to the infrastructure's capacity. For instance, an aging population requires more nursing home capacity.

Another factor in shaping capacity is Vermont's CON administered by BISHCA. The process could be more rigorous but does attempt to discourage building more capacity than is needed. No process is available to control situations like Fletcher Allen's excess capacity. But, in general, CON plays a role in why Vermont's overall health care costs are lower than the national average.⁶¹

⁶¹ Vermont Health Care Expenditure Analysis, BISHCA, 2002.

The link between capacity and need is not perfect, because no perfect way exists to assess health care needs in a population—even a small population like Vermont's. On the general population level, however, health care needs emerge a bit more accurately than one might expect. Some health categories have fairly predictable use patterns: 7 percent of Vermonters have diabetes, 25 percent have high blood pressure, and 5 percent have heart disease. These percentages form a reasonable guide to the capacity needed.

The population's need for health care should determine the capacity of its health care services. This link is particularly important, because it emphasizes that health care extends beyond our personal needs. It's a collective need—Vermont's whole population impacts the capacity of health care services. The important realization is that we all play a *statistical*, rather than an individual, role in shaping the capacity of our health care services. Whether we have insurance or not, or are healthy or not, or go to the doctor or not are not the determining factors.



Why is this? If we're healthy, why can't we just forget about health care until we fall ill? First of all, we are a statistical member of Vermont's population, which renders the occurrence of health care needs that, in turn, act as a rough

Health care
belongs
on the same list
as other
shared services
like police,
highways,
libraries,
and schools.

guide to the capacity of the health care services provided. Second of all, for these services to exist, they must be used pretty much all the time. In effect, while we are healthy, we depend on a statistical segment of Vermont's population to be sick enough to use the services. In this respect, Vermont's health care services are *shared* by us whether we are well or ill.

Later in this section, we make the point that an understanding of health care and its problems is best achieved at the population level and not the individual level. This point is especially important in paying for health care.

The Services

In Vermont, health care services are distributed at a local, then regional, then statewide basis. Beyond that are out-of-state services. Starting from the local level, each step up embraces a larger geographical area, includes a larger population, and generally provides more and different kinds of health care services that are unavailable at lower levels.

The most important features of Vermont's health care services are the following:

- (1) As we track services from the local to the regional to the state to the out-of-state levels, health care becomes increasingly intensive and usually more costly.
- (2) The more intensive the care, the fewer patients under treatment.⁶²
- (3) The reason why the State of Vermont has no heart, liver, lung, or bone marrow transplant units is because the population does not manifest enough need to support them.

Below is an outline of Vermont's health care services at the local, regional, and statewide levels, plus some out-of-state connections. The services at each level are not meant to be exhaustive, but rather indicative of the type of service.

⁶² Fletcher Allen's trauma unit had a relatively small number of patients on a yearly basis in a highly skilled, labor-intensive, and expensive environment.

THE OUTLINE

LOCAL PHYSICIANS

- Primary Care (checkups, vaccinations, diagnosing and treating acute and chronic illness, such as diabetes, back pain, high blood pressure, high cholesterol, sinus infections, etc.; minor surgical procedures, pap smears, simple orthopedic procedures, such as setting fractures, eye care, dental care, etc.).
- Home Care.
- Nursing Home.

REGIONAL FACILITIES

- Community Hospitals (congestive heart failure, complicated pneumonia, emergency care, surgery, intensive care unit (ICU), obstetrics, mammography screening, CT scan, cancer care, etc.).
- Drug Rehabilitation.
- Dialysis Units.
- Magnetic Resonance Imaging (MRI) Scanners.

STATEWIDE (OR CENTRAL) HOSPITALS

- Fletcher Allen Medical Center (ICU, neo-natal ICU, coronary stent procedures, neurosurgery, trauma care, burn treatment unit, heart surgery, cancer care, skin grafts, hand surgery, emergency care, etc.).
- Dartmouth-Hitchcock Hospital in New Hampshire, and Albany Medical Center in New York, also function as Vermont statewide hospitals, offering the most intensive care procedures. Vermont, however, has no jurisdiction over them.
- PET Scanners.

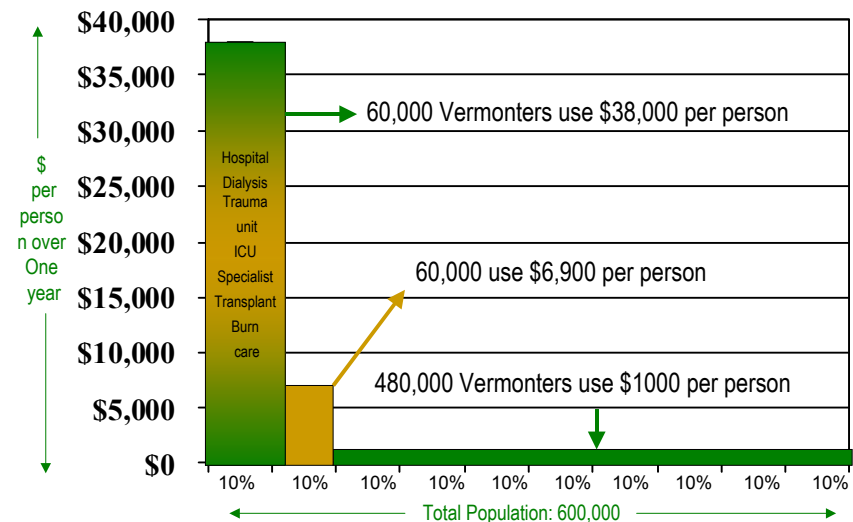
OUT OF STATE ONLY

- Transplants (heart, liver, lung, bone marrow, kidney).
- Rare Disease Treatments.
- Barometric Chambers (carbon monoxide poisoning, gangrene).
- Highly Specialized Surgical Procedures (conjoined twins, pediatric heart surgery, and others).

Looking at this outline of services, the reader may arrive at a surprising insight into health care costs and how they are distributed. This insight will lead us back to the point that services are both gauged and supported financially at the population level rather than the individual level. The outline supports our discussion of the direct links among costs, capacity, need, and population.

A further point emerges that is very important to financing health care. As you move up the intensity scale from local to regional to state to out-of-state, the number of patients needing a procedure are fewer while costs are greater. The same is true of a number of other procedures. The existence of a trauma unit in Vermont tells us several things. Our population is sufficient to support a trauma unit, which means that enough trauma patients will emerge each year from our population, and that our population is willing to bear the costs.

Most Expensive Services Used by Fewest People



For a clearer picture, imagine an individual Vermonter. We'll call him—not to be too original—John Smith. We imagine Smith and his medical biography to be entirely ordinary. The costs in parentheses are approximate and on today's scale of charges.

- Smith is born at his regional Vermont hospital (\$10,000). He has some minor problems in the delivery and has to stay a few extra days. He pays periodic visits to his pediatrician, receiving vaccinations and routine checkups (\$400).
- At age 12, he develops appendicitis, which causes a perforation. The initial evaluation is made by his pediatrician at the local level, who sends him to his regional hospital for an appendectomy. A week of hospitalization is required due to complications (\$10,000).
- At 20, he falls skiing and suffers a complicated fracture of his right leg. He is sent to the nearest regional hospital where he undergoes surgery to set the fracture (\$5,000).
- Smith, now in adulthood, is a good patient. He drinks very little, does not smoke, exercises regularly, and eats a balanced diet. He sees his local primary physician for routine checkups (\$1,000).
- Other than normal colds and several flu episodes, Smith's health record is uneventful until he reaches 50, when he develops high blood pressure. Given his healthy lifestyle, he is surprised. He goes on medication prescribed at the local level (\$600 per year for his medications).
- Smith is asked to see his primary physician four times a year to monitor his condition and overall health (\$1,500 a year for routine care).
- In his late 50s, he begins to suffer vision problems and has bilateral cataracts removed by a specialist at a hospital in the next county (\$2,000).
- At 65, Smith is diagnosed with prostate cancer. An abnormality is detected by his primary physician and he is sent to his regional hospital for further tests. He is diagnosed with prostate cancer and undergoes a prostate removal (\$17,000) and radiation therapy (\$25,000).
- At 70, Smith suffers a heart attack with no warning signs. He is hospitalized for a week in his regional hospital. He receives thrombolytics (clot-busting medicine), a stent (tube inserted in the heart artery to prevent clogging), and multiple tests before being discharged. He is put on two more medicines plus aspirin: one for borderline cholesterol, and one as a precaution against another heart attack. He

undergoes intensive cardiac rehabilitation at his regional hospital (\$38,000).

- He does well under this regimen. Then at 88, he shows definite signs of memory impairment. He forgets to take his heart medicine. His blood pressure goes out of control. He resists his family's attempts to bring someone into the home to look after him. He insists on living alone. His primary physician is consulted far more frequently (\$2,000).
- At 90, Smith suffers a stroke from controlled high blood pressure. He is sent to his regional hospital. From there, he is placed in a local nursing home. Smith remains there for the next two years. He dies peacefully in his sleep at age 92 (\$120,000).

The next biography is of a disease: diabetes, which 7 percent of the Vermont population is expected to have at some time. Type II Diabetes is the most common form of diabetes. The American Diabetes Association⁶³ describes diabetes as a condition in which *“either the body does not produce enough insulin or the cells ignore the insulin...Over time, high blood glucose levels may hurt your eyes, kidneys, nerves, or heart.”*

- Type II Diabetes emerges in John Miller, a corporate executive, at age 48. He begins feeling poorly. He loses weight, feels fatigued, and urinates more than usual. He finds himself drinking water all day long to quench his thirst. John hates going to his local family doctor but finally gives in at the urging of his wife.
- His family doctor diagnoses Type II Diabetes, high cholesterol, and high blood pressure. He recommends diet and exercise. They try that regimen for six months. John tries very hard to lose weight and begins to exercise more than he used to, but it doesn't work. He does not bring down his sugars, his blood pressure, or cholesterol to low enough levels. His doctor prescribes oral medications (\$500 per month). Visits to his physician the first year cost around \$1,000.
- He continues to try and control his health habits but never quite manages them well enough to get off his medication. After ten years, Type II Diabetes begins to take a heavier toll on his health. He suffers

⁶³ The American Diabetes Association's website is www.diabetes.org/.

86% of
health care
spending
is for
20%
of the
population.

numbness in his feet and his doctor detects kidney damage. By this time, he has been on insulin for several years. Because he does not have sensation in his feet, he develops sores from shoes that are too tight. An ulcer develops and gets infected. John ends up in his regional hospital with a foot infection, which requires surgical treatment and IV antibiotics. Despite treatment, John develops gangrene, and the surgeon amputates half of his foot (\$20,000).

- Not surprisingly, at this point, John begins to take his disease much more seriously. He makes honest efforts to control his sugars to perfect levels. His kidneys show some compromise, but he is able to delay kidney failure for several years past their expected demise. After another ten years, however, his kidney problems reach a point requiring dialysis. He goes to a free-standing regional dialysis unit (\$52,000 per year).
- John finds dialysis very confining. He has to go for treatment four hours a day, three days per week. After two years, he chooses to have a kidney transplant. No kidney transplant units exist in Vermont, so he travels to an out-of-state hospital for the transplant (\$100,000).
- Once done, he continues with local primary care visits. He also visits a specialist for followup on his kidney transplant at Vermont's state-level hospital, Fletcher Allen. He remains on diabetes medication, blood pressure medicine, and antirejection medication (\$16,043 per year).
- At 72, John develops pneumonia after contracting a common cold. He's hospitalized and given intravenous antibiotics. But his condition worsens, and he is put on a ventilator. The ventilator prolongs his life but, unfortunately, his temporary loss of oxygen during the course of pneumonia causes severe brain damage. He is put in a nursing home. He dies in his sleep within a year (\$100,000).

Our original observations are borne out: the further up the intensity scale of health care, the fewer patients but higher costs. This pattern is confirmed by studies. Their general conclusion is that the bulk of health care spending is for a small percentage of the population. The figures are that 86 percent of

health care spending is for 20 percent of the population.⁶⁴ That means 80 percent of us—504,000 in Vermont—spend very little on health care annually.

A note of caution here. Two false conclusions can be easily assumed here. One is that the 20 percent each year can be individually identified. But 20 percent is a statistical category. It does not address individuals. The chronically ill could be identified individually, but some portion of the 20 percent are propelled into the category by life events or accidents. Their identity is after the fact.

We raise the point for this reason: Floating around discussions of health care reform is the idea that, if we could only coerce the high-cost category to use less health care, we could lower costs dramatically. We could, the theory goes, if we knew who they were. But aside from the chronically ill, we often don't know.

Even if moral and ethical concerns were omitted, how would this be done? Nearly all in the 20 percent high-cost category also fall into the life-and-death medical category. It's an idea so blinded by costs that it leaves out the human element. For instance, who would be willing to suggest that we save money by putting a premature baby on a ventilator only half the time?

A second false conclusion is that, because most of us need little health care, it's not our problem. Let the high-cost category figure out a way to pay for its health care. The recent cost figure per annum for the 80 percent low-need segment of the population is \$900. Much current discussion on health care reform is going in this direction. If we could shift responsibility for high-cost health care to those who are getting it, we could solve much of the problem.

The authors' position is that this approach is little more than wishful thinking. Shared services cannot work that way.

Vermont
health care
has
shared
services
but not
shared
financing.

⁶⁴ *Medical Expenditure Panel Survey*, Agency for Health Care Research and Quality, 1999, at <http://www.ahrq.gov/data/mepsweb.htm>.

Shared Services

The very meaning of shared services is that we share in their use and in their financial upkeep. The story in Vermont right now is that we do the first but not the second. We have, give or take a little, the right amount of health care services for our population. Vermonters who need health care have access to these services. What we don't share is fair and equitable financing of these services.

Habits of thinking are difficult to break. One most pernicious habit regarding health care is to think of it from the individual point of view. This perspective is excusable when you need medical attention but not when the subject is Vermont's health care services. Several unfortunate assumptions creep in.

For one, we assume that the existence of health care services is someone else's responsibility, not ours. For another, we put the emphasis on "coverage." The assumption is that, if the individual has coverage, the rest will take care of itself. Coverage stands for payment of the individual's care. Thus, individual responsibility can seem to be the whole story.

Our argument in this book is that health care is a collective responsibility. Health care services are shared services. They are population-based; they are not individual-based. The existence of health care services depends on enough medically needy payers to emerge from Vermont's population to meet these costs. All payments for these services are an investment in tomorrow's health care being available.

"Coverage" and "investment" may sound like the same thing, but they're not. Investment carries the connotation of being directed, fiscally efficient, and responsible. Coverage is a catch-as-catch-can method. However, as practiced in Vermont and in other states, coverage is undirected, fiscally inefficient, and bears no responsibility to health care services.

Understanding that services and infrastructure are shared by all of us and so we all have a responsibility to pay for them is, in a nutshell, the heart of the problem to be solved in health care.

What Are We Paying For?

We're not
purchasing
treatments.

We're paying
to sustain
health care
services
for everyone.

We think that we're paying for the service that we get. Or that's what it looks like to us individually. But, in a real sense, we are doing something very different. We are paying our share of the costs to sustain the service's capacity for the next patient. The next patient does the same for the next patient and so on. So what we're really paying for is to have the service be available when we need it. The fact that the services are there for us means that we benefited from the patients who came before us.

Indeed, some payments are made directly at the time. However, most come later from private insurers or public insurers, like Medicaid and Medicare. If the service's sustaining costs are not met after everything is added up, then the services are ripe for the cost shift. Cost shifts, of course, are not an investment scheme but a desperate pay-as-you-go accounting in the absence of any responsible payment system.

In this situation, administrative costs to chase or deny payment for services are at least twice as high as they might be under a responsible health care system. The costs accumulate in the payer end and in the health care provider end. As things stand now, cost shifts are necessary. Under a truly efficient and integrated system, half or more of these cost shifts would be unnecessary. We are paying a lot of money that could be saved. Reliable estimates put the amount at around half a billion dollars in Vermont.⁶⁵

This cost burden falls inequitably and unfairly on the shoulders of individual Vermonters who buy health insurance, on employers who buy health benefits for employees, on employees, on taxpayers, and on the health care services and their professional staff.

To envision remedies for these inequities, we must accept the reality that these services are shared and start at the population level. Singling out individuals for a helping hand will help those individuals but will also inevitably sow disorder elsewhere in Vermont's health care sector.

⁶⁵ Woolhandler, Himmelstein, and Wolfe, *IJHS*.

Let's Take Another Look



Health care systems in some countries around the world have been in place for more than a century. One common feature is that they all provide health care for a lot less cost per person than we do in the United States—even less than Vermont, which has some of the lowest cost per person.

The usual response to such comparisons is dismissive, claiming that the health care in other countries is inferior to ours. But there is no basis for that opinion. As on other issues in American life today, the popular media act as a distraction from the actual facts on health care. American health care has a mixed record compared with other countries but, in general, ranks lower than many other countries in certain aspects of health care. This comparative assessment does not mean that excellent health care cannot be obtained, especially in Vermont, but only that we lag behind health care in other countries in an embarrassing number of categories.⁶⁶

We can learn about health care systems in other countries in a number of ways,⁶⁷ but first-hand knowledge is best. Vermonters who have taken ill while traveling in Western Europe have developed a pretty good idea of how some systems work from the patient end. Con Hogan, one of the authors, is acquainted with the Danish health care system and recently experienced the Irish health care system. (He offers a fascinating personal account in Appendix E, “*Northern Ireland’s Health Care System*.”) The existence of better systems is important: we don’t have to reinvent the wheel.

Health care systems can be very different—and are. The differences are probably more instructive than the similarities. For example, a number of common features include:

⁶⁶ See Appendix G, “*International Comparisons*,” for health indicators among industrialized nations.

⁶⁷ See Appendix H, “*Short List of Reputable Sources on Health Care*,” state, national, and international health care information.

- all deliver quality health care at much less cost per person than we do,
- all depend on some sort of cost management controls,
- all have some built-in capability for responding to problems on a systemwide basis,
- all strive to maintain an array (or infrastructure) of health care services adequate for their populations' needs.

This last feature deserves our attention.

Vermont already has an adequate infrastructure. What we don't have are the means to sustain that infrastructure into the future. We're paying for it now, but the costs throughout the economy are becoming unbearable. To restore sanity to how we pay for health care, we should look to health care systems in other countries. How do they do it? The differences in approach can aid us in how to do it in Vermont. In any case, the first requirement is a health care system with which to work. Vermont doesn't have one.

What we want to do in this chapter is describe how a universal health care system could be formed around Vermont's existing health care services. Our intention is to stay specific to Vermont's economic, political, social, and cultural landscapes. This exercise will start at the state level and move to the regional and local levels.

Some functions are necessarily located at the state level, but as many as possible are located at the regional or local levels. These locations are deliberate and, we think, important. Also, although we are tackling these issues from the health services end, none of us wants to feel that s/he has lost a say from the patient end. Our mantra, whenever and wherever possible, is local control.

To even begin to imagine a health care system for Vermont requires a set of guiding principles. These "principles" will act as litmus tests. Any proposal will be put to the test. Principles hold the system together. Then we propose a list of "goals" within the system. Goals take principles a step closer to practical reality. Our list is not exhaustive and can be expanded as long as new goals stick to the principles.

Vermont has
no health care
system,
just an array
of health care
services.

Everything in our discussion is driven by two general ideas: First, the aim of the system is to sustain the shared health care services needed by all citizens of Vermont. Second, the aim of the health care services themselves is to provide the health care needed by any citizen of Vermont. Our overall aim is a healthy population.

Principles

A word about the concept of principles. Most efforts at change of any kind start with a statement of principles. As we toss around ideas, we soon find ourselves negotiating principles. The idea of having principles as a foundation for change is taken for granted. Instead, we are trying to take the idea of principles very seriously.

Let's consider what principles are not. They are not situational, nor are they short-term conveniences. They are not special interests of any organization or individual. They are also not limited to only what we know how to do.

Ideally, principles should be clear, declarative, and positive. They should be bigger than any organization or individual. They should be connected to the heart and the mind—and, as they're health care principles, perhaps the body as well. They should be universal in that they extend beyond political cycles. In essence, principles should represent our deepest fundamental values.

These thoughts take us back to the framing of the U.S. Constitution. In it, a fundamental principle declared that "*all men are created equal*." Yet this principle was stated at a time and in a context that accepted slavery and disallowed women the vote. Clearly, "*all men*" did not embrace all men nor women. If the practice of the day fell short, the principle itself reached high. Over time, the principle took hold in practice, enriching our nation beyond expectation.

Such perspective is behind the authors' consideration of the following set of principles for the health care of all Vermonters.

- (1) All citizens of Vermont will be eligible to receive medical attention from our health care services.

- (2) All citizens of Vermont will have physical access to health care.
- (3) The patient will retain freedom of choice of physician and health care service.
- (4) The physician will have freedom of professional practice.
- (5) The financing will be fair, sustainable, and affordable.

Others have proposed similar lists of principles, such as the National Coalition for Health Care,⁶⁸ which represents 200 major national and international corporations, including Verizon and General Electric. The National Coalition's principles are:

- Health Care Coverage for All
- Cost Management
- Improvement of Health Care Quality and Safety
- Equitable Financing
- Simplified Administration

Vermont's Coalition 21: Transforming Health Care for the New Century⁶⁹ (see Appendix F for more information) also proposed principles for health care. Coalition 21's principles are:

- The policy of the State of Vermont is to ensure universal access to and coverage for essential health care services for all Vermonters.
- Health care coverage needs to be comprehensive and continuous.
- Vermont's health care delivery system will model continuous improvement of quality and safety.
- The financing of health care in Vermont will be sufficient, equitable, sustainable, and fair.
- Built-in accountability for quality, cost, access, and participation will be the hallmarks of Vermont's health care system.

Our list—the first set of five—is intended to generate fruitful questions as we move from these principles to an integrated health care system with more

⁶⁸ The National Coalition's website is www.nchc.org/.

⁶⁹ The Vermont Coalition 21's website is www.snellingcenter.org/coalition21/index.html.

elaboration and detail. Readers will have questions of their own. Here are some of ours:

- ▶ How do we retain and sustain our health care services?
- ▶ How do we ensure their quality?
- ▶ How do we see that our health care services are the right capacity, enough but not too much?
- ▶ How do we meet their costs?
- ▶ How do we ensure that costs are reasonable and efficient?
- ▶ How do we decide if we have the financing to meet these costs?

The use of “we” in these questions refers to all Vermonters—as it should.

Goals

The overriding goal of an integrated health care system is to sustain health care services so as to maintain or restore the health of all Vermonters. With this in mind, a list of system goals would look something like this:

- (a) the health care services’ high-quality of medical care would be retained,
- (b) they would be fairly financed,
- (c) cost management measures would be applied across the infrastructure of health care services,
- (d) responsibility for the services would fall to a system agency (public, quasi-public, or private) and charged with carrying out the principles of a universal health care system in the name of all Vermonters.
- (e) decisions affecting the services would be accountable to the public and be made in an open and transparent manner,
- (f) all planning would be based on population.

This list of goals within the system seems fairly comprehensive but not exhaustive. Other goals may occur to readers, which will be welcome as long as they stick to the principles so as not to compromise the integrity of the system.

What we propose to do now is offer a rationale for each of the goals mentioned above, even when we might expect this to be quite obvious, such as the maintenance of high-quality health care services.

High-Quality Health Care

This goal must rank as the least controversial. Vermont is fortunate to have some of the highest quality health care in the country. Yet, if things keep going as they are, quality may well end up as one of the victims. Already other countries have better outcomes in most health care categories than we do in the United States.⁷⁰

Vermont's size undoubtedly plays a part in its strong culture of medical ethics. The strongest impetus for quality exists within the medical culture rather than from external pressures brought by monitoring or censure. Professional camaraderie and its obverse, peer pressure, are significant internal factors that promote high-quality health care. Both are at work in Vermont. Because of this, patient expectations are high. The Vermont Program for Quality in Health Care, Inc.,⁷¹ provides general quality indicators.

In theory, "perfect" information would promote a public role in enhanced quality, engendering competition among health care services based on quality, not price. Price is sometimes raised as a subject for competition, but a moment's reflection discourages this idea within health care. We've put scare quotes around perfect, because therein lies the problem. If you dip below general indicators and trends, you encounter a prohibitive number of variables. At the micro level of the physician, most information would be difficult to interpret, even if we had it.

The more promising level of information is the unit service level in hospitals, for example, the cardiac unit, the trauma unit, the intensive care unit, etc. The right kind of information can offer trends within standards of care and other clues about quality, but such information must come with realistic cautions.

⁷⁰ Hussey et al; and G. Anderson, P.S. Hussey, and OECD, "Comparing Health System Performance in OECD Countries," Project HOPE, *Health Affairs*, Vol. 20: No. 3, 2009, pp 219-232.

⁷¹ The Vermont Program for Quality in Health Care, Inc.'s website is www.vpqhc.org.

Fairness to the health care services must be balanced with useful decisionmaking information for the patient. At any rate, Vermont health care does not now have the method or the technology to gather and sort information from all its health care services. A health care information system, such as the one we envision, is expensive and, therefore, an investment decision for the future.

Fair Financing

The first rationale for this goal is surely because almost no Vermonter would claim that how we now finance health care is fair. At the patient end, from which we have urged readers not to view, unfairness is in stark relief. So far, solutions from the patient end have only contributed to disorder and unfairness. That's why we ask you to abandon that viewpoint and instead look at the health care services end. From this viewpoint, the problem is actually far easier to see. How do we adequately finance Vermont's health care services? And how do we do it fairly?

Currently, we are falling short on both counts. Someone might well comment that, as a population, we are paying the health care bill now and the services are still there. True, but the costs to the economy and our population are approaching the breaking point.

Public financing is another possibility. All other health care systems have it. Even if this weren't so, public financing would come up for discussion because 60 percent of our health care is already publicly financed. Without Medicare and Medicaid and other sources of public funding, we simply wouldn't have the health care services we have today. This is tax money.

The word "tax" has taken on dreaded overtones. Yet, we all depend on tax dollars paying for what we cannot do for ourselves. In that sense, we are a nation of tax hypocrites. We complain publicly, yet we depend privately. Like everyone, we rely on using roads, on police and fire departments, on public education, on environmental protection, defense, disaster relief, the court system—all of these public services depend on tax dollars. The parallel to health care is obvious. Health care, too, is a public service—or should be. At the patient end, we resent paying high premiums; yet, as a society, we depend on the services being there.

For large social contracts, like roads and public safety, we have agreed that the fairest form of financing is taxation. For many reasons, health care in our country has avoided this consensus—but not entirely. As we pointed out, 60 percent of health care services are publicly financed, and the public share continues to grow. Some form of public taxation is inevitable. Its fairest form is progressive, such as income taxes. Its least fair form is flat, such as sales taxes.

The rationale for a fully publicly financed health care system is that not only is it the fairest way but also the most manageable and least costly way. The way we do it now—an ill-matched combination of public and private money that, because of disparate sources, is unmanageable and unpredictable—is more costly and damaging to our overall economy.

A tax replaces all other costs at the patient end and provides a comparatively secure, predictable financing source. A tax satisfies the commonsensical fairness of we, the public, paying for something we all use. The most persuasive reason for financing health care through taxation is to get rid of half the existing administrative costs. Reliable estimates put these savings at close to half a billion dollars.

Cost Management

The goal of cost management depends on budgetary controls. Under BISHCA, Vermont does a fine job of collecting and interpreting information.⁷² One of BISHCA's functions is cost containment. In this regard, BISHCA administers two programs: one is budgets for Vermont hospitals, the other is the CON process, which tries to prevent unnecessary expansion of facilities. Both are contributing factors to Vermont's lower health care cost per person compared with the rest of the country—but not compared with other countries, which are lower still. One of the fallouts from the recent Fletcher Allen scandal is to call into doubt this process. (See Appendix I, "*The Long-Term Role of Fletcher Allen.*")

⁷² Vermont Department of Banking, Insurance, Securities, and Health Care Administration's (BISHCA's) website is www.bishca.state.vt.us/HcaDiv/hcdefault.htm.

One purpose
of an
integrated,
comprehensive,
health care
system
is to
control costs.

The kind of budgetary process that we are talking about takes into account all aspects of a system as overseer of projected expenditures. Hospitals account for a large chunk of health care expenditures in Vermont, nearly 33 percent in 2002. Physicians account for 16 percent. An integrated approach—that is, a systemwide approach—would take both into account and more. Still, Vermont has some elements of a systemwide cost management process already in place.

Cost management applications can take many forms and do so in health care systems around the world. The choice of budget controls is one area in which the world's health care systems vary widely. The point on which they all agree is that some overall, systemwide budgetary oversight is indispensable.

Vermont could leave things as they are, as long as current programs were enhanced and expanded to constitute comprehensive budgetary oversight across the health care infrastructure. One current omission is physicians' fees for service. The logical step would be to negotiate uniform fees within specialties to bring some sanity to a payment process.

The effectiveness of cost controls applied so far at the patient end of health care are questionable. Their potential for effectiveness may also be questionable. Most cost controls have led to vastly increased administrative expenses. Once again, the authors contend that the patient end is the wrong end from which to work. For cost controls to be effective, they must be applied at the health care services end.

Health care services form the bulk of our health care and, as such, generate most of the costs (70 percent of total health care spending). Therefore, health care services are the logical place to start applying cost management.

As we've argued earlier, capacity is the most effective aspect for managing cost increases within acceptable limits because most of these costs are fixed. More capacity, more costs; less capacity, less costs—but also less health care, as capacity translates directly into the availability of health care services.

Due to the infusion of new treatments and technology, the normal tendency of health care services is to expand. The normal tendency of budgetary controls is to contract. This opposition between budgetary controls and health

care capacity is where hard decisions are required. Because these decisions are made at the health care services end, they are based on population. If decisions were allowed instead at the patient end, the only question would be which individuals could afford the services. If you happen to be one of those, the illusion that all is well is perpetuated. This illusion obscures the fact that, when enough patients cannot afford these services, prices go through the roof for those who can pay and budget cuts start with staff reductions.

Cost management at the health care services end is an exercise in social will and conscience. Cost management at the patient end is a repugnant practice of rationing by price.

Responsibility for Health Care Services

An absence of any responsibility for health care services themselves exists at the patient end of health care. No payer assumes any responsibility for their maintenance, sustainability, or continuation, including all private insurers, businesses, and municipalities that contribute toward employee health benefits as well as Medicaid, Medicare, and individual payers. The reasonable assumption is that someone is minding the store. No one is.

Vermont's Department of Health and Human Services has responsibilities for public health programs, Medicaid, and a number of other programs. Aspects of Vermont health care are under regulatory responsibility but only "aspects." Our assumption of responsibility turns out to be mistaken and completely unfounded. In the event of a financial catastrophe that might terminate some health care services, no one is charged with the responsibility to step forward and say the buck stops here. This absence of a responsible authority ought to come as a shock, except that we are so used to trusting that health care services will be there for us.

A true health care system—not the enfeebled array of health care services that Vermont has now—establishes lines of responsibility. Awareness of a public trust ensures that a health care system maintains and sustains its health care services into the future. The glue that holds this together is public responsibility toward the health care of an entire population.

Health care
services
are shared,
not consumed.

Accountability to the Public

The goal of having a health care system accountable to the public is basic. Accountability and responsiveness are necessary features of a health care system. They are two sides of a public trust. Few businesses anywhere can match the continuing changes in circumstances that a health care system confronts. Thus, responsiveness to change is a fundamental requirement both of the health care services themselves and the system providing them. In the best of circumstances, the system is not only responsive but flexible. Flexibility tends to increase with decentralized decisionmaking and authority: so, the more authority at the local or regional level, the better.

In Vermont, the most sensible location for vested authority is probably at the level of regional hospitals. Vermont has 14. That means the system invests as much decisionmaking as possible in the regions. This delegation allows the regional entities the latitude to respond to local conditions and needs.

Population-Based Planning

This goal may sound more like a tool. Yet, population-based planning is intimately connected with the other goals. Population-based planning takes the needs of population groups into account. For example, accountability to the public may require the accumulation of data about a county's aging population in order to ensure their access to available services. Health care arise out of a population's need, acknowledging both that (a) not everyone uses the services equally and (b) not everyone can pay for the services equally.

The population-based aspect of health care sheds light on managing costs as well. We have a choice. One is to create a health care system that manages costs at the health care services end where 70 percent of the costs occur. The other is to manage how the population uses the system's health care services. The first means managing the overall costs presented by 14 hospitals; the second means managing 630,000 Vermonters use of services. No expert is needed to see that the first is cost-efficient and the second is labor-intensive, which leads to exorbitant administrative costs.

When we tack on the word "planning" to population-based, we are in the realm of a system. Only a health care system is capable of undertaking

Capacity
is the
array of
services
and
facilities
that constitute
the
health care
infrastructure.

population-based planning across the infrastructure of health care services and facilities in Vermont. BISHCA has some say in this regard but doesn't extend across all services. Its responsibility is limited. BISHCA's limitations create gaps through which problems capable of solution slip into intractability. The same could be said of all solutions that propose limited answers. Population-based thinking is a good test for any proposal. If a proposal for health care reform does not draw its strength from the population as a whole, instead segmenting the population into medical categories, the result will not be an integrated health care system.

Population-based planning allows the management of capacity (the health care infrastructure of services and facilities), allows efficient response to trends, furnishes projections for the future, offers a ground plan for investment, emphasizes shared services and shared financing, and lays a foundation for transparent decisionmaking that benefits everyone. In sum:

- All health care systems subscribe to the above goals in some form or another.
- All health care systems seek to provide health care to everyone at the lowest cost possible without compromising quality.
- All health care systems confront the needs of aging populations and the mixed benefits of medical technology.
- All health care systems seek to find solutions.
- Where all health care systems differ is in what solutions they favor and what elements they emphasize.

Can We Afford It?

Health Care Finances in Vermont: a Longer View



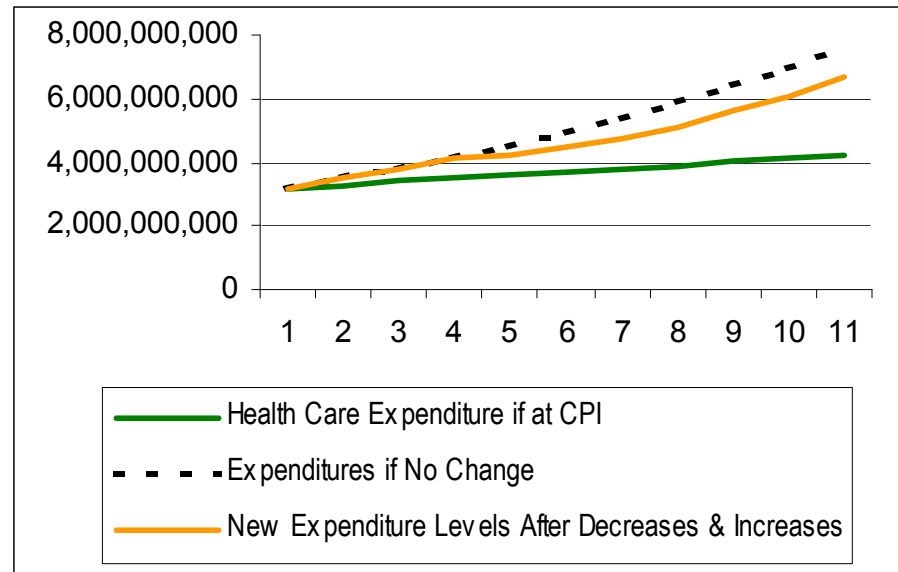
Health care financing has become a short-term scramble. How does this provider or that hospital or home health agency get through the year financially intact. Nothing seems guaranteed these days, neither our lives nor our health care. Most of our government is disciplined enough to function within the limits of economic growth or, more precisely, keep at or near the rate of growth of the CPI. However, in several crucial societal functions, this discipline is not there, specifically in prisons, higher education, and, most strikingly, health care.

If health care were to grow at the rate of the CPI, the \$3.2 billion currently being spent in Vermont would grow to \$4 billion over the next eight years. But health care spending in Vermont will reach \$4 billion in only four years and will redouble astoundingly to \$8 billion ten years from now: \$10 billion seems inconceivable. However, nothing on the horizon suggests that our spending in the future will be less than the current average of 9 percent per year. If we could at least create a scenario that shows even a modest reduction in the current growth rate, while at the same time provides access for all Vermonters, then we have introduced hope into the equation.

We need to create a set of scenarios as targets to give us hope of a better future for our people and our pocketbooks.

To achieve a hopeful scenario, we need to consider what in our health care system will cost more in the future and what could possibly cost less. By systematically looking at the possibilities, we can begin to create our own future in health care rather than have an unacceptable future defined for us. Setting targets and expectations for change is an important exercise. The old adage of “*define or be defined*” is more appropriate than ever.

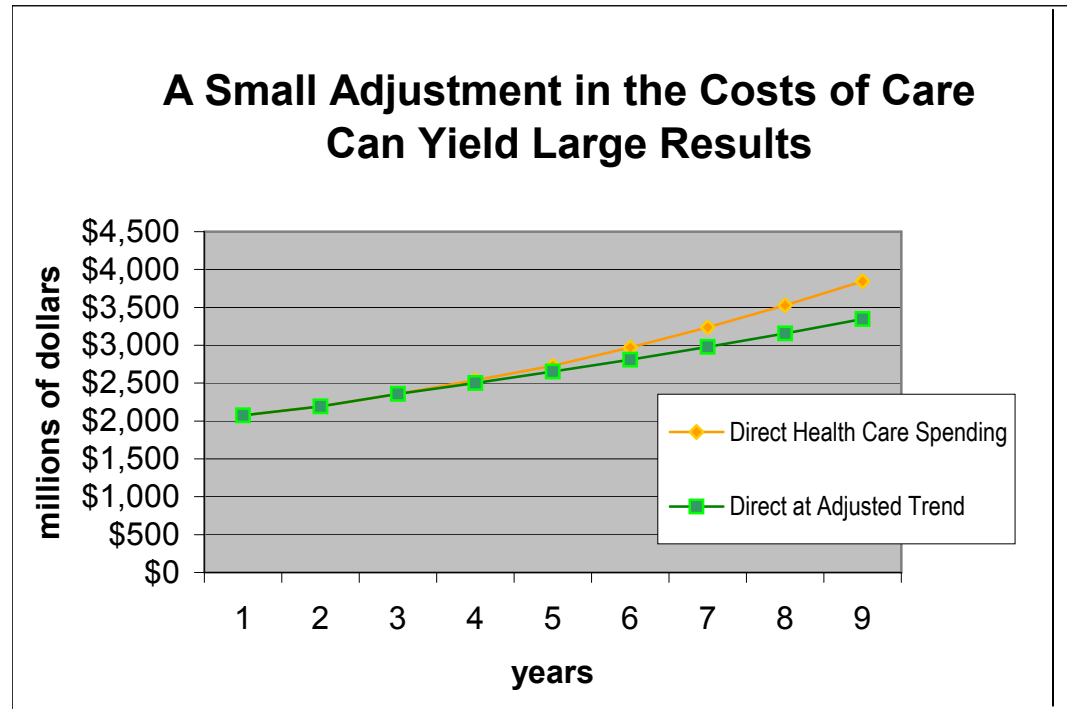
A Better Future



- First** Important costs will go up. They are straightforward. It will cost more to cover the remaining uncovered Vermonters. It will cost more to insure the underinsured with the kind of benefits of fully covered Vermonters.
- Second** Medicaid funding with its looming near-term deficits needs to be uprighted.
- Third** Information technology needs increased investment essential for streamlining and lessening the burden of administrative costs. Increased costs will also be associated with an improved quality monitoring in the system.

The other side of the ledger has potential places to reduce costs. The costs of administration—in *this bloated, duplicative, repetitive, and administrative-heavy enterprise*—greatly need reduction. Most importantly, we must find ways to reduce the rate of growth of health care services, which is rising at a rate of 9 percent per year. If we can reduce that rate of growth to about 6 or 7

percent, which is still more than two times the rate of growth of the CPI, this reduction would have an enormous positive impact on the growth of overall health care costs.



A mixture of these changes could result in a growth scenario that is significantly less than current and projected expectations. Such changes could serve as the target-setting environment within which we can make a run at bringing this system into some semblance of control.

If Vermont is successful in fully covering its uninsured and underinsured, yet unsuccessful in bringing the overall growth of health care to more reasonable levels, then the political will to make major and needed change in our health care system cannot be summoned. Political will is the determining factor for whether serious change is possible.

We believe that, with common sense consolidation and more regionalized cost control, health care spending in 2010 could be a full \$1 billion less than projected or approximately 20 percent less than forecast. This achievement will take great concentration and remarkable political will as well as the public will of all Vermonters to do things very differently.

We Already Afford It

At the end of 2003, Vermont spent \$2.9 billion on health care. At the end of 2004, that figure was approximately \$3.2 billion. Each year, we got the health care services we needed. At the end of each year, health care and health care services were left standing, neither shrunk nor shut. We are entitled to say that we can afford it, because we are already paying for it.

The notion that “*the money is there*” is supported by technical studies at the national level. In fact, these studies report that overall health care costs are sustainable for another 35 years (a little more than a generation), if rising costs stick to within two percentage points of the GDP and longer if less than two percentage points.⁷³

Our subjective response is that this cannot possibly be sustainable. Our impression is that we’re staggering under rising health care costs that are getting worse by the minute. Technical studies, of course, are objective. So we have to suspend our subjective impression and accept that health care costs, technically speaking, are sustainable. Our discomfort, not to say panic, at how things are going is not a factor.⁷⁴

But is this really true? Health care, we’ve argued, is built around shared services; shared services are built around a population’s health care needs. The decision of whether we can afford the shared services lies not in the individual but in the whole population. Individuals cannot afford to finance health care services. Financing health care is a population-based enterprise, just as the health care services provided are population-based.

Only
“WILL”
can
introduce
“HOPE”
into the
equation.

⁷³ Michael E. Chernew, Richard A. Hirth, and David M. Cutler, “Increased Spending on Health Care: How Much Can the United States Can Afford,” *Health Affairs*, Vol. 22, No. 4, July/August 2003, pp. 15-25:

⁷⁴ Incidentally, we think studies are a good thing. At the end of this section, we describe three studies that we believe Vermont ought to undertake for the sake of a clearer view of financing health care.

A decision to pay for health care then is subjective as well as objective. The money may well be there. But the question is: do Vermonters want to spend it that way? Publicly financed spending in health care is already around 60 percent and expected to go higher. That's a lot of money. Of course, we'd like to have a say in how it's spent. In fact, much of our subjective discomfort comes from having no control over how this money is spent.

Basically, we are sidelined; we play no part in any decisionmaking process. In fact, there is no decisionmaking process. Individually, we have choices. We can choose to buy health insurance or not, to go to the doctor or not, to take care of ourselves or not. But, if you add all our individual choices together and claim that they represented Vermonters' health care preferences, you'd have nowhere to take this information. No process exists to act on the information.

A health care "system" remedies this. A system depends on decisionmaking across its entirety, including not only technical questions, such as "*how much can we as a population reasonably pay,*" but also subjective questions, such as "*how much do we actually want to pay?*"

Choice

Individually, we have our choices, which are valueless to anyone but ourselves. On other important matters, we have no choice.

We have no choice about taxes. We have no choice about what part, how, or whether taxes pay for health care. We have no choice about Vermont's health care services. We have no choice about health care expenditures. We have no choice about Medicaid and its debt of \$50 million going on \$90 million. We have no choice about the cost of health insurance or what or who it covers or not. We have no choice about the kind or location of our health care services.

We also have a limited voting say in property taxes, which go toward supporting health benefits for public employees. There isn't much else. Implied in choice, of course, is a modicum of control.

Control

The ramifications of health care spending at recent rates are what unsettle us. This spending, coupled with our lack of any decisionmaking role, combines to paint the situation, subjectively, pretty dire.

When we shell out for higher insurance premiums each year, we're not happy. Groups of employees, such as teachers fighting with school boards over higher premium shares or reduced benefits, are far from happy. Businesses are less and less accepting of the situation.

We worry about the erosion of health care services in some states and the excess distribution in others.⁷⁵ We worry about their pernicious effects on society and the economy. We personally feel their effect on our moral and ethical feelings. These worries play a large part in our social relations with other Vermonters.

Universal
access is a
prerequisite
for achieving
potential
savings in
health care.

The reader ought to be, as we were, startled to recognize that none of us in Vermont have any control over health care spending. It ought to come as a shock that, over the past year as \$3.2 billion was spent, no one was in charge. *The same holds for the year before that and each year before that!*

For several decades, we have witnessed a scramble to impose some sort of control over health care costs. Attempts have concentrated on the patient end of health care, i.e., on coverage, with disregard of the health care services end where 70 percent of health care spending occurs. That's where real possibilities for cost management reside. As a result, we have expended a great deal of ingenuity on the patient end, while concurrently disavowing any wish to create a central entity—public or private—that could actually exercise control over the bulk of spending. In lieu, this vacuum has produced the curious spectacle in which we, as individuals, are asked to somehow curb health care spending because no one at the polity level wants to do it.

⁷⁵ Elliott S. Fisher, David E. Wennberg, Thérèse A. Stukel, Daniel J. Gottlieb, F. L. Lucas, and Étoile L. Pinder, "The Implications of Regional Variations in Medicare Spending, Part 1: The Content, Quality, and Accessibility of Care," *Annals of Internal Medicine*, Vol. 138, No. 4, February 2003, pp. 273-287.

We understand. It's not an easy thing to do. It's far easier to duck the whole issue and instead imagine that somehow insisting on pocketbook responsibility at the individual level will add up to responsibility at the polity level. Unfortunately, nothing backs up that idea. Proven beyond any doubt, the only place where health care spending can be controlled to our advantage is at the polity level: in other words, as an organized system.

A Warning Signal

Many warning signals have flashed. The rate of increase in health care spending for years now is the main one. Another warning signal right now is the rate of rising debt in Vermont's Medicaid: \$50 million and expected to zoom to \$90 million shortly. Medicaid, which is tax-financed health care for those with income below a qualifying line, also includes the Dr. Dynasaur program, which pays for health care services for children.

What is happening in Medicaid is bad news, because its interrelatedness within health care has a domino effect. Here is what we know. As the number of uninsured in Vermont grows, some substantial percentage qualifies for Medicaid. In order to pay for more enrollees, Medicaid has no choice but to spread available funds more thinly. More thinly means that health care services receive less than fair payment. At some point, these health care services develop their own red-ink problems. To survive, they resort to the "cost shift." (For more on the destructive effects of the cost shift, see *"The Cost Shift Has Reached a Dangerous Point"* (page 47).

What are the options for Medicaid? The state could raise taxes to cover the shortfall. However, that's a fiscal solution to a systemic problem. The state could take away funds from another program. But which one? The state could raise the qualifying bar for enrollment in Medicaid. But the bar would have to be pretty high to make a dent in the problem. Almost any choice the state makes will affect health care services, especially the last.

The lesson in this will be played out in the Legislature before long. Any fiscal remedy confined to one part of health care at the expense of the others parts is going to have unintended and unwelcome consequences both to health care and to the economy. Our failure to acknowledge the disconnect

between our health care services and how we pay their costs will lead to damaging effects. The decisionmaking link is missing.

Where Does Money Come From?

Where did the \$3.2 billion come from? Here are the figures for 2004:

\$738 million from health insurance payments,
 \$534 million from self-insurance,
 \$454 million from out-of-pocket payments,
 \$547 million from Medicare,
 \$809 million from Medicaid, and
 \$115 million from other government-supported programs.⁷⁶

Tax credits
and tax-free
accounts
increase the
public share
of health care
spending
because of a
loss in tax
revenues.

Over the past five years, health care spending, on average, has increased 9.1 percent per year. Over five years, the biggest percentage jumps were in Medicaid (on average, 12.8 percent) and self-insurance (on average, 12 percent). Public spending (Medicaid, Medicare, and other government-financed programs) went up quite a bit faster than private spending (on average, 11.1 percent against 8.1 percent).

There's more to the story. An aspect often overlooked is what we may call "stealth taxes." That is, public spending that normally escapes our notice. Public spending is financed either by taxes or other revenues. Of total health care spending in 2004, \$1.73 billion will be identified as private and \$1.47 billion as public. However, the cost to the public is greater than indicated. Not figured in is the money exempted from federal taxes that employers use to help buy employees' health care benefits. Public spending on health care in Vermont is about 46 percent of the total. Lost federal tax revenues are public money as well. When tax cuts are figured in, public money accounts for about 60 percent of total health care spending.

This kind of invisible cost extends to all other tax set-aside plans. Any proposal that offers tax credits or tax-free accounts to pay for health care indirectly increases the public's share of health care spending because of a

⁷⁶ *Vermont Health Care Expenditure Analysis Forecast, 2002-2006* (actual and projected figures), BISHCA, December 2003.

loss in tax revenues. In 2004, tax-exempt health benefits will cost state and federal governments an estimated \$209.9 billion in lost revenues.⁷⁷

At a local level, property tax increases are a visible response to health care spending. Pressures on property taxes from school board budgets are responding to the rising costs of teachers' health care benefits. Here's another example of how the cost shift is an invisible, unlegislated tax on purchasers of private health insurance.

The point to be gleaned about invisible taxes feeding health care is the interconnectedness of the spending effects. Amending health care spending for one group or another will have unintended consequences for all Vermonters and for our health care services. The disconnect between health care services and health care spending is a serious one. One affects the other in complicated ways. Isolated proposals stand little or no chance of working. A benefit to one group is an expense to other groups or to health care services themselves.

The disconnect we're speaking of is too serious to ignore. Individually and collectively, Vermonters want health care services. Individually and collectively, we're not happy paying for them as we do now. No link exists between health care services and health care spending. No fully responsible agent links the two. No decisionmaking or problemsolving process exists. Fixes have been responsive to narrow constituencies but unresponsive to health care in general.

Where Does the Money Go?

Where does the \$3.2 billion go? We can say where the money went in 2002 based on the most recent official figures. In 2002, health care spending was \$2.8 billion:

\$906.0 million for hospitals,
\$448.0 million for physician services,
\$352.0 million for drugs and supplies,

⁷⁷ John Sheils and Randall Haught, "The Cost of Tax-Exempt Health Benefits in 2004," *Health Affairs*, Project HOPE, Web Exclusive, February 2004, W4-106-W4-112.

\$299.0 million for other administration and miscellaneous providers,
 \$187.9 million for government health activities,
 \$182.0 million for nursing homes,
 \$140.0 million for dental services,
 \$112.0 million for other professional, and
 \$106.4 million for home health.

Over the last two years, the percentages for each category changed a little but not a lot. Applying 2002's proportional shares of total health care spending of \$3.2 billion to 2004 estimates, we get:

\$ 1.65 **billion** for hospitals,
 \$512.0 million for physician services,
 \$512.0 million for drugs and supplies,
 \$342.4 million for other administration and miscellaneous providers,
 \$288.0 million for government health activities,
 \$208.0 million for nursing homes,
 \$160.0 million for dental services,
 \$128.0 million for other professional, and
 \$121.6 million for home health.

Money In, Money Out

Who is in charge? The answer is no one. Yet no business in the world would tolerate or survive under these conditions. The fond hope that disparate cost-management controls operating separately would add up to an effective mechanism for keeping Vermont health care spending under control has proven wrong and, of course, costly. It has also proven dangerous for the survival of our health care services as we now know them.

With hindsight, we acknowledge the obvious. Agents who both collect money and pay it out, such as Medicaid, Medicare, private health insurers, et al., are beholden only to themselves. Without any coordination, they act in their own behalf, paying little heed to how their actions affect others or, especially, the health care services themselves.

In the absence of system oversight, these agents simply go about their business. Who could blame them? The problem is that their business affects

our lives. Each part of health care invariably affects other parts, often adversely. No health care system is in place to balance or consolidate for the benefit of Vermont's health care. Such necessary oversight depends on a real, truly integrated health care system.

First Steps

To even begin to consider a model of integrated public financing for Vermont's health care, more information is needed. Lewin Associates,⁷⁸ an out-of-state firm, concluded in a 2001 study that total spending was adequate to pay for all Vermonters' health care. Is this true today? We need more up to date figures. We propose three studies:

- A cost analysis of Vermont's health care facilities that would provide a clearer picture of their fixed, all-but-fixed, and variable costs.
- Propose several tax-financing models that would sufficiently finance Vermont health care, exclusive of Medicare and Medicaid.
- An ambitious look at the effects of various financing mechanisms on Vermont's economy over time, which has not been done in any state so far. The effects to measure would extend beyond the health care economy itself into all corners of the public and private business economy and nonhealth care spending.

Why Are Costs So High?

Why are costs high! The price of health care is a function of several important trends and realities, including investment in infrastructure, more expensive and available technology, an aging population that requires more health care, high drug costs, and high administrative costs.

Most health care costs are invested in services (70 percent). Services represent the utilization trends of a whole population and not the choices of individuals. For example, the Fletcher Allen expansion created a larger

⁷⁸ The *Lewin Report* is online at www.vthca.org.

Capacity,
not use,
is critical to
understanding
health care.

operating budget than may be needed.⁷⁹ Once BISHCA allowed a 7 percent increase in what insurance companies may be charged, Vermonters are now being burdened through a cost shift. That increase will find its way to an increase in premiums and indirectly in taxes for all of us. Mind you, that is before we have any patients actually in the beds.

The only costs that are dependent upon individual use are variable costs, such as drugs and medical supplies. Some may say that doctors and other nonsalaried fee-for-service providers are not a fixed cost. But in all other health care systems, medical professionals are rightly seen as the major contributors to capital costs. They come under the heading human capital. We've termed them as "all-but-fixed costs." Health care is labor intensive. Use of health care services plays a small role over the short-term but figures importantly in large trends over the much longer term.

Most costs are tied to capacity and the health care infrastructure. If we want to control costs, we must look at capacity and infrastructure. Excess capacity is one of the places most in need of scrutiny as the largest driver of health care costs. Studies also show that excess capacity is a culprit in excess utilization.⁸⁰

Fortunately, health care utilization rates in Vermont are well below the national average and, in some measures, below the international average.⁸¹ Vermont's competitive position is one reason why the current fashion with health savings accounts has serious limits for Vermonters. Our state has historically lower utilization rates.

One of the components of excess capacity is the presence of more specialists than needed to serve the population. Like excess technology, excess specialists drive utilization, sometimes unnecessarily. Any procedure carries a risk. Therefore, unnecessary procedures can result in unnecessary morbidity and mortality.⁸²

⁷⁹ J. Zicconi, "Fletcher Allen Defends Steep Rate Request," *Times Argus*, August 26, 2004.

⁸⁰ Fisher and Wennberg have made a convincing argument in this regard. Fisher, et al.

⁸¹ Organization of Economic Cooperation and Development, 2004; and *The Vermont Health Care Quality Report*, 2003.

⁸² Barbara Starfield, "Is U.S. Health Really the Best in the World?", *Journal of the American Medical Association*, Vol. 284, No. 4, July 26, 2000, pp. 483-485.

Institutions also compete to create excess capacity in order to get their market share. For example, the recent \$1 million advertising campaign by Fletcher Allen in northern New York was to maintain market share in the face of new capacity added at the Champlain Valley Medical Center in Plattsburg.

Competition among health care providers, especially hospitals, can be a stimulus to creating excess capacity. Hospitals in Vermont are nonprofit entities. Still, competition among them exists. It exists between community hospitals and our academic medical center and between the latter and out-of-state facilities, such as Dartmouth Hitchcock, Plattsburg, and the Albany Medical Center.

The advance of technology toward efficiency, smaller size, and cost effectiveness means that smaller hospitals can now compete for patients who used to be the sole domain of larger hospitals. Despite the CON process exerting some theoretical control over technology purchases, hospitals compete for patients as their primary way of offsetting substantial fixed costs. A race is on to stay competitive, to gain an edge, and to gain more market share. Since hospitals represent about 32 percent of our health care spending, the stakes are high indeed.

Currently, we have no mechanism with which to determine the health needs of the general population. Consequently, we cannot accurately match capacity appropriate to a population's needs. In this situation, capacity is being defined ahead of need and, to some significant extent, is creating need.

This problem of excess capacity is well hidden and not understood by the general public. However, excess capacity is one of the most important drivers of ever-higher costs of health care.

Given the above, how do we contain these costs?

We could begin by investing in only what the population needs. We could also use a better process of negotiating prices with physicians and hospitals. We need to apply a statewide drug formulary. We need to implement efficiency by using only the amount of administrative tasks necessary to pay adequately, fairly, and uniformly for services.

How to do this? We start with five basic questions.

- (1) What do we need?
- (2) What do we have?
- (3) What will it cost?
- (4) How can we get more for our money using prevention and evidence-based medicine?
- (5) How will we pay for it?

Can We Control Costs in the Current Environment?

Can we control costs now? The answer is no. The reason is this: we have no means to do so. It's peculiar how we got to this point.

Capacity
constitutes
most of the
costs
and
most of the
care.

Over time, the elements of health care in Vermont evolved into a loosely associated set of independent entities that constantly interact with each other. These entities comprise a health care ecosystem that provides fairly decent quality care in Vermont.

In the same regard, the way we pay for health care has devolved into an almost incomprehensible mess. The nonmedical management side of health care has become so disorderly over the last 20 years that a bloated bureaucracy emerged to grapple with it. Ultimately, this bureaucracy collects the money owed for the services provided. To maintain itself, this bureaucracy costs anywhere from one-fifth to one-third of the income from health care services.

In discussing what to do about this enfeebled arrangement, the sound you hear is the grinding of axes. Everyone has their self-interest to protect. These interests are in conflict, which, in turn, conflicts with our health care services. Vermont has, within reasonable margins, the health care services it needs but not the fiscal management it needs. No means exists to resolve the conflicts. Under current circumstances, they are irresolvable.

The majority of proposed remedies hold one thing in common. They begin at the patient end. Such proposals want to reduce patient “use” of health care,

which they perceive as a leading cause of high costs. They want patients to make better medical decisions based on price, which they also perceive as a cost saver. They want patients to take better care of themselves and, if they don't, to somehow erect punitive measures to coerce them. They want to discriminate between patients who go for a lot of health care and those who don't, making the former group pay more than the latter group.

We apologize for being overly repetitious, but our argument is that cost-management remedies begin at the health care services end, not the patient end. The difference in Vermont is between addressing the costs of the services of 14 hospitals or addressing the medical-seeking behaviors of 630,000 people. Until now, we have leaned toward the latter, because no one was in a position to steer another direction. No one was running the ship. Now we see what we bought into. Nearly one-third of our health care spending goes to administrative bureaucracy. At least half of this, say, half a billion dollars, is unnecessarily spent regulating patients on the one hand and chasing down dollars on the other.

A Budget Approach

Coming at the problem from the infrastructure end of health care—that is, the health care facilities and services—helps us see a much more effective way. We need, above all, an overall integrated budget (sometimes called a global budget) to get a grip on total health care spending. A budget stretched across the entire system is the principal cost-management mechanism. Its integrative approach takes into account potential effects throughout health care from any action in one or more sectors.

A global budget is an expenditure target that surrounds the entire health care sector and sets clear limits on the amount budgeted. A short article⁸³ that deserves reading sets out the differences between two cost-control approaches. Global budgeting is described in terms similar to ours:

In contrast to utilization review, global limits, such as expenditure targets, focus on the collective behavior of large

⁸³ Kevin Grumbach and Thomas Bodenheimer, "Reins or Fences: A Physician's View of Cost Containment," *Health Affairs*, Vol. 9, No. 3, Winter 1990, pp. 121-126.

groups of doctors and patients, rather than the individual physician/patient encounters. If physicians as a group provide so many services that budget targets are exceeded, fees are adjusted downward, creating a general incentive for a more judicious use of resources.

Hospital budgets alone account for more than one-third of all Vermont's health care costs. Cost management of physicians' practices is achieved, relatively speaking, by negotiating uniform fees. Uniform fees have the advantage of eliminating the need for bloated payment bureaucracies within the provider practices. Vermont's BISHCA already approves our hospitals' budgets but doesn't gather or regulate them under a global budget.

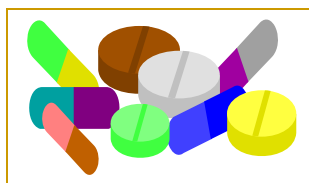
As is, nobody has a clear idea how much is going to be spent in Vermont on health care in any year. We get the figures after the fact. Of course, figures are projected, but actual spending figures are provided two years later. Other countries' health care systems have a far better grasp of their spending for the year ahead, because, in addition to projected spending, they have budgetary lids on annual spending in some or all sectors.

The Impact of Population-Based Health Planning

The fundamental idea behind population-based health planning is to determine, over time, the needs of the health care infrastructure for any given population. The basic act of defining those needs helps in planning the provision of health care services in that area. This process can lower the capacity and, thereby, lower the cost of health care in regions that currently have more capacity than needed.

Some of this work already occurs at a state level, for example, in determining the number of nursing home beds in a region. This work is needed at a regional level in consonance with other health care sectors, such as the number of physicians needed or the need for home care. We could define these capacities for a given community or a region of the state. Such proactive health care planning could also take into account special and emerging needs in a given region.

A Drug Formulary



By way of discussing drugs, we remind ourselves that not much difference exists between Advil, Motrin, and Ibuprofen for treating pain. The difference is cost. Many versions of drugs treat the same disease. One way of streamlining rising costs in this area is to create what are known as “drug formularies.”

A drug formulary is a list of the most effective drugs for the least cost to treat particular diseases. In essence, a list of preferred drugs is created by sorting drugs by type. An example of a type might be all drugs used to treat hypertension. Their effectiveness in each category is judged. The most effective drugs in each category are listed in order of preference with the suggestion that those at the top be more widely used.

Drug formularies already exist. Medicaid has one. So do private insurers. The problem is that each formulary is different. No coordination exists among them. Physicians then find themselves prescribing one “preferred” drug for one patient and another “preferred” drug for another patient, even though both patients have the same disease.

A single unified drug formulary for the entire state would contribute to cost control. Prescribing patterns would become more uniform, which would lead to reduced drug costs. For example, over 120 blood pressure medicines are on the market. Physicians have neither the expertise nor the time to track all their costs, side effects, and interactions with other drugs.

In a larger market than Vermont’s, drug formularies exert the power of bulk buying (the WalMart approach). Because of its small size, Vermont has only so much leverage for potential savings. Vermont’s market alone is not large enough to have purchasing power impact. We could, however, think beyond our state’s borders, let’s say, across New England. Interstate thinking could save money.

An arrangement that Vermont made with New York to create electronic cards for welfare recipients is one example.



Administrative Savings

This past year, Vermonters financed about a billion dollars to administer our health care. Administrative costs break down into two categories: payer and provider. Public payer administrative costs, like Medicare and Medicaid, are comparatively low. Private insurer administrative costs are comparatively high. Provider administrative costs—hospitals, doctors’ practices, etc.—are imposed on them by the disordered way we pay for health care, which, under current circumstances, is necessary. Under different circumstances, at least half a billion dollars would have been unnecessary. What are the different circumstances?

Uniform reimbursement fees would be a step in the right direction. The big step, though, would be to meet the aim of a health care system. That is, all Vermonters would have access to financed health care. Decisions about whether the care was necessary would fall to physicians and patients, not administrators.

Consolidating the payment system is another big step. These actions together could render half the current administrative costs unnecessary. That’s about half a billion dollars in savings.

Prevention

From the individual’s point of view, prevention can promote health. From the health care point of view, prevention can reduce costs. Most prevention programs are long-term; benefits are only realized in the future. Public health programs to prevent teenagers from smoking, for instance, take about 30 years to impact health care costs.

Prevention can produce dramatic results and cost savings, if we demonstrate patience. However, all preventive measures do not necessarily result in cost savings. The primary reason for prevention lies in a desire for better health and better quality of life.

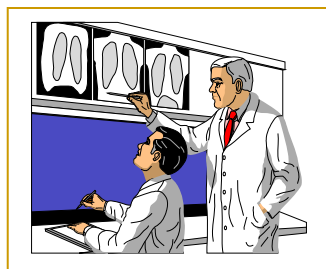
We can distinguish two general types of prevention. Primary prevention seeks to prevent diseases, such as cancer. Secondary prevention seeks to

prevent complications from an existing disease, such as a stroke in a patient with high blood pressure. Primary programs are usually less expensive than secondary programs, which call for a regimen of ongoing treatments and diagnostics.

One claim about prevention is that, if we track the etiology of hospital admissions and their related costs, fully one-half of the costs can be traced to lifestyle. Misuse of alcohol looms large in this. The connection is not obvious, because we don't publicly identify certain diseases and death as influenced by alcohol. Yet, alcohol is implicated in various organ failures, diabetes (which impacts about 7 percent of Vermonters), much heart disease, and eye maladies. Misuse of alcohol extends to social confrontations, such as gun violence. Indeed, 80 percent of prison populations are convicted for a crime committed during the use of alcohol or drugs.⁸⁴

Prevention investments in these gross contributors to Vermont's health care costs should be multiplied. Not only should the investment be greatly increased, the effectiveness of the investments should be enhanced through an integrated approach within regional health care systems.

The connections between primary care prevention, admittance to a hospital, the use of more community-based options for our elderly, instead of expensive nursing homes, are some examples of integrated ways that prevention can reduce health care costs, both in the short and long term.



Evidence-Based Medicine

Like the rest of us, physicians can fall into habits that cannot be described as cost-effective or patient-beneficial given current clinical evidence. An example is X-rays for back pain. Exceptions exist (traumatic injury, young children, onset of pain in the elderly) but, generally speaking, X-rays for back pain are a waste of money.⁸⁵ The tendency of the medical profession is often to do them anyway.

⁸⁴ Vermont Department of Corrections 2004.Data Book.

⁸⁵ Goodyear-Smith et al., "Recommendations for GPs Regarding Imaging with Respect to Low Back Pain," *New Zealand Family Physician*, Vol. 29, No. 2, April 2002, pp. 97-101.

We need to break old habits and adapt to new clinical evidence, which will take time and effort. As new evidence emerges, we must adjust. Costs may not necessarily decrease, although, in some instances, they will. But better medicine will result that will reduce unneeded procedures.

Price Negotiations

Price negotiations are a difficult topic for hospitals and physicians, but a necessary step.

- First* The results provide a firmer estimate of how much will be spent on health care over the year.
- Second* Uniform reimbursements greatly simplify administration. The clear gain for physicians will be dramatically lower administrative costs within their practices.
- Third* Hospitals will benefit from negotiated budgets for the same reasons. We remind the reader that one out of every three hospital dollars currently goes to administration.⁸⁶
- Fourth* Price negotiations will offer providers a stable and more predictable revenue.

Investment in Information Technology

The gap between the use of information technology in business and health care simply doesn't make sense. Over the last 20 years, businesses completely recast the way they work through the acquisition of information technology.

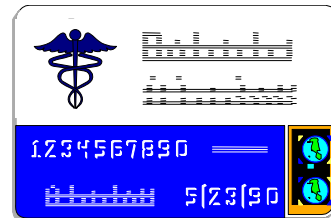
Technology offers unusual opportunities for system interconnectedness, both on the medical and administrative sides. Interconnectedness could draw our health care services into closer, more efficient, and much speedier cooperation. Health care uses a great deal of technology within each health

⁸⁶ Woolhandler, Campbell, and Himmelstein, *NEJM*.

care service but has not taken advantage of these interconnections. The primary reason is that Vermont's health care, which is a loose arrangement rather than a system, acts as an obstacle to any across-the-board improvements.

Efforts have been made and failed miserably. In the early 1990s, an effort to install common information technology standards in Vermont failed. Although not a public failure, the failure had a thousand invisible cuts. No one was in authority to do anything about it. Con Hogan, one of the authors, recalls visiting the CEOs of the leading insurers to obtain planning information for the state in his role as Interim Chair of the Health Care Authority. He sought some quite innocuous information held by insurers to share with the State of Vermont as a matter of good will. Most everyone he encountered regarded this request as an invasion of their turf. This effort came on the heels of the collapse of broader-based planning by the Legislature and Administration.

Today, anyone who visits a physician encounters repetitive paperwork, requiring the same information already filed with other services or even in the same service. Although slowly changing, this annoyance is still the norm.



A Vermont Health Care electronic card, which consolidates a person's entire health care record for any provider they choose, would make perfect sense. We already do this for Medicaid recipients and welfare recipients where services, such as health care, food stamps, child care, fuel assistance, and other benefits, are consolidated onto one electronic card. We could simplify all transactions between payers, providers, and patients and eliminate reams of paperwork in one stroke. Other possibilities await. Protocols, best practices, current warnings of one kind or another could be consolidated electronically. The list of potentially useful technology initiatives is long.

About ten years ago, Fletcher Allen won approval for a \$29 million information technology investment from state regulators that promised \$130 million in productivity savings over ten years. The project was never undertaken. The finances of Fletcher Allen today might look quite different, if the project had been successfully implemented.

Information technology in health care is a story of opportunity lost. Rapidly evolving information technology is an important part of our lives, whether the bar coding of produce at the grocery store, electronic payment of our bills, the EZ Pass systems on major highways, satellite technology for our entertainment, or wiring our communities, such as Montpelier did. The lack of information technology—in a sector that represents 14 percent of our gross domestic product—is a testament to how high the protective walls are around the health care sector and how barely connected are its sidewalks.

Information technology could figure prominently in efforts to control costs, as with many businesses, and in efforts toward quality control, as with many more businesses. We hear of small technology breakthroughs, for example, the computerized pharmacy distribution system in St. Albans' small hospital or the real-time online laptop system by nurses at Dartmouth Hitchcock for the registration process. These little victories have yet to add up to anything truly significant in controlling costs in the larger sector. A federally funded, model-building investment of \$100 million over a five-year period could jump start this process, which has to happen sooner or later. We recognize this upgrade is going to be difficult for a state whose entire capital budget is only about \$40 million.

A serious barrier against dramatically improving information technology in health care is a lack of unified vision, strategies, or incentives across the disconnected pieces of Vermont's health care sector. This vision needs to connect directly: to the relationship between the patient with specific health care needs, to the process of providing care to meet those needs, and to the results of the care that the patient receives. We have yet to conceptualize the role of information technology in these terms. Until we do, we will continue to improve the *pieces* and miss the *system* potential of information technology.

A Glimpse of a Future System

A health care system, unlike the loose and enfeebled arrangement we now depend upon, offers real prospects for improved health care. A system holds the potential for more local, regional, and statewide control of how our health care dollars are spent. Multi-year budgets could manage spending

curves that lie somewhere between current growth rates and the CPI. Fiscal efficiencies could bring together all revenue streams into a protected trust fund from which the system would draw funds for hospital budgets and payments to physicians. Regional budgeting around hospitals could provide management flexibility and creativity at the local level. In turn, regional budgeting could promote a needed degree of integrated planning, which is absent today, as a function of the overall health care infrastructure.

A system restores autonomy to physicians who have watched their freedom of practice ebb over the years. A system strives to establish integrated information technology to boost its powers of efficiency and to give Vermonters an informed say in their health care. Reliable and readily accessible indicators furnish the best grounds for competition among health care services.

A system stands fully responsible for the health care services provided, thus promoting greater peace of mind among Vermonters who will be free of today's corrosive worries over how to pay for their health care. To citizens, a system restores the dignity of knowing that whatever fateful differences they experience in health and well-being, they stand equally before Vermont's health care infrastructure.

What Choices Are Possible for Each of Us

We prize choice. It's a fundamental concept of our lives. It arrives in two forms: one, the individual; the other, the collective. We might, for example, choose to take scenic Route 100 on our way to Rutland instead of a stretch of Interstate 89. Ensuring Route 100's scenic route was a collective choice, not ours alone. The same is true in health care.

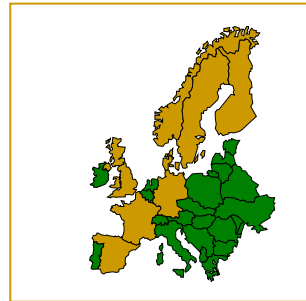
At the least, we want individual choice of primary physician and hospital in which we receive care. A list of other personal choices might include choice of generic over brand name drugs, choice of where we go to die (home or hospice), choices associated with living wills, advanced directives, and degree of medical intrusion, as well as some choice of treatment protocols. With the current State of Vermont's health care, some of these choices are available; some are not. A system would fully restore all of them.

Choice does not exist for the individual in some areas within health care. One example is the location and size of expensive components of the infrastructure, namely hospitals. These choices are functions of larger populations. Little choice bears on where we receive highly specialized intensive care, which is particularly true of a rural state like Vermont. Even densely populated urban areas have limited choices for some health care services. For example, treatment facilities for certain congenital heart defects, which affect as few as 1,500 babies nationally, are few and far between.

Individual choice in health care, in most ways, works as a function of collective capacity. For individuals to have any choice at all, health care services based on collective capacity must first be in place. This dynamic is particularly important in Vermont, because we lack the population density and financial capacity to provide all possible infrastructure choices. The two go hand-in-hand. That's why Vermont has no heart transplant units.

In a previous section, we pointed out that, as you move up the ladder of treatment intensity, the costs are higher and the patients fewer. This mismatch leads us to understand that the only feasible way to meet costs is not at an individual level but at the population level. If we choose to want particular health care services, let's say, a trauma unit, then we are left no choice but to support it collectively if, collectively, we have the financial will to do so.

What Can We Learn from Other Places

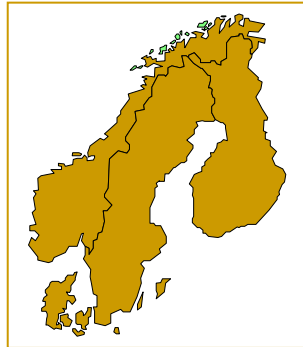


The world is smaller these days. Global communications are now instant. If we chose, we can learn about practices, traditions, and outcomes in distant places. However, in regards to health care, we have paid little attention in any organized way to what is happening in other parts of the world. If we did, we'd find important lessons to learn. Instead, our public discussion has focused on what is *wrong* in health care systems in other places. What we need to do is examine what is *right* about them. We would find that health care quality in many other systems far exceeds ours.

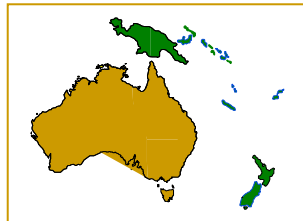
The first thing we might notice is that other nations pursue a variety of choices and options regarding financing of health care, system structure, control, and delivery. Several general patterns recur. The most important



feature is that, at some level, all citizen of these countries are included for both health care access and coverage. Governor Dean, in his run for the Democratic presidential nomination, was fond of rattling off a seemingly endless list of countries that provide universal access and coverage ending, usually, with “even Costa Rica.” The same pattern can be found throughout the western block of Europe, all of Scandinavia, the United Kingdom and their commonwealth, including Canada and Australia. When one looks at key indicators of quality, such as life expectancy or low infant and maternal mortality, our health care is clearly not superior to health care in other places.



Another important feature concerns financing. Other countries have found fairer ways to finance their health care systems. All of them publicly finance between 70 percent and 90 percent of their health care services.⁸⁷ The approach to public financing varies from country to country. For example, Germany, France, and Japan have systems primarily financed through some form of payroll tax. They are considered “multiple risk pool payer” systems and are highly regulated. In other countries, financing is accomplished through national health insurance systems. Canada, Denmark, Norway and Sweden finance their health care systems through broad-based taxation as single-payer systems akin to our own Medicare. Here in the United States, we do it differently. We pay for health care through the public sector, the private sector, payments by individuals, co-pays, and other mechanisms. Private financing in the United States winds up being about 40 percent. In Norway, it is approximately 10 percent.



Health care systems in other places are also differentiated by the degree to which government is involved in the delivery of care. Examples of “socialized” medicine—where physicians are salaried by the government and hospitals are managed by the government—exist in the United Kingdom, Sweden, Spain, and in U.S. Veterans Hospitals, the Walter Reed Hospital, and the U.S. military.

In other systems, health care is publicly financed but privately delivered. These systems include Canada, Japan, Germany, Denmark, Australia, and

⁸⁷ Organization of Economic Cooperation and Development, 2004, at www.oecd.org.

France. In 2000, France was designated the number one health care system in the world for quality, fairness in financing, and delivery of care.⁸⁸

Another important feature concerns the degree to which health care is controlled by central governments and at what level (national, regional, or local) predominant control is located. In Denmark, most financing for health care is community-based and carried out by local authorities in their 14 districts.⁸⁹

The lesson here is that most other countries have found ways to tailor their health care systems to national priorities and local conditions. Most of these countries cede important roles to their communities. We all recognize this as similar to the Vermont way of thinking.



Denmark offers an alternative to the military draft that enhances health care. Danes can volunteer to serve the elderly for two years. As a result, local long-term care programs in Denmark are staffed by the young and energetic. To go into a long-term care facility in Denmark is to experience facilities with relatively low-technology care but vibrantly high-social care. The lesson is that health care can be molded to satisfy local conditions, even if financed from public revenues at the national level.

Some additional international comparisons can be found in recently published documents by the Paris-based Organisation for Economic Co-operation and Development (OECD). For example, hospital stays in the United States are significantly less; the average number of physicians per capita are roughly similar; and the United States has significantly fewer hospital beds per capita. Yet, the same comparison tell us that per capita health care expenditures in the United States are more than two times the national average of other industrialized nations. Our health care quality, infant mortality, life expectancy, and other significant health indicators are not stellar. See Appendix H, “*International Comparisons*,” for more detail.

⁸⁸ “Health Systems Improving Performance,” *The World Health Report 2000* (Washington, DC: World Health Organization, 2000).

⁸⁹ Vermont has an interesting history of comparing itself with Denmark. In 1912, the Vermont Department of Woodlands and Fisheries published, as part of its annual report to the Legislature, a comparison of “outcomes” between Vermont’s and Denmark’s agricultural practices. The study showed that Denmark produced higher per capital yields in bacon, potatoes, and other agricultural products. The whole purpose of the report was to learn from another place.

The general point is that health care is financed and delivered in different ways throughout the world. Because other countries' systems cost much less and show better quality in important categories, we can learn much from them. We can learn from their successes and their mistakes. Little is gained from pretending that we, of all countries, know best.

How Do We Fit In?

The Role of Patients in a Changing System



Vermont's population and its citizens who use health care services are at the center of change. Together, we are moving from a health care system in name only to a new and truly reconstructed and integrated system. A system that emphasizes the role of consumers would locate a large part of budgetary and health care decisionmaking in regional and local entities where the role of patient receives the emphasis it deserves. The relationship of the health care services to the population is the determining factor in how the system functions.

Under the envisioned system, patients have greater freedom than now to choose their physician and health care services. The potential for informed choice will be even greater when health care catches up with the revolution in information technology. An interconnected health care system is in a position to provide information technology for both patients and physicians.

Patients are now in the best position ever to do their own research regarding disease and its treatment through the World Wide Web. Its use and capacity is exploding. Patients can be more involved in ongoing decisions about their personal behavior related to health, such as prevention, lifestyle, and even tertiary care procedures.

Individual choice would extend to buying supplemental insurance and opting out of the publicly funded health care system altogether. An individual may wish to go beyond the public benefit package for a medically unnecessary procedure, such as vanity surgeries like tummy tucks. In this case, the individual chooses to pay out-of-pocket for health care services from physicians outside the public health care system but continues to contribute, as a taxpayer, to support the health care system. This dual participation could serve as a good indicator or measure of satisfaction with the system itself and, over time, contribute to quality improvement.

A system can institute co-pays with sliding scales related to income as modest incentives to avoid unnecessary care. The use of Vermont's health care capacity by its citizens is, in general, lower than the rest of the country, so we start from a favorable position. Modest co-pays might help to keep health care use in check. They might also inhibit seeking health care services that cost more in the long run. It's a matter deserving closer study.

The Role of Physicians and Nurses

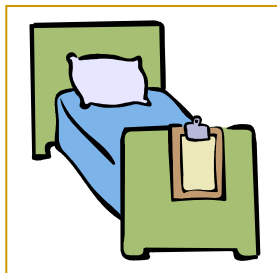


In the envisioned system, the medical roles of physicians, nurses, and technicians would remain unchanged. Primary physicians would continue as the bulwark of local care and gatekeepers to health care service networks at regional and state levels. However, a system would enhance the role of doctors in decisionmaking by no longer having third-party insurance payers review their decisions.

Nurses would continue as the backbone of direct care.

Physicians and nurses, by being part of a consolidated payment system, would experience far less administrative paperwork. The method of payment to physicians would be a matter for extensive discussion. Some Vermont physicians are currently salaried. Others are paid on the basis of the number of procedures performed. Another matter deserving closer study.

The Role of Hospitals

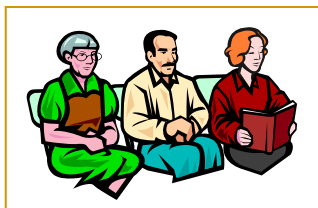


Hospitals occupy the center of our health care system. They represent something tangible and meaningful to citizens in the area. Hospitals would gain in their community role as the organizing point for a region's health care.

Hospitals would function under a fixed-cost budget, possibly a rolling three-year budget. They would be the collectors and providers of comparative outcome data. Their budgets would be based on population planning for their region. In addition, communities would subject hospitals to an increased level of scrutiny and participation.

Vermont hospitals' current responsibility for charity care could be expected to disappear under a publicly financed system.

The Role of Community Health Clinics and Centers



No health care system will ever be perfect. For one reason or another, some people will always refuse to participate or fall through the system's cracks. These people may look for help from community health clinics.

Community clinics serve a greater need than just providing health care services. They act as a safety net. They also serve as a conscience for whatever health care system is in place. They are voices for the people.

We can envision a shift in the role of community health care clinics along the continuum of providing services to promoting prevention. The volunteerism and idealism associated with community clinics is a value so important to all of us. Their work truly defines service above and beyond the call.

The Role of Communities and Citizens in Health Care

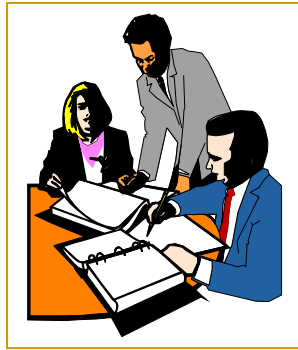


Communities are becoming more deeply involved in planning their own futures. In the broadest sense, deep and wide energy for positive change exists in our communities, but that energy needs to be tapped. In many ways, we have watched and been part of a renaissance of community life, particularly in economic development and certainly in the arts. The “creative economy” is becoming more visible and important in our economic and social life.

In the City of Barre, for example, we have seen: a rebirth of the venerable Barre Opera House; a second life for one of the beautiful old neighborhood schools, which had been abandoned but is now home to the Vermont Historical Society; and the reworking of an abandoned granite shed, which is now under redevelopment as the Granite Museum. This project, when completed, will celebrate the granite traditions and, by definition, the rich ethnic heritage of the city and surrounding communities of Barre.

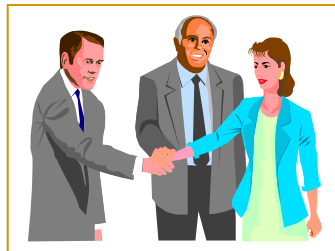
Such reawakening is happening in community after community in Vermont. Our state has a yearning for a richer community life. This kind of new attention and energy in our communities is a good foundation for community involvement in a new and improved health care system. Local oversight, governance, accountability, and fair distribution of resources can flourish under such community spirit. See Appendix I, “*A Short List of Reputable Sources for Health Care Information*,” for more detail.

The Roles of Contractors, Vendors, and Payers



A reconstructed and streamlined health care system would affect current payers the most, including existing insurance companies and possibly Medicaid and Medicare. The potential is also there to form new entities, specializing in the consolidated administration of health care financial transactions. They could evolve into administrative vendors. They would no longer be involved in risk assessment or in the definition of health care products. They would be bidders on operating a consolidated billing and processing system statewide. Given that some small proportion of the population would choose to opt out of the public system, existing payers could play a possible role in providing supplemental and alternative insurances.

These major changes would result in greatly reduced transaction costs for the administration of health care. These features are key to the overall administrative savings required of a reconstructed system.

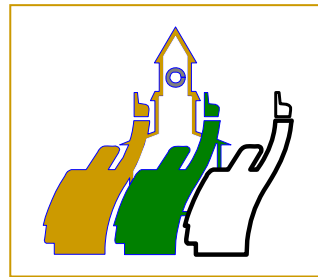


The Role of Employers in a Reconstructed System

A consolidated and primarily publicly financed health care system would essentially break the link to employment in the 60-year history of health care in the United States. This dependence is already frayed. The percentage of people receiving health care through their employers is slowly but steadily shrinking. Reciprocally, as this percentage shrinks, the percentage of those dependent on the public payers, especially Medicaid, increases.

Over time, the disproportionate costs to employers have businesses seriously reconsidering their long-term role as conduits for their employees' health care benefits. In a reconstructed health care system, businesses would be absolved of any decisionmaking on employee health care. Businesses could, if they wished, provide supplemental benefits to their employees in addition to the new system's benefits to all Vermonters.

The Role of State Government



Because the key future relationship will lie between the health care services and the population as a whole, the public must have vigorous representation on its behalf at all levels of government. At the state level, the primary function would be setting an annual unified health care budget along with multi-year projected budgets.

State government could also take up regulatory and information-gathering functions as currently carried out by the Vermont Program for Quality in Health Care, BISHCA, and other agencies. Paul Harrington, executive director of the Vermont Medical Society, put it well. He said that, as a result of the information gathering and fiscal analyses that BISHCA did at the behest of the Legislature since the early-1990s, there is a “*structure in waiting*.”

An interesting experiment occurred in Rochester, New York, some years ago. The city's existing hospitals formed a coalition that constructed a consolidated budgeting and budget control system, even though these functions were technically independent. For some years, the health care costs in Rochester grew at rates considerably less than the growth in the rest of the State of New York and the nation. In the mid-1990s, reimbursement changes at the federal and state levels affected cooperation among these hospitals. They experienced a falling out and costs rose rapidly. Details of this are part of a 1993 General Accounting Office study.⁹⁰ At that time, Rochester was a city of about 242,000, roughly 38 percent of Vermont's population today.

⁹⁰ “Rochester's Community Approach Yields Better Access, Lower Costs,” *Report to the House Committee on Government Operations* (Washington, DC: Government Accounting Office, January 1993).

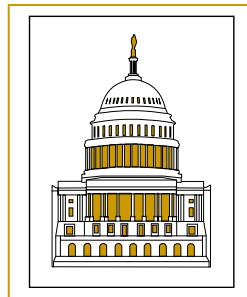
We need to think of health care as a public good in the same way that we consider public utilities as public goods. That is, subject to regulation and quasi-judicial proceedings involving rates, capacity, and future plans.

Another possibility is a more intensive role for state government along the lines of a “public service” model. In this model, the public agency actually owns the health care system. In our view, this model proposes an unnecessary and unfortunate role for government to undertake. However, controlling costs through the implementation of a model similar to the public utility model is well worth considering.

The Role of Nongovernmental Organizations and Foundations

How well Vermont provides universal health care access, maintains high-quality health care, and controls health care cost in a reconstructed health care system will invite intense scrutiny. A system is intended to be self-assessing on a rolling basis. Still, independent evaluations cannot hurt and are much more likely to help the process of continuing adjustments to meet new conditions.

Foundations and nongovernmental organizations can help in this role. They are in a particularly strong position to provide Vermont and its citizens that vital service of ongoing assessment of a system in the process of becoming.



The Role of the Federal Government

Cooperation and support will be an essential role of the federal government. Medicare is a universal single-payer system for people over 65. It covers over 40 million people in the United States. Vermont’s relationship to this vital program is fundamental and cannot be disrupted. To make the most of a new system, federal waivers would be needed.

Medicaid, the state and federally funded program for the poor, would also require significant waivers to mesh smoothly with a newly reconfigured

health care system. Without the waivers, the new system could still function but would not realize its full potential in administrative savings.

Welfare reform is a good demonstration of learning by example. The federal Personal Responsibility Act of 1996 addressed how information learned across states in the early-1990s had stimulated the most significant changes in welfare policy in our country's history. Techniques were widely disseminated across states, which served as a basis for sharing and importing ideas from states that had been acting on their own. Vermont, for example, had instituted statewide welfare reform in 1994. Out of that came the largest change in welfare and welfare-related policy since the 1930s.

This kind of environment and relationship with the federal government is what states need at this important time. Yet, in reality, the federal government and the State of Vermont are tending in opposite directions. Vermont is rapidly coming to recognize that some sort of system to ensure health care for all its citizens is a stark necessity.

Federal proposals seem stuck on the idea that significant cost controls can be achieved at the individual level—the patient end. A movement toward “vouchering” health care coverage has emerged. There is even talk of vouchering Medicare. That is, giving seniors tax credits, vouchers, and other individually oriented means to choose how, where, and under what circumstances they receive health care. The major difference between this and our ideas lies on the financing side.

We contend that vouchering ignores the reality that 70 percent of health costs are incurred by 10 percent of the people. Therefore, vouchering as a primary technique cannot result in significant cost savings. Further, vouchering has the potential of destabilizing the financing of our health care services. Nevertheless, the federal posture on these issues is very important.



The Role of Vermont

To us and to many others, some state in the near future will inevitably break down the barriers and undertake financing health care differently. Vermont is small enough that investment by the federal government in such

an initiative would certainly be feasible from a fiscal point of view. The investment to reconfigure health care in Vermont might be small, but the lessons learned would be a large gain for other states.

We envision an independent BISHCA-like agency assuming overall budgetary control and then allocating authority and responsibilities to regional areas around community hospitals. Such an agency would be responsible for defining the general health care benefit package to which all Vermonters would have access. Authority to implement local budgets and to distribute health care benefits would be conferred to regional and local levels. This decentralized delegation of authority is consistent with Vermont's way of doing business and with its "*shire*" history.

Our argument throughout this book is that change is only possible by encompassing the whole population of Vermont. Without including the whole population, health care reforms cannot achieve cost controls and systemic improvements.

What Are the Benefits?

Costs That Will Go Down



A consolidated health care system in Vermont would result in a set of costs that should go down, both in the short and long term. This set includes costs for administration, worker's compensation insurance, secondary illnesses from more and better prevention, previous overuse of medical care, medical errors, charity care, and long-term costs for managing chronic disease.

Administration holds the potential to reduce costs for intermediary personnel across the system. These costs include functions of health insurance brokers, benefit utilization managers, accounts receivable personnel, and numerous other ultimately unnecessary functions.

Costs That Will Go Up

Some costs will go up. These costs include expansion of benefits for the estimated 16 percent of Vermonters who are underinsured and increased costs for the uninsured. A one-time cost—but a savings in the long term—is a substantial investment in information technology as part of the streamlining process. The important monitoring of quality, which plays a larger role in a recast health care system, will also cost more.

We believe the net amount of these costs and savings will be significantly less than the unchecked costs under the current health care arrangement.



What Are the Obstacles to Overcome?

A number of obstacles, of course, are in our way. These obstacles emerge from normal worries and fear of change, the sheer size and complexity of the problem, and the substantial interests of those who will not benefit from change.

Size and Complexity of the Health Care Issue

The sheer size of the health care challenge is daunting. Still, larger and more complex systems undergo almost constant reorganization and refocusing. The Vermont Agency of Human Services is in the midst of a complete review and reorganization of its delivery systems. The agency is changing many elements of its organizational chart, improving customer service, and introducing technology in ways that ensure more effective interaction between the service system and the consumer.

Will reorganization solve all the problems? Of course not. Will the agency be able to do more with less? Of course it will. The budget of this agency is over \$1 billion, which is one-third the size of Vermont's health care costs.

Still, no political reticence surfaced in the Vermont Legislature or Administration for reorganizing the Vermont Agency of Human Services; they took the plunge because of a strong commitment to improve the agency. Why are we so reluctant to tackle our health care with similar determination? We need that same kind of fearless commitment on behalf of health care for Vermont's people

Special Interests of Those with Current Economic Gain

The special interests of those who gain economically from the current health care arrangement will perhaps be the most formidable barrier to moving forward. Health care is a lucrative business; many profit and earn

well from it. Change in the status quo is always risky. Those who benefit economically from the existing system will be hard to dislodge.

Large special interests have the resources to fight change. Washington's Capitol Hill has more health care lobbyists than the total number in Congress, both Members and staff. The cost of health care lobbying is immense.

Historical Inertia

The physics of inertia are straightforward. A body in motion tends to stay in motion. A body at rest tends to stay at rest. Resistance to change is natural and pervasive. Change is particularly difficult in the absence of a future direction or when people and organizations inside are comfortable and cannot summon the energy toward a common purpose.

All of these dynamics are at work in health care. The longer change takes to occur, the less likely it is to occur—absent, of course, a catastrophic event. Health care may or may not be approaching some catastrophic trigger. However, the damage that can be done to our health care capacity in an emergency environment is not a scenario to wish on ourselves. We'd do better to find the self-motivation to change our health care while we are still in the driver's seat and not driven ourselves by events beyond our control.

Fear of Increased Costs from a New System

Businesses often express this concern: *"If we change this system substantially, our costs will go up, and we'll have no control."* Businesses have every reason to be concerned about the future in Vermont and in the country. This expressed worry, however, describes the present not the future. Right now, costs are going up and we have no control over them. The whole point of reconfiguring how we pay for health care is to eliminate unnecessary costs and modify other costs to flatten the trendline.

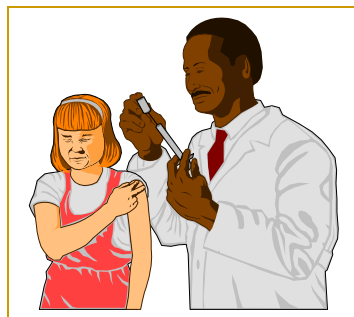
An associated worry is the business community's concern over higher taxes. It's true that, to finance a health care system fully, we would have to

establish some kind of broad-based tax. Thinking about financing health care as a public service—in the same way that we think about financing highways, education, police, and other public services—means that we all contribute to financing health care’s fixed costs. If businesses wish to continue the current financing scheme for their employees, costs will continue to skyrocket. If businesses want to modify their health care costs, then they will have to accept a tradeoff: a fair tax scheme with overall cost controls for unrestrained health care costs.

The State of Vermont’s overall budget has stayed in a sustainable mode since the early-1990s through three administrations of both major parties. Each administration, using central budget techniques coupled to close scrutiny by legislative committees, thoroughly examined all aspects of the budget. Each year, tough choices were made. Each year, major battles were featured toward the end of the legislative session and followed by difficult decisions. Vermont’s budget is a publicly financed system responsible to the public. It’s not perfect, but it’s a good and disciplined process. A health care system would be subject to the same intense process. This kind of budget discipline can moderate costs.

Other Worries About Change

Having the Government Too Deeply Involved



Government is already deeply involved. It acts as a *provider* of care (e.g., the Vermont State Hospital and Veterans' Hospitals), as a *regulator* (e.g., Medicare hospital regulations and licensing of health professionals), and as a *payer* (e.g., Medicaid and Medicare). BISHCA also plays a mild regulatory role as does Vermont's Department of Public Health and the U.S. Department of Health and Human Services. Medicare, the federally funded program for seniors, is the biggest payer in Vermont hospitals and a significant factor in health care regulations. Medicaid, the federally and state-financed program run by the state for the poor, is the largest payer for nursing homes.

Government financing, when added up to include tax breaks to businesses, represents 60 percent of the money in health care. Over the years, the proportion of public financing has increased compared with private financing.⁹¹

Social Security is another example of a government-sponsored program for which citizen satisfaction is high and administrative costs are low. Is health care for all of our citizens more like Social Security? Or is it more like shopping at the mall? The authors think this question is worth pondering. The contrast sheds light on where health care in Vermont should be going.

Will Rationing Result?

Rationing is a scare word just like "taxes." It's meant to replace considered thought with fear. It brings back images of food lines during the Depression, gas lines during the 1970s' oil embargo, and emergency

⁹¹ *Vermont Health Care Expenditure Analysis, 1994-2002.*

supply lines during natural disasters. Words like rationing are introduced into a discussion to cut short that discussion.

Discussing health care begins with the fact that, like all social systems, health care has finite resources. A great deal of political heat is generated around locating and defining where the limits are. Budgets are an expression of these dilemmas. We have societal needs and limited resources. How do we match them up?

Health care in Vermont, and anywhere else in the country, has no budget. The way health care needs have matched up with health care resources has proven to be unconscionably wasteful. Even in Vermont, health care is rife with rationing under another name. It's rationing under the guise of "coverage." Those who can't afford "coverage" frequently delay or skip care, because they don't have the money to pay out of pocket or are ashamed to ask for charity care. Rationing by the price of coverage is the most unfair and disorderly way to seek and identify the limits of health care.

All health care systems have to engage in tough decisionmaking in order to allocate resources in a fair and cost-effective manner. In reality, we must accept limits; when the limits are rational and systematic, they are much easier to accept. Resources in the United States far surpass most other countries; yet, because we've allowed random development of our health care, we get less for our money.

A publicly financed health care system in Vermont would breed less rationing not more. Its identification of the limits where rationing occurs would be a societal decision not a chance accident.

As a matter of public policy, Vermont constantly parses out scarce dollars. The entire legislative appropriations process is dedicated to this work. How much money should go to educational services or correctional services? How much money should go to our highway system and spent how and where? Conflicting demands on public revenues are nearly infinite, but the revenues themselves are finite. Legislators are fully aware that no amount of funds for any Vermont program convinces the program's constituents that its funding needs are met.

Health care should not be any different. Indeed we are already allocating some health care resources, but we're not allocating well enough. The budget mechanisms to do so don't exist. The principal way to allocate resources is to have a basic budget against which to assign allocations. Parts of our health care sector have this discipline, particularly the public side of health care.

A good example is in the Division of Rate Setting in the Vermont Agency of Human Services. Its mission is to negotiate annually the number and type of nursing home beds for Vermont together with the level of support for each bed. Strong disagreements with the private nursing home industry are not uncommon. Frequently, the industry focuses on how much support should be provided for acute care at the expense of home care for the elderly and vice versa. Each year, however, agreement is finally reached on how resources are to be allocated or, if you will, "rationed." The overall quality of Vermont nursing homes continues to be judged as high.

What is the line between allocation of resources and scarcity? The first is an assignment of resources. The second is a case of need overwhelming assigned resources. Allocation requires deliberate choices. Scarcity requires deliberate responses. Both function within a system. Without a system, we are left with chance encounters, random answers, and panicked responses. If we don't make an effort to change current trends, scarcity will make its presence felt in just a few years time.

The Quality of Our Health Care Will Suffer

Many reasons exist to doubt that the quality of our health care will suffer. First of all, Vermont enjoys a long tradition of high-quality health care that continues today, which is almost entirely attributable to the medical ethos here. Medical professionals in Vermont recognize a strong medical ethic and spirit of cooperation. Patients are aware of this, so their expectations are high.

Medical greed that surfaces in some other states is all but invisible here. Physicians, nurses, and others in the health care field are well known to work for less compensation in Vermont. Much of the tradeoff has its origins in a nurturing social and professional environment.

Two
conditions
are invaluable
for quality
health care:

adequate time
with patients;

and continuity
of care.

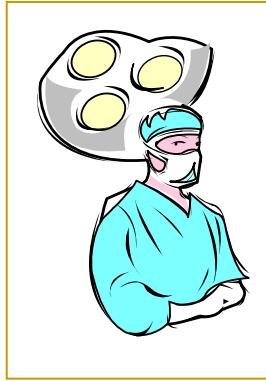
Nothing in a health care system is geared to tamper with this favored situation. It would be folly to do so. A health care system is aimed at supporting high quality. Any questions about this ought to be settled by examining health care systems in other countries. Many exhibit higher quality, as a general measure, and many rate higher than the United States in some measures by specialty. Vermont does better than other states; our task is not catching up to other systems but rather maintaining what we have.

No credible evidence argues against a health care system being able to maintain high quality. In fact, a good deal of credible evidence persuades that having a system is a valuable part of doing so.

A system is meant to be supportive of medical professionals. A system is meant to be supportive of patients as well by fostering the best possible conditions for medical practice. A system also offers potential of much better information networking to get the best possible medical outcomes. Quality indicators, which a system encourages, can be useful, but two invaluable conditions at the medical practice level are even more useful. These conditions for determining quality are adequate time with patients, and continuity of care. Our current health care compromises both of these conditions. A system would set these as goals, especially in primary care.

Allocation of resources, distribution of health care, and responsiveness to patients are indispensable functions of a system. All bear on quality of care. All are missing, in whole or in part, from our current health care sector. The weight of decisionmaking and responsiveness in the envisioned system lies at the regional and local levels. Delegating to these levels cuts down the distance and time from supervisory policies at the state level, which, in turn, lead to a more immediate responsiveness. The local level can also better keep quality in view.

The real purpose of reconfiguring Vermont's health care services into a system is not to invade Vermont's high-quality health care. The main purpose of an integrated system is to restore sanity into how we pay for this high-quality care. The goals are fiscal efficiency, moderation of costs increases, and fair financing along with preservation of quality health care services for all Vermonters.



Doctors Will Leave for Greener Pastures

Would doctors turn up their noses at a health care system and abandon Vermont? A survey 12 years ago found that a little more than half our doctors favored a universal health care system.⁹² No one doubts that the percentage in favor is greater today. The popular myth is that Canada's physicians can't wait to get out of their health care system. Is this true? In 1996, Canada had a net loss of 508 physicians from approximately 57,000. That figure was the highest in 10 years. The net loss in 2003 was 80.⁹³ Vermont has 1,200 practicing physicians. If Vermont lost in the same ratio as Canada did in 1996, we'd lose about 10.5 physicians. If Vermont lost in the same ratio as 2003, we'd lose about 1.5 physicians.

The likelihood of Vermont's doctors rushing to other states is small to none. Conditions of practice here are excellent, as long as you ignore the administrative overload caused by our current health care arrangement. Of course doctors complain bitterly about the administrative nightmare, but it's no different, perhaps worse, in neighboring states. The probability of our physicians trading what they have here for another state's equal or worse problems, because we institute a system that provides them far greater freedom of professional practice indeed strains credibility. In fact, since Vermont is already attractive to medical professionals, any improvement in conditions of practice would likely draw new physicians to Vermont.

Government Won't Pay Its Bills Fully

Government being remiss in payment of bills is a legitimate concern in light of how Medicaid underpays for care. Would it be any different under a health care system? And if so, why?

Payment problems with Medicaid are not a reflection of Medicaid itself. The basic problem is that Medicaid is underfunded. The program and its administration are efficient in themselves. But without the funds to meet the

⁹² Two surveys: one by the Vermont Medical Society, 1993; the other by Physicians for a National Health Program, Vermont Chapter, 1992.

⁹³ Canadian Institute for Health Information's website is http://secure.cihi.ca/cihiweb/disPage.jsp?cw_page=AR_35_E

Vermont's
health care
goals are:
fiscal
efficiency,
cost control,
fair financing,
and
high-quality
care.

increasing demand in Vermont for health care for the state's poor, a program deficit is inevitable. A health care system would interrupt that cycle of insupportable medical costs that drives Vermonters into poverty and, thus, into Medicaid. A system would curb pernicious and costly imbalances that touch on more than 100,000 Vermonters in one way or another. A health care system would seek balance and efficiency.

Let's be honest. Government, in times of budgetary crunches, goes to where the money is. The Vermont Agency of Human Services, which operates Medicaid, consumes about half the state's entire budget. So, if budget reductions must be made, those charged with doing something about it tend to "*follow the money*." Politically, it works because only a narrow class of people are affected.

In a universal health care system, however, such an approach is politically far more risky. That is because a system not only spreads responsibility but also spreads accountability. A failure to fund payments adequately reaches beyond any one class. It affects everyone. It affects the health care services everyone depends on. The effects are neutral as to rich or poor. A publicly financed system makes no class distinction. It bases the health care that every Vermonter expects solely on need.

We don't mean to sound overly cynical about political choices. Still, the reality is, if powerful, well-connected, highly organized people suffer identical effects of budget mishaps in their health care, they will make themselves heard. The guiding principle that our health care services are shared prompts their response, loud and clear, that they expect those services. That's what politics in Vermont is all about. Our deliberations between elected representatives and the electorate are intense and personal.

There Won't Be Any True Cost Control

Health care costs will go up. In fact, they are going up—in every nation. The reality of this cost inflation must be acknowledged. Aging populations, new technologies, and rising drug costs are all involved. Rising costs in the United States and Vermont surpass other countries with health care systems.

Costs controls aim to modify the upward trendline of costs. It works in health care systems around the world. Notions that systems are the cause of health care's fiscal problems in other nations fly in the face of all available evidence, not to mention common sense. The trendline in the United States and Vermont is far too steep, in both practical terms and subjective terms. It's damaging our economics and our competitiveness and it's highly unnerving. We know that no workable means exist to influence the trendline other than having a health care system. A system is exactly what we are missing.

I Won't Be Able to Get Health Care Outside Vermont

Each year, about 20 percent of the Vermont population newly arrives; about the same percentage leaves to live elsewhere. A fair number of Vermonters make a living outside the state. Others winter in the south (an annual Barre Day takes place in Venice, Florida, each winter). Vermonters travel extensively; many travel overseas for vacations, pleasure, or work.

A Vermont health care system has to take the population's mobility into account. No barriers should stand in the way of paying for health care beyond state borders other than clear guidelines and sensible planning.

Higher Taxes Will Take the Place of Premiums

The basic worry here is that, if the State of Vermont takes responsibility for financing our health care, uncontrolled taxation will result. Health care costs are growing at five times the CPI, which qualifies as a runaway rate. The taxes on the state's economy (whether explicit or disguised) are keeping pace, because we are paying the higher costs. In this regard, the prime selling point of a health care system is the resulting budgetary discipline.

Common sense tell us that we'll spend less under budgetary discipline than without it. We also have the example of other countries' budgetary disciplines. Their health care systems pay less than half what we do.⁹⁴ Taxes

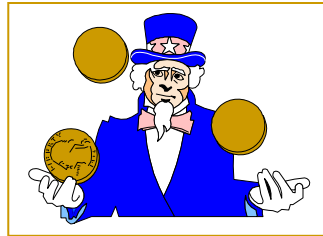
Health care
takes a
bigger bite
out of income
than taxes.

⁹⁴ OECD, 2004.

of some kind—explicit taxes, not disguised levies—will take the place of premiums. Wholly reliable studies on such taxation have yet to be conducted, but certainly these taxes will be less than their current premiums for nearly everyone. We now pay the highest health care taxes per capita in the industrialized world.⁹⁵

Government Will Spend Health Care Money Elsewhere

The expenditure of government money on other than health care is another legitimate concern. A system's fiscal discipline ensures that annual budget requests will be predictable within reasonable margins, which greatly minimize the potential for any surprises. Predictability is a tangible benefit of a system but does not erase old habits of government in raiding other funding sources. State government tends to look upon dedicated funds as fungible. This borrowing-from-Peter-to-pay-Paul policy isn't publicly touted but, nonetheless, occurs. Some examples:



- At different times, the money from the Transportation Fund was used to make up Medicaid shortfalls.
- Money from the General Fund has used to aid the Transportation Fund.
- Money from the Vermont Lottery is scheduled, by law, to support elementary and secondary education.
- In turn, the amount generated by the lottery goes beyond the needs of the Education Fund, so other ways to use the Fund are sought.

Health care, at this point, benefits from these kinds of transfers. Important Vermont programs, such as higher education, are underfunded to pay for health care. Government-supported higher education has consistently had less than a 5 percent annual increase for some years, despite that the actual costs of higher education have risen at twice the rate of inflation. To discerning eyes, health care and higher education look locked in a funding struggle with the latter losing ground. A dedicated revenue source is of central importance for a health care system.

⁹⁵ *Ibid.*; and Woolhandler and Himmelstein, *Health Affairs* (data are for 2002).



We'll Lose Our Technological Edge in Health Care

This worry reflects the scenario that U.S. health care is the leader in medical technology. But that scenario is flawed. It's nice to think it true and take pride. But it isn't true. Other countries make advances in medical technology all the time.

- The CAT scan is a product of ingenuity in the United Kingdom.
- The science for bone marrow transplants had its start in Canada.
- Canada is also responsible for pancreatic transplant techniques.

Such advances outside the United States comprise a fairly long list. Evidence that a health care system impedes technological advances or destroys initiative is nonexistent. See Appendix H, *"International Comparison,"* for more detail.

We'll Lose the Power of the Marketplace

The power of the marketplace can be an awkward fit with health care, particularly in Vermont. First, the market for health care is pretty clearly defined, because health care needs are relatively stable within a population. Second, medical choices and options are also pretty well defined. Third, most important, people tend to make health decisions based on quality not price. Perhaps this leaning is because patients are not usually direct purchasers of health care services.

In Vermont, the idea of having a "market-driven" health care system is even more unlikely because of the rural nature and low density of our population.⁹⁶ The nature of Vermont's population is one reason why we have not experienced more private insurers coming into the state. We also have to remind ourselves constantly that 80 percent of health care purchases are made by 20 percent of the population.

In sum, Vermont has no market-driven system for health care nor is one likely.

⁹⁶ Richard Kronick, David C. Goodman, John Wennberg, and Edward Wagner, "The Marketplace in Health Care Reform: The Demographic Limitations of Managed Competition," *New England Journal of Medicine*; Vol. 328, No. 2; January 14, 1993, pp. 148-152.

The New System Will be Subject to Political Favoritism

Our health care system is a study of inequities, some surprising. One notion is that Medicaid patients receive better health care benefits than many Vermonters with private insurance. Some wonder why the elderly are favored by the universal Medicare program. Some Vermonters pay much more and others pay much less for the same health care. People with plenty of money can buy full health care coverage and services wherever they wish. Some people are underserved, because health care services are not adequate to local needs in some areas of Vermont.

Some trace of inequity is almost certain to surface in a reconfigured system, because no system is perfect. Nevertheless, a system will be far better than what we have now. The concept of shared services makes inequities and favoritism easier to suppress. We share the services; we share a benefit plan; we share a stake in health care financing; so, we grasp the idea that your health care is my health care and vice versa. Neither can exist alone.

Bestowing as much local control as possible on regional systems will make a powerful advocacy base for fairness across the entire health care system.

Covering Uninsured / Underinsured Will Increase Costs

We need to stop and realize that, in one way or another, all Vermonters already absorb the costs for the uninsured and the underinsured. Approximately \$90 million is spent annually in the form of charity care and free clinics. A publicly funded system promises to pay for this care, not trick us into paying for this care through hidden charges.

At the same time, a system offers relief. It can erase a great deal of administrative costs in the neighborhood of \$500 million. It can modify the annual 10 percent growth in costs. However, by nibbling around the edges, we can achieve none of this. Instead, the scale of change determines the breadth of opportunity for significant improvement and control of current runaway costs.

The scale of health care is so large that only significant change of the same scale can result in the benefits everyone desperately desires. Indeed, coverage for all Vermonters brings the opportunity for systemic cost control and quality improvement.

The Business Case



The historical reluctance of businesses to involve themselves aggressively in major changes to our health care sector is puzzling. If Vermont health care were in business's hands, no one doubts that they would have little tolerance for the current wasteful practices. For example, businesses do a good job of measuring fixed costs and capacities for current and projected levels of output. Health care doesn't do this, except at micro levels. What ought to be one hospital's imaging capabilities (CT and MRI scans) in one region? BISHCA's CON process goes in the right direction but comes nowhere close to regional and systemwide planning for capacity.

Administrative costs are an important consideration for all businesses. The Green Mountain Power utility is an example of a major Vermont business that has seriously addressed administrative costs. Rate payers and customers have benefited from that attention. Administrative costs are about 9 percent of revenues. Vermont's health care overhead is somewhere between 26 percent and 30 percent.

Competition has resulted in major improvements in cost, quality, and productivity in almost all aspects of business. In a largely unregulated set of enterprises, health care ought to have benefited from similar dynamics. It clearly hasn't. Businesses' relentless search for improved conditions has the effect of driving down costs.⁹⁷ In health care, however, wide differences in cost, quality, and access across geographic areas have not responded to the same dynamics. The results of clinical trials take an average of 17 years to be fully shared and integrated across the health care spectrum.⁹⁸ That kind of developmental cycle is unacceptable in the business world where constant competition drives improved value to the customer.

In health care, the value to the customer decreases as costs go up and quality and access go down. Such an oppositional relationship is particularly vexing,

⁹⁷ Michael E. Porter and Elizabeth Olmsted Teisberg, "Redefining Competition in Health Care," *Harvard Business Review*, June 1, 2004.

⁹⁸ *Ibid.*

because value is diluted when unnecessary costs are added to the system. The hardest competition in health care is misplaced. Its focus is cost shifting. The time and energy involved in the contrived competition of passing costs onto others adds no value to health care and may actually dilute it.

How Do Businesses Deal with Uncontrolled Rising Cost?

The reluctance of Vermont businesses to involve themselves in health care reform is doubly puzzling, because they are both unwilling participants and victims of the very practices that need reforming. Competitive edges are crumbling because of escalating health care costs to businesses for providing health benefits to their employees. As other nations have shown, a health care system offers practical possibilities to modify health care costs.

Let's imagine that businesses abandon their position on the sidelines. How would they approach reform of problems confronting Vermont health care?

First

Almost all businesses have short-term, mid-term, and longer-term strategic plans. Even at 15 percent of our economy, the health care sector is doing no serious planning. Creating a basic set of fiscal targets around which control mechanisms can function is an important first step.

Second

Businesses consolidate purchases at lower costs. Some attempts to do this were for pharmacy products that are tax financed. However, forming a single-risk pool of all Vermonters would be a major step toward consolidating purchases and purchasing power.

Third

Businesses pay close attention to fixed costs. When a manufacturing plant's capacity is reached on the first shift, the response is to add a second shift rather than to purchase more equipment to meet the demand. Purchasing more equipment increases capacity and adds to fixed costs. Adding a second shift within current capacity is more efficient. The tendency in our health care sector to add capacity is an important factor in driving up fixed costs, which are then parceled out to Vermonters, including Vermont businesses.

Fourth

Businesses exploit technology to fuel cycles of greatly improved productivity. The business process is streamlined as is communication with

customers. Use of the World Wide Web is now standard business procedure. Written records have given way to electronic records. Technology has reduced overhead, and email has reduced distances between customers and businesses. Health care use of technology lags far behind.

Fifth

Businesses limit risk by contracting for goods and services well beyond one year. The public sector also uses long-term planning and contracting, particularly our utilities, where 15-year contracts for delivery of power are not uncommon. Businesses would apply some of the same long-term planning ideas to health care.

Sixth

Businesses configure marketing strategies to develop long-term consumers for their products. The health care analogy might be to develop better prevention and early intervention programs, which have the effect of adding long-term value.

Seventh

Businesses regularly review their sectors, assessing which have diverted from the central core of the enterprise. If businesses were plunked down into the middle of the health care enterprise, their first assessment would be that health care services barely qualify any longer as the primary product. The unnecessary complexity of delivering services absorbs so much time and energy—and produces so much bad publicity and ill feelings—that it's best to get out.

On the Other Hand

Let's imagine that Vermont businesses push to achieve health care reform. What would be in it for them?

They would probably get out of the struggle to provide health care benefits to their employees. However, businesses are already in too deep to extract themselves from these health care obligations. Under a new system, businesses, like everyone else, would share fairly in the financial support of health care.

Getting out of the health care insurance business greatly lowers barriers to positive employee relations, such as contract negotiations, age

discrimination, and retirement issues. A bonus of a universal health care system is that employees would no longer be dogged by questions of health insurance. This relief would affect full-time workers, part-time workers, and workers tied to jobs they dislike. Health insurance is a cause of friction between employees and employers. It hobbles workers from seeking workplaces where they'd be happier and more productive.

Vermont businesses could gain a favorable position in the marketplace, because high health care costs would not drag down their ability to compete. Stability and predictability of costs cannot be underestimated in business.

For 15 years, a sore point with Vermont businesses has been the jump in workers' compensation costs. A universal health care system would modify this by accepting all workers for needed health care.

Faced with difficult cost-control situations, business knows how to apply the 80/20 rule. However, health care budgets are so widely distributed and independent of one another, that this kind of discipline is not possible.

80 / 20

The “80/20” Rule and How It Applies to Health Care

A respected concept in business is the 80/20 rule.⁹⁹ Business people believe that, if you work wisely, a 20 percent effort can result in an 80 percent return.

Often, a core business generates 80 percent of the profit, while ancillary parts of the business generate 20 percent. Yet business people will be the first to acknowledge that they often spend 80 percent of their time and energy on issues that lie outside the core business. All of us have seen businesses that tie up their top management team in the planning and implementation of a new office building. In the process, they may unintentionally lose touch with the needs of the core business. After all, the core business was what allowed them to consider a new building in the first place. We've all seen cases where 80 percent of time, money, and energy is expended on a 20 percent return.

⁹⁹ Richard Koch, *The 80/20 Principle: The Secret to Success by Achieving More With Less* (New York: Doubleday Currency Book, 1998).

It's worth relating the 80/20 rule to health care. Health care gives us some very clear and recognizable 80/20 situations. For example, of 370 conditions and diseases, only 15 accounted for 56 percent of the \$200 billion increase in health care spending between 1987 and 2000.¹⁰⁰ The same applies to an end-of-life algorithm: a large proportion of what we spend on health care occurs in the last months of our lives. On an even broader front, 20 percent of our population uses 80 percent of our health care resources.

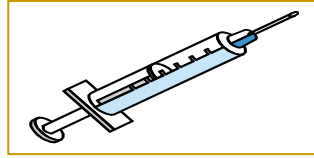
The 80/20 rule offers a path to strategic thinking about how to impact the overall cost of health care. If the 80/20 rule could offer a much better distribution of efforts and results than now exist in our health care, then the concept could help us create more specific strategies and approaches to curb unsustainable costs. For example, the ratio of health care costs to administrative costs is closer to 80/20 in most westernized countries than in the United States. Our ratio is 70/30 health care costs to administrative costs. The U.S. ratio is out of whack.

The 80/20 rule can guide us in systematically breaking down Vermont's immense and complex health care sector and building it back up into an effective and consolidated health care system. The 80/20 rule can enhance concrete thinking.

A good example of the 80/20 rule in operation is in Governor Douglas' plan to better coordinate treatment of chronic illnesses. Medically, this idea is good. The Vermont Chronic Care Initiative notes that over one-half of all Vermonters have at least one chronic illness. This proportion translates into 315,000 people. These people represent about 72 percent of all physician visits, 76 percent of all hospital admissions, resulting in 78 percent of all health care spending in Vermont.¹⁰¹ This disproportion is another example of the 80/20 rule, where 20 percent of energy, focus, time, and resources has only a small positive effect.

¹⁰⁰ Study by Kenneth E. Thorpe, Emory University economist. Ceci Connolly, "15 Illnesses Drive Up Costs: Conditions Linked to 56 Percent of Increase in Health Care Bills," *The Washington Post*, August 25, 2004, pg. A03.

¹⁰¹ *Legislative Briefing*, Vermont Department of Health, January 6, 2004.



On a positive note, one of the best examples of the 80/20 rule is prevention. For example, one dollar invested in immunization by age two will result, on average, in \$22 in avoided future medical costs.¹⁰²

¹⁰² Con Hogan and David Murphey, *Outcomes: Reframing Responsibility for Well-Being* (Baltimore MD: The Annie E. Casey Foundation, 2002).



How Do We Get There From Here?

What has eluded us for some years now is a credible process to foster change. We've no shortage of ideas. However, for lack of an effective process for change, good ideas have gone for naught—or worse. Good enough ideas have been marginalized and minced and parsed to levels of impotence. The following thoughts begin to construct a process for remedying health care in Vermont that might work.

Thinking in design-build terms allows us to put together a plan without sinking it with details too early in the process. We can confine details to the chunk actually under construction. This partitioning leaves room for the necessary give and take from all involved. Opportunities to hear all proposals figure importantly in the outcome.

The authors suggest that BISHCA (or a newly designated agency) be empowered to present to the Legislature one major achievable initiative every year for five or six years. The process would ask that each proposal, as presented, be voted up or down as a whole. This process is in keeping with the base-closing model. Its most appealing feature is limiting the influence of special interests.

Thinking About Phasing

Virtually all of our discussion so far has been about how a universal system would improve health care all around. Little consideration has been given to the process and timing of change. Some key elements for change include:

- A “*sense of urgency*” is an important element of any change process. Few Vermonters these days can claim not to feel a sense of urgency about health care. The financial pain inflicted by the current system is real and growing, which will act as a natural impetus for change.

- Another key element is the creation of a “*guiding coalition*.” At this point in Vermont, such a coalition would not be difficult to unite. A promising sign is the recently formed Coalition 21: Transforming Health Care for the New Century. (See Appendix G for more detail.) Possibly, Coalition 21 could serve that purpose with a little help and resources.
- A third element is “*formal authority*” for change as orchestrated by the Legislature, followed by rigorous evaluation of a staged implementation.
- Developing a “*change strategy*” is also a key element. Some of what we’ve discussed so far sketches what must be done. The authors hold a preliminary vision of major change taking place over several biennial legislative sessions. Initial legislative objectives would be to set up specific authorities and responsibilities that lead to action.

Expending time and energy to find an ideal sequence of legislative actions is futile at this point. Any start will eventually necessitate addressing all relevant principles and processes that are intricately interrelated with health care. Indeed, these interrelated sectors are a cause of Vermont’s health care problems. Rather than seeing the connections, we have viewed these sectors as autonomous and set them adrift to work alone.

For example, modifying the upward trend of costs is difficult, if not nearly impossible, when outsized administrative overhead is not also addressed. To do this requires more localized attention and authority over regionalized budgets working under a statewide supervisory budget.

Cause-and-effect links begin to multiply among sectors until their interrelatedness exerts itself. In respect of this interrelatedness, we recommend a series of legislative decisions along the following lines:

- (1) Recognition and authorization of the key principles for a future health care system in Vermont.
- (2) Agreement on the best methods of developing these principles into actions.

- (3) Laying down a schedule for phasing in the work over a period of time substantial enough to get it done right.

Our view of the work takes this shape:

- establish a unified budget with teeth,
- fix the financing,
- negotiate reimbursement rates,
- adopt a common benefit plan,
- establish regional population-based planning and assessment authorities,
- identify areas for long-term prevention programs, and
- establish a drug formulary.

When these tasks are achieved, we can look back with a real sense of pride.

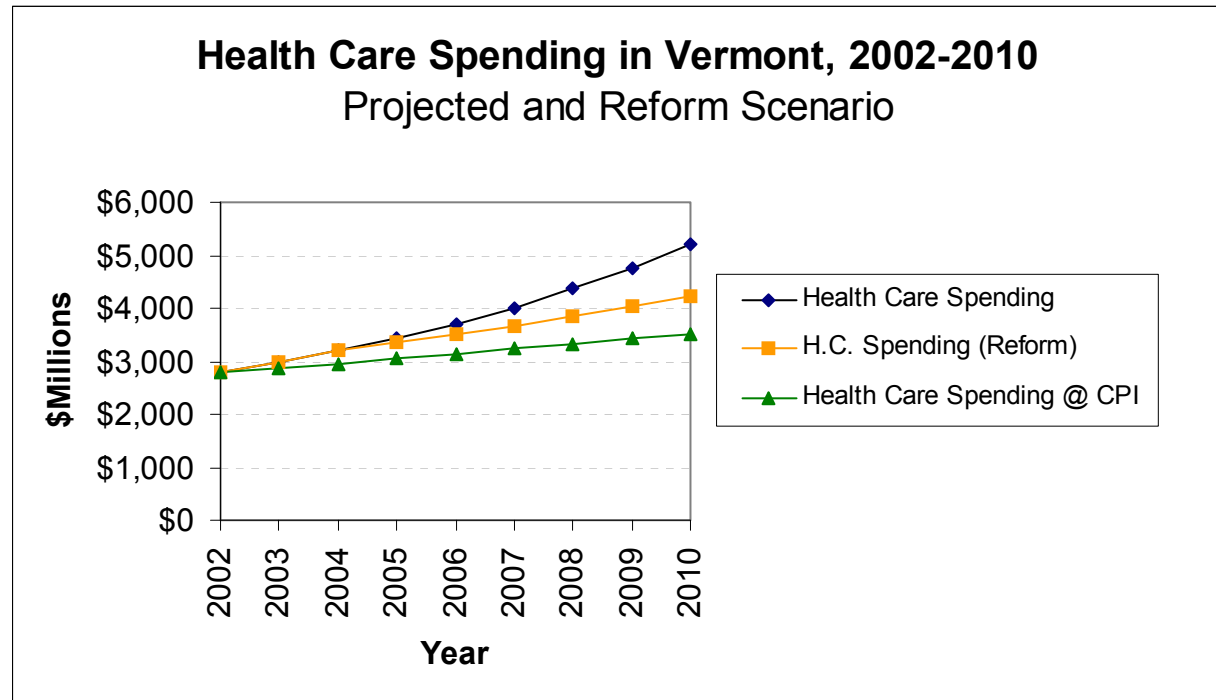
At each stage in the unfolding of a health care system, decisions need to be made that integrate the key elements. Much work needs to be done—more than can be chronicled in these pages. This work needs to be done in an environment of commitment and investment toward change. A better future of health care for Vermonters will require businesses, nonprofits, local government, citizens, and all parts of the current system to explore possibilities. A broad and growing coalition is needed to bring about change.

We Need to Set Financial Targets

Setting financial targets in large complex organizations is an essential part of long-term planning and cost control. At this point in Vermont's health care, we have no such targets. We simply have forecasts of future costs of a system with no controls. As a result, the rate of increase in health care spending is forecast at least three to four times the CPI rate.

An important early step in gaining a modicum of cost control is to set reasonable targets for spending from the current year to the year 2010. In the graph below, we have done just that. Following are the elements and

rationale for what we believe are achievable targets for the entire health care enterprise in Vermont. The percentages and dollar amounts that follow do not refer to total health care spending but to spending within the major components of health care and administration.



We believe that the cost of direct care can be gently controlled. Using existing trends, current forecasts show the growth in health care costs now at just over 6 percent, increasing over the next seven years to 9 percent. We believe that, by constructing a unified budget and applying conventional controls employed by businesses of all sizes and types, we can control the growth rate of health care to approximately 6 percent, which is at least two times the CPI growth rate.

This approach would result in avoiding costs of over half a billion dollars annually to the year 2010; by then, we will have avoided \$1.3 billion in accumulated costs.

Total administrative costs in the Vermont health care sector have been steadily growing. Based on current trends, administrative costs are projected to increase from the current growth rate of 7 percent to 9 percent by 2010. We strongly believe that a target for administrative costs in Vermont health care should be limited to 1 percent growth rate per year. This approach to targeting will not result in cuts to existing administrative spending per se, although we believe that room exists for such cuts, depending on the approach employed to control spending for administration.

By simply limiting the growth of administrative spending to 1 percent a year, the costs avoided annually by 2010 would be half a billion dollars and, on an accumulated basis from now to 2010, would approach one billion dollars from projected spending (if evasive action is not taken). With this approach, administrative spending would decline from somewhere between 26 percent and 30 percent today of each health care dollar spent to about 18 percent by 2010. This rate of spending is still high for administration but is much more defensible than the current wasteful level.

The accumulation of these changes in care and administration, plus increased spending to achieve universal health care targets, would, if achieved, result in an annual cost avoidance of almost one billion dollars per year by 2010 and would result in an avoidance of overall health care costs of almost \$3 billion by 2010. Although this growth rate is still twice the CPI rate, this outcome is much more reasonable and less worrisome than current forecasts. Such an approach can only be achieved if a unified budget is constructed and targets for spending are introduced, implemented, and closely monitored.

“Plan the work and work the plan.” Even with considerable variations and exceptions, the overall fiscal result of such a plan will be satisfying. We could ensure health care access for all Vermonters. In some ways, universal access is a prerequisite for achieving the potential savings in our health care system.

We Need to Offer Options and Models for Change

Following is an example of a specific proposal that moves Vermont toward a universal system. This proposal embodies essential principles of a universal health care system and acts as a platform from which to launch a fully completed system in the future.

The specific purpose of this proposal is to pay hospital coverage for all Vermonters, while keeping spending within a targeted rate of inflation.

Hospital spending represents about 32 percent of total health care spending in Vermont. By offering universal hospital care for all Vermonters, several important goals and milestones can be met. Their achievement would constitute major progress toward universal health care, such as:

- remove from business the burden of providing the hospital part of employee benefit plans,
- provide hospitals with predictable and more flexible budgets,
- lessen the burden of administration on hospitals,
- eliminate upfront the Medicaid shortfall and cost shift, and
- foster peace of mind in all Vermonters who, at one time or another, will need hospital care.

A health care trust would be the payer for hospital care. The remainder of care outside of our hospitals would be paid by private and public insurers. Premiums to business and employees would drop accordingly, because private insurers would no longer be responsible for the highest-risk, highest-cost hospital care.

How Much Would It Cost?

The total cost would be about \$1 billion (32 percent of \$3.2 billion total spending as of 2004). Roughly half of it comes from Medicare and Medicaid, which would require federal waivers for Vermont to proceed. That leaves about \$560 million for the State of Vermont to finance.

How Would It Work?

All hospitals would receive a pre-negotiated lump-sum budget each year. The costs of delivering all hospital care would be paid from these budgets. Costs of billing to patients would be erased. Significant savings to hospital administrative costs would accrue.

How Would We Pay For It?

Needed is \$560 million. We envision two possible ways to finance this.

- One arrangement is a payroll tax of 3.6 percent on employers and 2 percent on employees, assuming a total Vermont payroll of \$10 billion.
- Another arrangement is a broad-based tax on all Vermonters.

The \$560 million includes paying off the entire Medicaid shortfall but does not account for savings in hospital administrative costs.

Summary of Test Model Benefits

Lessening administrative costs would surely result in a flurry of flexibility and creativity at the hospital level. It would also:

- take unnecessary nonmedical burdens off physicians' shoulders,
- begin to relieve business of costly burdens, and
- show Vermonters the first important step to universal health care.

Simply put, universal health care will be a function of comprehensive financing and infrastructure.

Health Care Is “In the Public Interest”



How we look at health care will define, in large measure, the direction we take to remedy the current problems. If we consider health care as consumable goods—like purchases in a store, online, or from a catalogue—we’re taking the narrow view from the patient end. From that viewpoint, we will continue having individuals, businesses, and other sectors pay for health care. We’re also conceding any possibilities for managing costs or bringing health care to all Vermonters.

If we instead consider health care as we do our highways, utilities, civic buildings, national defense, or prisons, we will have crossed an important threshold. We’re then viewing health care as a system of shared services for the public good. This insight gives rise to the concept of public investments to serve the public interest.

Important shared services in society are not individually based. Recognizable examples are fire and police protection, streets and highways, public schools and libraries, and the Vermont National Guard. The common characteristic among these shared services is that we cannot provide them for ourselves individually, but we can provide them as a community collectively. The authors think health care services belong on that list along with police, highways, and libraries.

Over the last two years, Con Hogan has had the privilege of traveling and working in Ireland, Northern Ireland, Norway, The Netherlands, Australia, Denmark, England, Israel, Chile, and the Falkland Islands. These countries organize and deliver health care in largely different ways. In some places, quality is the issue; but, in each place, all citizens are eligible for health care simply by right of citizenship.

Health care is considered a public good and a shared service for all citizens. That way of thinking ought to form the foundation for a reconstructed system of health care in Vermont.

The Politics of Change

Change to health care in Vermont has been occurring for decades. For many of those decades, the pace of change—regulatory activity, planning, and ideas for covering the uninsured—remained in general balance with the ability of the state and private payers to foot the bill. In this last decade, cost increases have quickened the pace of change. The gap between the costs of health care and our willingness to pay has widened rapidly.

Former Governor Richard Snelling, after his first terms in office in the late-1970s and early-1980s, would occasionally fret about the pace of change. He felt that our institutions had lost the ability to foster change. We were increasingly out of sync. Problems that our society now faced were growing more quickly than our ability to catch up and change their trajectory. At the time, one issue that worried him most was the growing national deficit, which no party or politician wanted to face. He felt so strongly that after completing his six years as Governor (and an unsuccessful run for the U.S. Senate), he devoted several years trying to focus national political will on the country's rising deficit. But people did not feel strongly enough. Next to other issues, such as war and peace, the national deficit never gained the kind of traction in people's minds to become a serious concern.

In 1991, when Snelling regained the office of Governor, he clearly expressed that the rising costs of health care had a dangerous potential of harming Vermont's economy. Yet, he encountered the same difficulties in trying to focus political will on the explosive growth of health care costs in Vermont as he did on the pace of institutional change in the nation.



What resulted from Snelling's efforts can be charitably described as incremental change over the past decade. Some ground was gained on access and quality, two issues in the health care trinity. But setbacks in the costs of health care overshadowed any modest gains. We have reached the point in Vermont where rising costs are now demonstrably affecting quality and access. Prospects of serious deterioration are on all three points of the triangle.

How has major change in important issues occurred in Vermont over the last quarter century? What will drive political change? And who has to be at the table for change to occur?

Some Change is Underway

Political change within health care is already underway. However, when access for the poor defined health care reform, public support was nil. Now that health care costs are seriously hurting businesses and the middle class, there's a groundswell of public support. Health care reform is rapidly becoming the dominant political issue in Vermont.

In the mid-1990s, during the Clinton mega-effort on health care, the middle class, in general, was able to absorb the costs of health care. That debate was also confined to health care access for children and the poor. When the health care industry itself led the charge against any reforms, at either the national or state level, the middle class and businesses were generally disinterested in pursuing major change.

Today, those dynamics—basically, “*It’s not my problem.*”—no longer exist. The middle class has lost economic ground over the last decade under the burden of health care costs increasingly shifted to their shoulders. Insurance premiums are currently rising at four to five times the rate of inflation. Estimates of premium increases for 2005 are calculated at 13.7 percent.¹⁰³ Voices that were silent ten years ago are now heard talking.

The Drivers of Change

One expression of this reversal is found with the National Coalition for Health Care Change. This coalition represents major corporations across the nation that have adopted a set of broad-ranging principles for change. They begin by espousing the principle of health care for all citizens. Proponents for this rather radical change in thinking are big players, such as: Verizon, General Electric, Alcoa, AT&T, General Motors, Georgia Pacific,

¹⁰³ Survey by Hewitt Associates, *Hartford Courant*, June 3, 2004

Employer-
based
benefits
are an
accident
of
history.

Kellogg Corporation, Safeway, Qwest Communications, SBC Communications, and the American Academy of Family Physicians, among many others. Some major corporations, such as IBM, are entering into quieter coalitions with other major companies seeking options for change.

Growing interest among large corporations is not surprising as they pay a disproportionate share of health care in the United States. Hundreds of corporations throughout the country are working on the problem. They are fed up with the American health care system. They are tired of competitive disadvantages with the Japanese, Germans, and others in the global economy due to health care costs. As a result, many believe that change in health care will be led by large corporations when their tipping point is reached.

Vermont's newly formed Coalition 21—comprised primarily of businesses and nonprofit organizations—has begun deliberations from its position that any set of solutions must include universal health care coverage for all Vermont citizens and more effective control of health care costs.

Most Vermont politicians are confronted ever more seriously by their constituents on health care issues. Citizens are increasingly worried about how much longer the employer-based system can continue. They are worried about the economic burden they will assume and the benefits they will lose as employers seek ways to cut health care costs.

State government also knows that the battle to provide health care for the poor is being lost because of the rapidly rising Medicaid deficit.

Fertile Ground for Change

In August 2004, Churchill Hinds presented his long-term view of health care to the Coalition 21. At the end of his wise presentation, he observed that big change will occur in Vermont's health care only when the people finally cry "uncle." The authors are hearing sounds of "uncle" all over Vermont, from government, businesses, the nonprofit community, and individual citizens.

Change is best in an environment that can accept and absorb change. At the moment, Vermont's health care is in a relatively good environment, good

enough to orchestrate serious, large change. In most states, this is not true. Other states have a combination of poor health care quality, very limited access, and extraordinarily rising costs that render change much more difficult. Only a major collapse could force real reform. Fortunately, Vermont still retains fertile ground for constructive, major change.

If we act judiciously, we will be able to bring the costs of health care to a more sustainable level, while also ensuring access and coverage to all of our citizens. To do this, we must understand how hard this change will be and how long it will take.

Medicare is one health care reform that took over a decade to adopt, starting in the late-1950s. The lesson in that is: if we fail to prepare for change now, then when the only chance for change arrives, we will lose out. Getting ready for change is important for achieving change.

Past examples of extensive change can be reassuring. Think of the dilemmas that faced Franklin D. Roosevelt when he was elected President in the depths of the Depression. The situation was so bad on all fronts that Calvin Coolidge said:

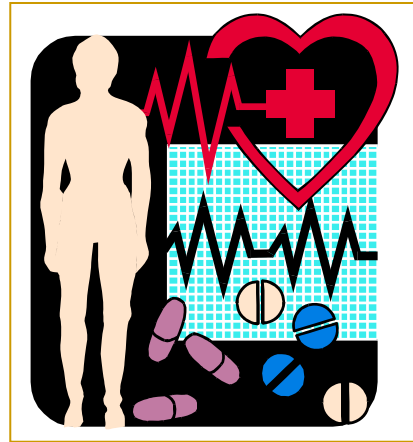
In other periods of depression, it has always been possible to see some things which were solid and upon which you could base your hope, but as I look about, I now see nothing to give ground for hope...

Vermont's health care has much more solid ground upon which to base hope. Roosevelt was known for not having a blueprint for action. What he did have was a basic philosophy. He said:

It is common sense to take a method and try it. If it fails, admit it frankly and try another. But above all...try something.

So far in Vermont, we've been paralyzed by inaction. Roosevelt's advice is exactly what we need to begin.

Summing Up the Opportunity



In one sense, we already have universal health care. All Vermonters can get health care services thanks to the medical community's strong ethic: *"Treat first, ask for payment later."* So, in theory at least, Vermont has universal access. In practice, however, that strong medical ethic is under strain.

Our trust that health care will be available when we need it rests on a shaky foundation. Stress fractures in Vermont's health care have begun to show. We can no longer rely on the current unregulated, disorderly way we pay for health care. The problems emerging have one benefit. They have exposed how unorganized, inefficient, and unfair our health care is.

The time for significant and purposeful change is now.

Necessary change will bring resistance by those who have a major stake in the current health care arrangement. Expected opponents will be pharmaceutical companies, insurance companies, and perhaps some of our current health care institutions and administrators. Change is hard, but the prospect of failure is harder.

Failure Is Not an Option

We cannot allow Vermont's health care to deteriorate beyond the point of no return. Vermont is still in a position to control the destiny of its health care. But the window of opportunity is closing. Now is the time to prepare for change and begin the process to retain what works and fix what doesn't. Failure to do so will not only produce unfortunate health care consequences but will also result in serious economic and social consequences for our state and its people.

Time is not on our side. Yet, significant reform takes time. We may need several years to get moving and perhaps a decade of hard work before we see

Health care
is a
collective
responsibility.

changes. However, the costs of health care are rising so fast that each year of delay will multiply those costs.

For example, if we take five years to bend the cost curve with some visionary thinking, health care spending will have risen from \$3.2 billion to \$4.7 billion. That's the best-case scenario. The not-so best case would be to delay doing anything. For each year we delay, the health care costs in Vermont would accumulate to half a billion dollars. If we delayed action for ten years, the annual cost of health care would increase to \$1 billion per year—in Vermont!

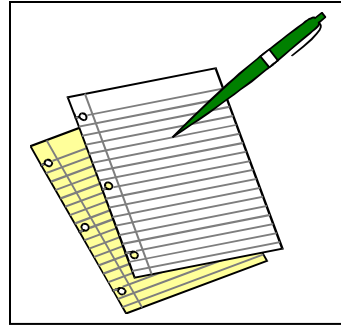
The cost of doing nothing quickly turns dangerous. In time, the cost of doing nothing will overwhelm any chance for change. The message here is: The time to construct a visionary plan for health care in Vermont is upon us. We can procrastinate no longer.

A quote from Albert Einstein may be the best ending. Einstein said:

Insanity is defined as “continuing to do the same thing, and expecting a different result.”

For decades, we Vermonters have been doing the same things in health care and hoping for different results. It hasn't worked. We need to do things differently.

Afterword



The authors make a powerful and persuasive case that significant change is needed now in the delivery and financing of health care in Vermont. They well document the problems facing Vermont's health care and clearly indicate that our current "system" is not sustainable. An urgent call is made while acknowledging the recognized foundation of strengths in Vermont's current delivery of health care services.

The experienced authors suggest adoption of, and commitment to, a set of guiding principles for reform. They offer attainable goals as the basis for change. They clearly describe the barriers and recommend specific steps to implement in moving Vermont toward a more rational, cost-effective, and sustainable approach in providing health care for all Vermonters.

The basis of this change is adoption of a population-based distribution of services with outcomes measured to assure that access to quality services is equitably provided with a centralized financing system. Such a system would work well for Vermont.

This book is a "must read" for all Vermonters involved in shaping and implementing a future health care system.

All readers will be motivated to re-think historic policy positions that have produced the current features of health care in Vermont. An openness of mind to fundamental change is needed and required if change is to occur. This transformation will not be easily nor quickly accomplished but, as the authors state, if we start now, we have time to plan for rather than respond to the crisis that we will face in the future if no change is made soon.

We wholeheartedly endorse this book and look forward to being part of the solution!

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- B Vermont's Health Care Spending
- C Indicators of Prevention in Vermont
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- F Coalition 21
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- I The Long-Term Role of Fletcher Allen

Appendix A

The Authors



Cornelius “Con” Hogan began his working life as a prison guard and spent 15 years in corrections. He is also a businessman, who successfully took a Montpelier company through a Chapter 11 bankruptcy against the odds. For 30 years, he, his family, and partners have operated a horse farm in Plainfield. He has worked for five different governors of both major parties. He was the Secretary of Human Services first for Governor Richard Snelling and then almost nine years for Governor Howard Dean. During that tenure, Hogan participated in Governor Snelling’s Bipartisan Blue Ribbon Commission on Health Care. He also headed up the Vermont Health Care Authority in the mid-1990s after the collapse of both national and state efforts to reform health care. During that time, he had ultimate administrative responsibility for the Departments of Public Health, Mental Health, Corrections, Welfare, Children’s Services, and Aging and Disabilities. After his tenure, he headed up the Bipartisan Commission on Health Care established by Governor Dean in an attempt to find broad political agreement. The Commission failed to achieve that consensus. Hogan was also a trustee of Fletcher Allen Health Care after the scandal at that institution. Hogan has approached the issue of health care from an incremental point of view, whether expanding Medicaid to cover more children or finding ways to cover single adults.



Dr. Deborah Richter has been a practicing physician for 18 years in Buffalo, New York, and Cambridge, Vermont. In Buffalo, she worked in an ER, an urgent care center, a county hospital, a Catholic hospital, an urban clinic, and an inner-city housing clinic. In these settings, she found many patients adversely affected by a lack of health insurance. For ten years, she did everything she could to call attention to their plight but encountered mostly indifference. In 1999, she moved to Montpelier with her family and began practicing in Cambridge. While her patients in Vermont were mostly rural compared with her patients in Buffalo, she heard similar stories. However, the difference was the medical ethos, which in Vermont was far more supportive. She continued to devote about half her time to health care

reforms that could maintain the state's high-quality medical care but, at the same time, would retain the care needed by all Vermonters. She founded Vermont Health Care for All and has become a public figure in the reform movement.



Terry Doran was a newspaperman for many years in Harrisburg, Pennsylvania, and Buffalo, New York. He was a reporter and editor. He has been active in health care reform for half a dozen years.



Appendix B

Ten-Year Spreadsheet for Vermont Health Care Spending

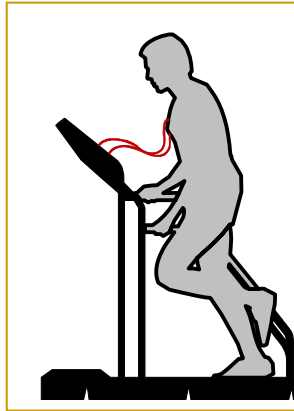
Health Care Spending Growth	0.09	Adjusted Direct Trend	0.06
Consumer Price Index (CPI)	0.029	Adjusted Admin Trend	0.01
Current % Admin (Payer)	0.075	Number of Uninsured	60000
Current % Admin (Provider)	0.2	Net Cost to Cover 1 Uninsured	2000

	<i>All figures in \$millions</i>								
	2002	2003	2004	2005	2006	2007	2008	2009	2010
BISHCA									
Health Care Spending	2797	2976	3196	3431	3682	4013	4375	4768	5197
Growth		0.06	0.07	0.07	0.07	0.09	0.09	0.09	0.09
Total Administration	724	781	836	894	952	1043	1137	1240	1351
Growth		0.08	0.07	0.07	0.07	0.10	0.09	0.09	0.09
Direct Health Care Spending	2073	2195	2360	2537	2730	2970	3237	3529	3846
Growth		0.06	0.08	0.08	0.08	0.09	0.09	0.09	0.09
Direct at Adjusted Trend (05)	2073	2195	2360	2501	2652	2811	2979	3158	3347
Growth		0.06	0.08	0.06	0.06	0.06	0.06	0.06	0.06
Cost Avoided				-36	-79	-159	-258	-371	-499
Admin at Adjusted Trend (05)	724	781	836	845	853	861	870	879	888
Growth				0.01	0.01	0.01	0.01	0.01	0.01
Percent of Total	0.26	0.26	0.26	0.25	0.24	0.22	0.21	0.20	0.19
Cost Avoided				-49	-99	-182	-267	-361	-464
TOTAL COST AVOIDED				-85	-178	-341	-525	-731	-962
NEW SPENDING									
Cover Uninsured				24	24	24	24	24	
				0.2	0.2	0.2	0.2	0.2	
H.C. Spending (Reform)	2797	2976	3196	3346	3505	3672	3850	4037	4235
Change from Base Projection	0	0	0	-85	-177	-341	-525	-731	-962
Growth		0.06	0.07	0.05	0.05	0.05	0.05	0.05	0.05

Health care spending 2002-2005 from BISHCA. 2002 is from Expenditure Analysis, Initial Release.
2003-2006 from Vermont Health Care Expenditure Analysis Forecast: 2002-2006 (12/2003) .

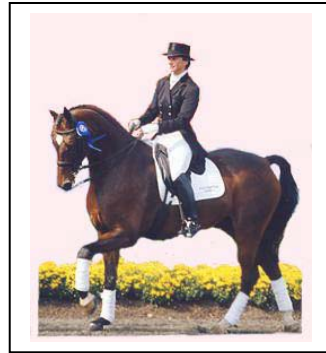
Appendix C

Indicators of Prevention in Vermont Over Ten Years



<u>Indicators</u>	<u>Percentage Change</u>
• Young Teen Pregnancy Rate	+43%
• Two-Year-Olds Immunized	+29%
• Infant Mortality	5%
• Repeat Births to Teens	-9%
• Teen Drinking	-9%
• Violent Crime Rate	-10%
• Reports of Child Abuse and Neglect	-10%
• Deaths from Motor Vehicle Crashes	-17%
• Suicide	-21%
• Deaths from Cardiovascular Disease	-24%
• Elderly in Nursing Homes	-24%
• Rate of Property Crime	-31%
• Child Abuse and Neglect, Substantiated	-32%
• Teen Smoking	-32%
• Late or No Prenatal Care	-35%
• Teen Birth Rate	-40%
• Child Deaths	-44%
• Alcohol-Related Motor Vehicle Deaths	-47%

Appendix D



A Horse with Good Health Insurance

The inequities in our health care system are bad enough to contemplate when we consider the haves and increasing have-nots among our population. But when we consider cross-species inequities, the plight of uninsured Vermonters approaches surrealism. Con Hogan's family, his daughter, and their farm partners have a 30-year horse operation in Plainfield, Vermont. They have a good number of horses known as Danish warmbloods. They are large elegant horses suitable for the art of dressage. Some of them, because of the amount of training they receive and their historical performance in dressage, can become quite valuable. For those special handful of horses, insurance companies specialize in providing full mortality insurance and major medical and surgical insurance. For a valuable horse, the expense can be considerable but necessary. The high price of replacing one of these wonderful animals and the emotional loss of a favorite equine friend make it necessary.

In December 2004, one of the farm's prized Danish warmbloods, "Andreas," was experiencing a severe case of colic. Colic is a stomach ache that occurs because of the lack of a regurgitative process in the horse. Colic can kill a horse simply as a result of the pain. The local veterinarian came to the farm twice that evening and administered an intravenous pain killer. By the morning, the horse was clearly in trouble. A serious blockage was somewhere in his digestive system. Andreas was loaded into one of the farm's trailers and began the three-hour drive to Rochester, New Hampshire, where a veterinary clinic had surgical capability. One way or another, the pressure on the horse's stomach had to be relieved.

Immediately upon arrival, the surgeon made the diagnosis that Andreas had a twisted colon, which is not an uncommon malady in the horse world. The decision was to operate. An anesthesiologist was brought in along with a surgical team of four experienced people. Andreas was anesthetized, placed in a sling, and laid on his back in an ungainly way with his feet up on the

operating table. He was being treated with intravenous antibiotics along with other monitors common in surgery for both man or beast.

In short order, the four surgeons had their hands and arms full of intestine as they sorted out and found the twist, then proceeded to replace what appeared to be the miles of intestine. The wound was sewn up. Andreas was taken to the recovery room, where he slowly came back to life.

Over the next week, Andreas continued recovery on his IVs and drugs. Ten days later, he was back in Plainfield where he continued convalescing. He is expected to recover fully and again be the marvelous riding horse that has brought so much pleasure to so many students and riders over the years.

Insurance covered all costs of transportation, diagnosis, surgery, recovery, his stay at the animal hospital, all drugs, and follow-up vet visits back at our farm.

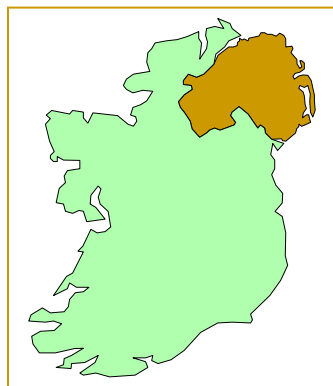
The best news is that a wonderful animal was saved and that the decision to go into essential surgery was not a function of whether we could afford it or not. We had provided insurance on the horse over the years and it paid off.

Nevertheless, there is a lingering sense of guilt. As I tell this story, I think about the more than 60,000 Vermonters who cannot afford health insurance and often put off important care because of that, while at the same time Andreas has full coverage. The insurance saved his life. But how many human lives are lost because people we care about don't have health insurance.

CON HOGAN, 2004

Appendix E

Northern Ireland's Health Care System



Some American aphorisms about health care are “*Don’t get sick outside the United States*” or “*The health care beyond our borders is not good*” or “*Wait until you get home to find treatment.*” On the surface, this advice appears to be generally good. However, on a very recent trip to Northern Ireland, where I’m a consultant on children’s issues, I had the opportunity to learn firsthand about Northern Ireland’s health care system.

The problem started innocently enough. My wife and I were taking a one-week boating vacation with some close friends on the Shannon River to be followed by almost three weeks of work across Ireland. When we arrived in Shannon after the long flight, I noticed that one of my feet was slightly swollen. I didn’t think much about it then; three days later, I clearly had a very bad infection that was rapidly spreading. We stopped overnight in the community of Athlone in the Republic of Ireland where I sought a doctor.

Without an appointment, I was able to walk into a doctor’s office for an on-the-spot visit. The doctor was clearly concerned about my foot and prescribed an antibiotic to take over the next few days. He also warned me that the oral antibiotics might not be strong enough to fix the problem. However, because we were on the move, I was unable to followup further, but it was a thorough visit and I felt well-served. The price to the private doctor was €30 euros equivalent, at the time, to about \$40 (U.S.), a modest price by our standards.

Several days passed and, in fact, the foot and leg were getting worse. By this time, my wife and I were staying with colleagues in the very rural northeast of Northern Ireland in the seaside community of Cushendun overlooking Scotland. On Sunday morning, we decided to try dealing with the problem again.

Northern Ireland has a telephone service that one can call to get the name, hours, and location of an off-hour service of private doctors, which backs up

the normal general practitioner service. Being Sunday morning, I didn't have much hope that this would work, but soon a friendly Irish voice was on the phone giving me the needed information. She identified a private doctor in Ballymena, about 30 miles from where we were staying, as the closest open clinic at that time of the day. She then called the doctor to let her know that we would be in her office in about an hour. We appeared at the doctor's office as scheduled and her concern was immediate. The foot and leg had gotten much worse. She suspected a serious and systemic infection and immediately called the nearest hospital in Antrim, another 30 minutes away, to let them know that we would be there quickly. After a quick ride to the Antrim Hospital, I was referred to their emergency room.

Antrim is relatively close to Belfast, and the hospital covers a rather large population of about 200,000 people. The hospital was of similar vintage as many Vermont community hospitals, although considerably larger. The emergency room was busy but, in short order, blood tests were taken to determine the extent and type of the infection. Then an X-ray was taken to ensure that the infection, whatever it proved to be, had not affected any bone. After those results were in hand, I was visited by a young physician, who trained at the medical school in Belfast. He was thorough, clear, and direct in his conversation. In short, I had a serious problem, and he recommended strongly that I be admitted to the hospital, where a regime of antibiotics could be effectively administered intravenously.

Over the next two days, I received the antibiotics as scheduled. The condition of my foot dramatically improved, and a followup regime of oral antibiotics was prescribed. Then I went on my way.

This experience left quite a few impressions. First was the professionalism, caring, good humor, and general effectiveness of the doctors and nurses. The diagnostic regime was thorough, and the care was timely and clear. Second, I was impressed by the "system aspect" of the health care. One step logically led to the next step. There was excellent interaction and communication between the private GP physicians and the public hospital system.

As in many countries, doctors can choose to operate outside the government system. However, all GPs in Northern Ireland are contracted to the National Health Service, which also offers incentives to treat special populations, such

as the elderly. Prescriptions cost about 6£ per item, in Irish pounds, an unheard of price in the United States. At the next level, the telephone referral service was government run, yet they referred me to the private GP, who then referred me to the public hospital in Antrim. This seamless quality of the multiple transactions was impressive.

Finally, an interesting moment came as I was to be discharged. I asked how much I owed the hospital for the emergency room services and the two+ days of admittance to the hospital. I was told that there would be no charge. I was stunned. My wife and I had mentally prepared ourselves for a bill of thousands of dollars, using our general knowledge of U.S. hospital billing rates. It made me realize how fortunate the people of Northern Ireland must feel—are—to have at their fingertips an excellent health care system that was easily accessible, usable, providing choice of public or private service, and, when care was accessed, not be at risk of sudden financial hardship.

I also noticed that hospital personnel spent no time on administrative and financial transactions, other than patient record keeping. No utilization review, no negotiations with payers, no physicians and nurses spending time coding their activity for billing purposes, and no billing. For example, I was told that the Antrim Hospital had less than a handful of accounting-related positions. I can't imagine how many accounting and related administrators are in equivalent U. S. hospitals with physicians and nurses spending important time coding paperwork for billing purposes. The physicians and nurses in Northern Ireland spend their time giving high-quality medical care.

I am sure that the Northern Irish health care system is a long way from being perfect. The newspapers have occasional accounts of problems with nursing salaries and adequacy of emergency room capacity. But we have similar problems in the United States.

For the first night of my stay at the Antrim Hospital, I was in the general emergency room ward. The meals were not of gourmet quality (meals weren't being served to gain market share, as they sometimes are in the United States). I did, however, get to know Charlie who was my roommate for the first night. He was a very old man from Antrim, whose son was his only caretaker. His story was that every other month or so Charlie would be dropped off at the hospital so that his son could have a free night. Here, this

behavior was dealt with by kindness and a wink. At home, we would have created systems to prevent such “abuse” of the system. But here, there was an acceptance of human nature.

Overall, based on my personal experience and considerable followup conversation with many throughout Northern Ireland over the next couple of weeks, I concluded that the overall price tag for their health care system, on a relative basis, is about half the costs of those in the United States and the care is generally effective, humane, and responsive. The people of Northern Ireland are very happy with the care that they receive.

We, in the United States, should have nothing to fear as we go about the process of learning from the experience of others.

CON HOGAN, 2004

Appendix F

Coalition 21: Transforming Health Care for the New Century



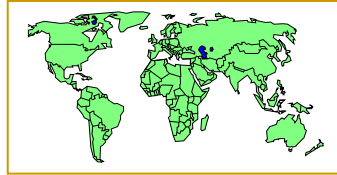
Coalition 21 is an effort of 20 stakeholder groups concerned about the growing challenges faced by all Vermonters with regard to health care. Over the past two years, a number of different organizations have developed their own statements, principles, and plans to address issues of access, affordability and quality. Rather than continue to address the current and impending problems by pursuing separate, parallel paths, the member groups organized a coalition in July 2004 to address Vermont's health care crisis. The goal of this joint work is to develop a plan to reform Vermont's health care system.

The Snelling Center for Government has agreed to organize and facilitate this process. Stephan Morse, former Vermont Speaker of the House and currently President and CEO of The Windham Foundation, has agreed to chair the coalition.

The principles of Coalition 21 are:

- The policy of the State of Vermont is to ensure universal access to and coverage for essential health care services for all Vermonters.
- Health care coverage needs to be comprehensive and continuous.
- Vermont's health delivery system will model continuous improvement of health care quality and safety.
- The financing of health care in Vermont will be sufficient, equitable, sustainable, and fair.
- Built-in accountability for quality, cost, access, and participation will be the hallmarks of Vermont's health care system.

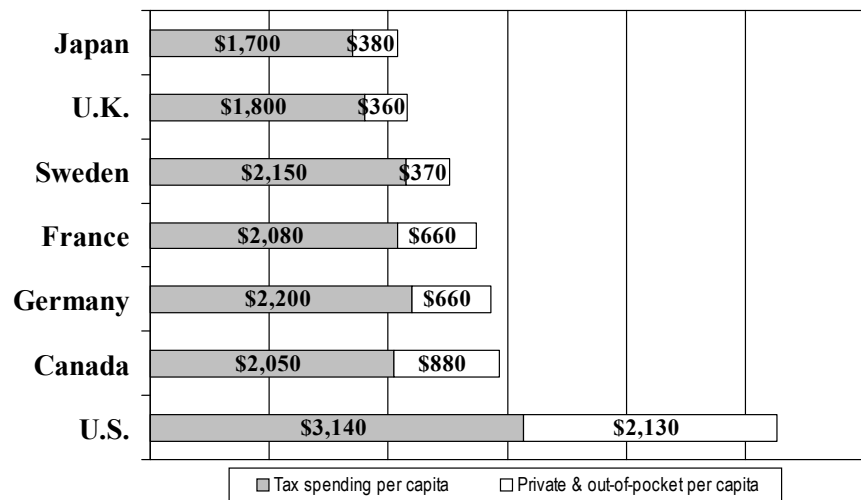
As of this writing, the Coalition has not announced its means to achieve these principles or goals. For more on the Vermont Coalition 21, go to www.snellingcenter.org/coalition21/index.html.



Appendix G

International Comparisons

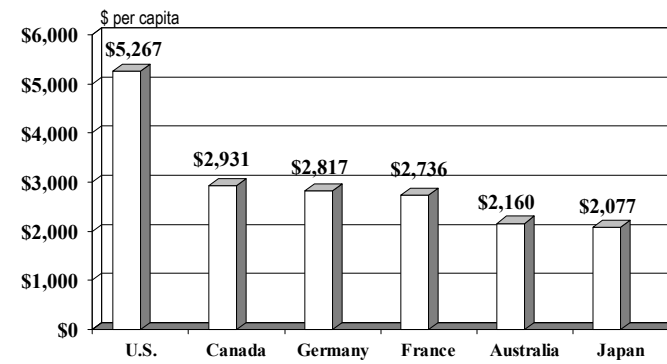
U.S. Tax Spending for Health Care Greater than Tax Spending of Other Nations, 2002



OECD, 2004; Health Affairs:21(4):88.

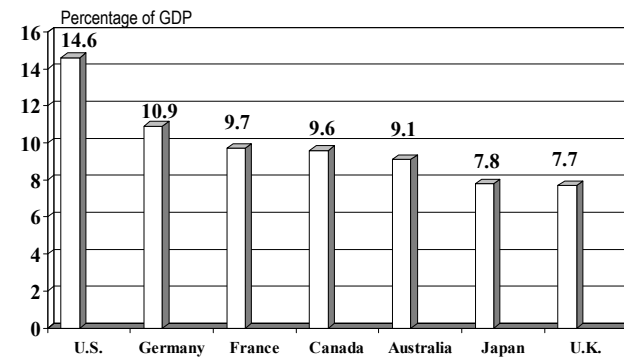
NOTE: Taxes include benefit costs for public employees and tax subsidies for private employers.

Health Care Spending, 2002



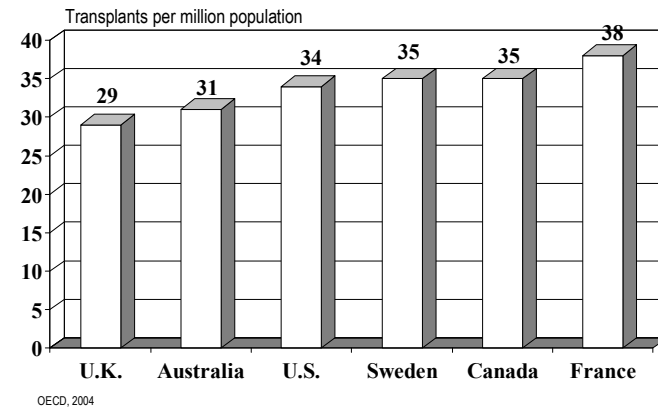
OECD, 2004.
NOTE: Data for Australia and Japan are for 2001.

Health Care Spending, 2002

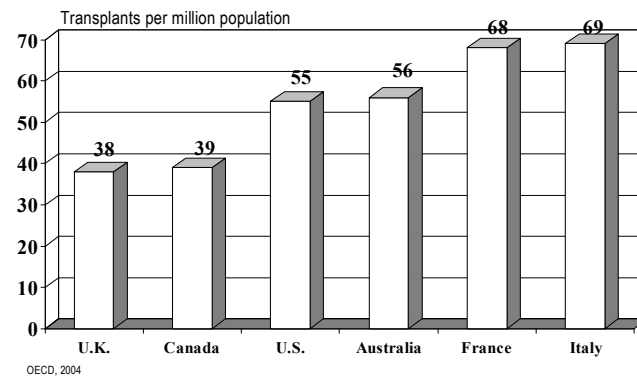


OECD, 2004.
NOTE: Data for Australia and Japan are for 2001.

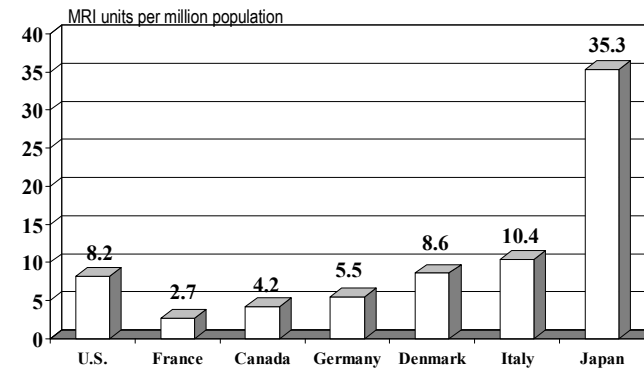
Renal Transplants, 2001-2002



Bone Marrow Transplants, 2001-2002

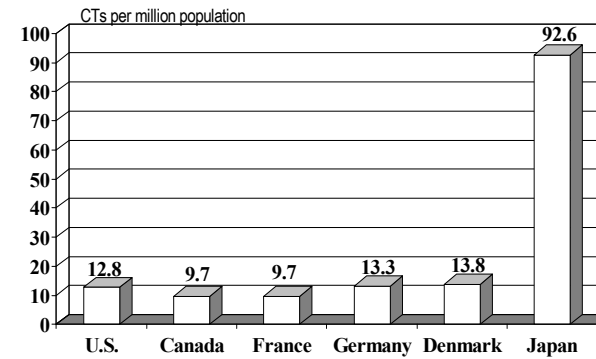


MRI Utilization, 2002



OECD, 2004
NOTE: Data are for 2002 or most recent year available.

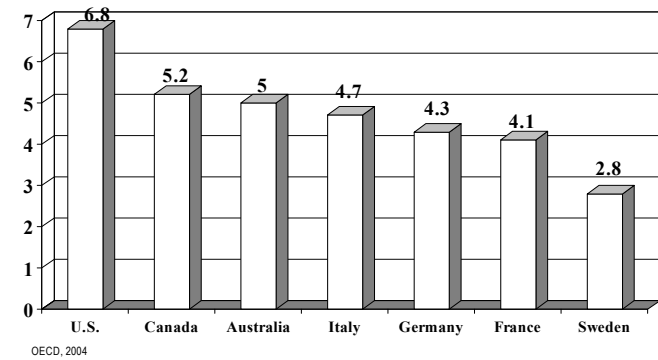
CT Scanners, 2002



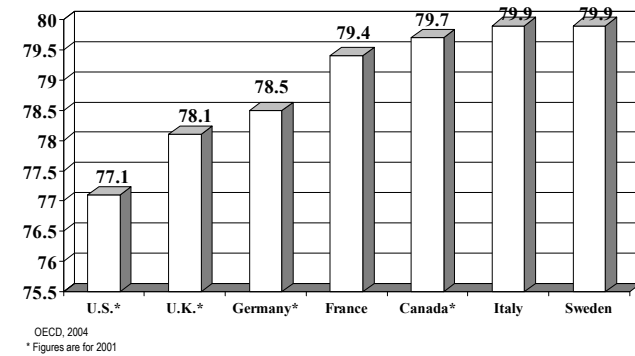
OECD, 2004
NOTE: Data are for 2002 or most recent year available.

Infant Mortality, 2001-2002

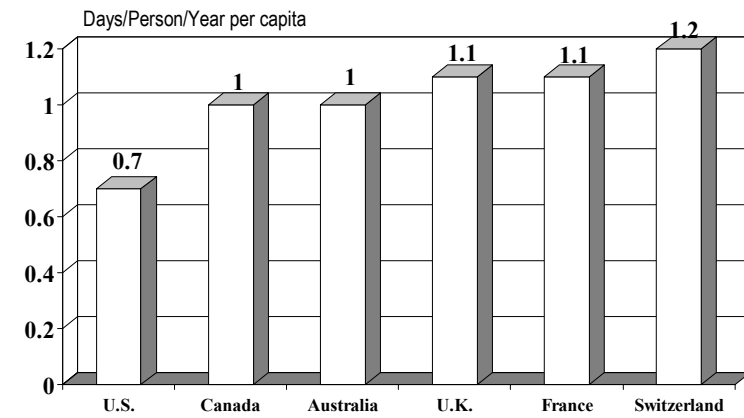
Deaths First Year of Life in 1,000 Births



Life Expectancy, 2002



Hospital Inpatient Days, 2002

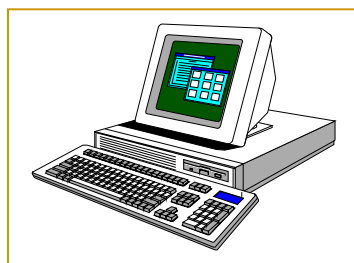


OECD, 2004

NOTE: Figures for Australia, France, and Canada are for 2001..

Appendix H

Short List of Information Sources on Health Care



VERMONT SOURCES

Department of Banking, Insurance, Securities & Health Care Administration
<http://www.bishca.state.vt.us/>
 Joint Fiscal Office <http://www.leg.state.vt.us/jfo/>
 Vermont Program for Quality in Health Care <http://www.vpqhc.org/>
 Vermont Health Care for All www.vthca.org

NATIONAL SOURCES

The Dartmouth Atlas of Health Care <http://www.dartmouthatlas.org/>
Health Affairs: The Policy Journal of the Health Sphere publishes six issues a year and offers online access to subscribers and limited access to others. <http://www.healthaffairs.org/>
 Institute of Medicine of the National Academies <http://www.iom.edu/>
 Centers for Disease Prevention and Control <http://www.cdc.gov/>
 U.S. Government Accountability Office reports can be searched by topic. <http://www.gpoaccess.gov/gaoreports/index.html>
 National Institutes of Health (U.S. Department of Health and Human Services) <http://www.nih.gov/>
 Physicians for a National Health Program <http://www.pnhp.org/>
 Kaiser Family Foundation www.kff.org

INTERNATIONAL SOURCES

The World Health Report 2000, "Health Systems: Improving Performance," available from World Health Organization at:
<http://bookorders.who.int/bookorders/anglais/detart1.jsp?sesslan=1&codlan=1&codcol=24&codcch=2000> and can be downloaded at:
<http://www.who.int/whr/2000/en/>
 Organisation for Economic Co-operation & Development has 30 member countries. Browse its website by topic. <http://www.oecd.org/home/>

Appendix I

The Long-Term Role of Fletcher Allen



In a reconstructed health care system, the role of Fletcher Allen in tertiary care and in its performance as a medical center would remain essentially the same. However, early in any process to reconfigure our health care services, the long-term role of Fletcher Allen would have to be addressed.

Is Fletcher Allen it an academic medical center or a hospital with community leanings? In fact, it is both. As an academic medical center, Fletcher Allen is an economic force on behalf of Vermont. It has a distinguished history of important research. Its medical school has benefited Vermont as a steady source of physicians. Fletcher Allen is also a high-cost and high-expenditure facility, specializing in the most expensive medical procedures. As such, Fletcher Allen consumes approximately a quarter of all Vermont's health care dollars, and this ratio is increasing steadily.

Notions that what we have is a health care system are disabused by the history and present status of Fletcher Allen. Some say that Fletcher Allen functions outside the regulatory structure to which the rest of Vermont health care is subjected. If we are worried about costs and how to control them, then Fletcher Allen is the prime candidate for a much greater degree of oversight.

However, Fletcher Allen has the potential to be a remarkable resource for a reconstructed health care system. Given its disproportionate size, Fletcher Allen is viewed by some of our community hospitals as more of a competitor than a cooperative partner. In a true health care system, hospitals would function in a coordinated and cooperative relationship, not a competitive one.

Other issues await to be resolved. What is Fletcher Allen's fundamental connection to the state and its citizens beyond the delivery of health care services. Fletcher Allen is sometimes viewed as standing above and beyond Vermont and Vermonters. No one questions its positive economic impact on the state; however, the connections need to go beyond economics.



For example, a number of Fletcher Allen policies are at odds with basic Vermont values, such as its extraordinary compensation practices for the top tiers of management. The compensations go way beyond what is acceptable compensation for other Vermont institutions. The president of the University of Vermont (UVM), a man at the top of his class, is compensated around \$300,000 a year. Recently, salaries for the top ten public universities in the nation were published with the highest about \$700,000. Fletcher Allen's CEO, who nearly everyone views as an extraordinary administrator, is compensated at almost \$900,000. This scale is because Fletcher Allen associates itself with institutions outside of Vermont rather than those in Vermont. Its bylaws, for example, effectively disqualify top-tier managers from other Vermont hospitals. Thus, searches for new administrators must take place outside of Vermont at academic medical centers where salaries double or triple those in Vermont.

A major step in addressing the long-term role of Fletcher Allen within a reconfigured health care system would be to restore fully its symbiotic relationship with Vermont's other hospitals. To do this, Fletcher Allen's board of trustees would have to be adjusted so that it no longer falls under the total control of the owners. Our recommendation would be to enlist representatives from local community health services and local hospitals to sit on the board, balanced by representatives from the current owners of Fletcher Allen, namely, the UVM, the Vermont Health Foundation, the Fletcher Allen physician group, and the Fanny Allen Corporation. The rationale for this shift is found in the relationship between UVM and the State of Vermont. Even though the proportion of support for UVM is minimal by most other states' standards, the role of the State of Vermont on UVM's board of trustees is significant.

The argument for significant State of Vermont participation on a modified Fletcher Allen board of trustees is even stronger than state participation on the UVM board of trustees. Only 11 percent of UVM revenues comes from the State of Vermont. About half of Fletcher Allen's financial support comes from the both the federal and state governments in the form of Medicare and Medicaid payments. In that sense, Fletcher Allen is more of a public institution than UVM and, therefore, deserves much closer public participation.

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This book is a “must read” for all persons in Vermont involved in shaping and implementing a future health care system.

CAROLYN C. ROBERTS

C.E.O. Emerita, Copley Health Systems, Morrisville, Vermont
Past Chair, American Hospital Association, Board of Directors
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The authors make a powerful and persuasive case that significant change is needed now in the delivery and financing of health care in Vermont.

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The best thing about this book is that it shows the way to make the compromises necessary for reform and the rationale for them.

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