Mark F. Herbert

PLAN B

THE ALTERNATIVE TO OBAMACARE

Thinker Media

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First Digital Edition

ISBN: 978-1-938240-87-4

Published by Thinker Media, Inc.

Epigraph

The next advance in the health of the American people will be determined by what the individual is willing to do for himself.

—John Knowles, former President of the Rockefeller Foundation

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Introduction: A New Social Contract

A few years back I was working with my daughter on a term paper comparing and contrasting different political agendas from the 1930s. Among the most interesting items that I encountered were a couple of related concepts much older than that, dating back at least as far as America's founding. I had probably read about them thirty years ago as part of a political science class as a college freshman, but I didn't retain the information or fully understand its implications then.

The two concepts were part of the Enlightenment philosophy by which our Founding Fathers distinguished the new nation from the feudal system that Americans had left behind. One of these ideas we have held onto with a passion, declaring it to be a cornerstone of the American experiment. This is the concept of *personal property ownership*. It means that through your own achievement, you should have the ability to accumulate and own property without regard to your prior economic or social status.

George Mason, the Founding Father who drafted the Virginia Declaration of Rights (a precursor of the Declaration of Independence), named certain inherent human rights in that influential document, including "the enjoyment of life and liberty, with the means of acquiring and possessing property." This is the philosophical foundation of the capitalist system. We hear this principle invoked every day, especially when we feel that the government is inserting itself where it doesn't belong.

America was a place where you could reinvent yourself. You could own property, build a business, and leave it to your heirs. Our largely agrarian society and vast frontiers, with what seemed to be an inexhaustible supply of land, fit this well.

The other principle, the one that we don't hear nearly as much about, is the right of *personal competency*: the right to build your skills, express yourself, and sell your products and services as you see fit. We see this expressed in words very similar to Mason's, but written by Thomas Jefferson the same year. In the Declaration of Independence, Jefferson used the phrase, "life, liberty, and the pursuit of happiness."

What's easy to forget is that these rights bring with them an implied responsibility. What are liberty and happiness if not self-determination? And how does anyone achieve self-determination without self-reliance?

Historically, people's career paths were determined by birth station or family occupation. In the United States, individuals had the right to pursue their dreams relatively unfettered by those constraints. And in accepting their rights, they had to embrace the concept of personal competency. The individual was in charge of his or her life, career, and prospects.

The Industrial Revolution soon altered this model in a couple of ways. America shifted from an agrarian society to industrial, creating a new kind of feudalism, and the country ran out of territory in which to expand.

In the feudal system, the serfs, or peasant class, were bound to the land. Without them, the nobility couldn't feed their subjects, but without the land to live upon, the serfs had nothing. In the late 1800s, an increasing number of American workers saw their economic fates as predetermined, dependent on factors beyond their control through policies set by the owners of mines, railroads, and factories.

Prior to a series of laws that Congress passed in the first half of the twentieth century—most notably the National Labor Relations Act of 1935—American businesses had created a new kind of industrial serfdom in which collective bargaining was formally or informally outlawed. Although there was no formal class system, as under the old European feudal system, members of the working class were often trapped by financial circumstance. Without employment, the workers had nothing. So they had to accept the owners' terms. The economic system worked to restrict the right of personal competency.

But even after labor reforms took effect and the number of hours in a workday and workweek were regulated and wages and workers' standard of living rose, employers and unions together gradually built what can be seen as another, still semi-feudal model. Large corporations in many ways continued to play the role of feudal monarchs and nobility; they just did it in a kinder, gentler way. Employers created a sort of corporate codependency, especially under the models of Theory X, as identified by management sage Douglas McGregor, and the scientific management principals put forth by efficiency guru Frederick W. Taylor.

Under this outwardly benign-seeming version of feudalism, employees, as serfs, couldn't be trusted or expected to make good decisions. Management needed to dumb things down. Employees would do what they were told, and in return the nobility, or management, would take care of them. And we (management) did. We promised lifetime employment; we provided for their health care and for their retirement. I'm not going to say management did these things willingly. Organized labor played a huge role in securing workers' gains, including industrial safety, limitations on work hours, and others. It does seem, though, that in a way both sides lost something in the bargain. We began to "take care of them," and they began to expect it.

When I entered the workforce as a manager, I was surprised at the things management didn't or wouldn't talk to employees about. We rarely invited them to participate in decisions about how

we did things. We didn't talk to them about how we made decisions about the business, their pay, or other related matters. Such information was on a need-to-know basis, and we had decided they didn't need to know.

In the sixties, seventies, and eighties, some interesting things came to pass. One of the first was international competition.

The Japanese and Germans began rebuilding their industrial bases, which had been destroyed in World War II. Looking for guidance, these countries' industrial leaders turned to management techniques being taught in US universities, techniques that brought some of the concepts of personal competency back into the workplace.

Unfortunately for US industry, its executives weren't as interested in the latest management theory as taught at business schools. In the same decades, US companies began using outsourcing and moving production offshore to reduce costs and avoid regulations—not exactly investing in personal competency.

Businesses also began to notice that some of the costs of taking care of their employees were becoming a heavy burden. We saw:

- Employers beginning to recognize the rising cost of health care as a challenge and responding by experimenting with managed care, cost shifting, reducing benefits, and other strategies.
- Organizations that had practiced no-layoff policies beginning to downsize their workforce, aggressively outsourcing and shipping jobs offshore.
- The advent of new defined-contribution programs, like 401(k) plans, replacing defined-benefit pension plans.
- Organizations reducing or eliminating retiree health benefit programs.

The government even participated by requiring corporate health care programs for retirees to be primary rather than secondary to Medicare. This created even more expense for employers and contributed to the demise of retiree medical plans in many employer-sponsored plans. The decision wasn't a moral or political one; it was financial.

A shift in employee attitudes followed. The social contract had been broken and employees became less trusting and less subservient.

As a human resources practitioner and consultant, I have often heard that the latest two generations, Generation X and the Millennials, are much different as employees than previous generations have been. They aren't loyal to employers. They want more freedom and definition of their work and involvement. They won't allow themselves to be lured into serfdom (and for good reason).

Gen X and Millennials won't form a meaningful relationship with an employer unless they feel they are being met at least halfway. I see their requirements as fivefold:

- Satisfying work content.
- Association with an organization that they respect and that respects them.
- A mutual commitment to them and their careers.
- Meaningful and timely feedback to help them improve their skills.
- Equitable compensation.

In addition to desiring feedback, they also describe other elements in an optimal employment environment. These are the four most important:

- Maximum delegation.
- Personal responsibility and ownership of their projects and tasks.
- Clear boundaries and a sense of the big picture.
- Shared ownership (credit) for end results.

Don't some of these things sound remarkably like what you would expect from someone who embraces the concept of personal competency? Maybe these generations are taking us full circle back to what Jefferson, George Mason, and the other Founding Fathers intended: a relationship between partners that respects and expects individual competency. Employers complain that these generations are much more transient than workers who came before them—that they feel loyalty to their profession and their own personal aspirations. That also sounds like personal competence.

Many human resources leaders and educators say that the flip side of empowerment is accountability. Isn't that what the right to personal competency means? When I hear "personal competency," I think of a trust-based relationship between equals. Maybe these new generations are taking us back to the beginning.

In fairness, if society wants to fully embrace Jefferson's model, employees need to embrace the bitter with the sweet. Personal competency also implies a meritocracy; you are rewarded

according to your capability and performance.

One of my colleagues has a model she refers to as KindExcellence™, implying that the two concepts in the name are fundamentally intertwined. You cannot have true kindness if you artificially lower expectations, and you can't be truly excellent if there is not compassion and consideration for the whole person in your decision making. Again, that sounds like the right of personal competency.

The other important thing to remember in concert with the principles of personal property and personal competency is the importance of a balance between individual rights and societal rights. The individual doesn't have the right to pursue personal goals to the obvious and callous detriment of others. In "Federalist No. 10" of *The Federalist Papers*, James Madison, writing under the pen name Publius (which he shared with Federalist co-authors Alexander Hamilton and John Jay), urged ratification of the US Constitution because of a need for a strong central government to deal with "great and aggregate issues" beyond the "local and particular" matters best left to the state legislatures. Anti-Federalists, writing under the pseudonym Brutus (among others), cautioned against ratification in part because the Constitution contained no explicit guarantee of individual rights. In one of many compromises that went into the document, Madison added such guarantees in the Bill of Rights.

Tension between a need for central coordination and the ideal of personal freedom has vibrated through American political thinking ever since. That tension is also central to the health care debate. Traditional wisdom indicates that there are only two ways of delivering health care: the free market or a governmental model. I reject that premise. There is an opportunity for collaboration between individual and institution. We can use personal competency in concert with government and corporate responses to solve this most complex societal challenge.

The Supreme Court had the luxury of examining this issue only in the abstract: "Does the government have the right to mandate an individual's responsibility to participate in the management and cost of his or her own health?"

The role of the court was to examine the *legality* of the Affordable Care Act, commonly referred to as "Obamacare." Their role was not necessarily to examine the underlying issues of how we got here or how we might construct different solutions.

There is too much at stake for us to leave it at that. As economic stakeholders, Americans are giving up a significant competitive advantage as a society and as a country. The current models contain fundamental flaws that are not being addressed by any of the solutions that have been put on the table to date. They are partial, do not address root causes, and leave out key stakeholders.

In this book I want to explore that premise with you—that the issue is bigger than Obamacare, bigger than the personal mandate, and that if we don't take steps to really understand and deal with the underlying causes that got us here, we are putting a Band-Aid on a hemorrhage.

Mark F. Herbert
June 2011

Part One: Setting the Stage

Chapter One: The Current Crisis

I have been involved with health care in at least a peripheral sense for more than 30 years, primarily as a consumer. As a practicing human resources manager and executive, however, I was also involved as a provider. Our company didn't, of course, directly provide health care and health care management services to our employees, but we had a very important role since we paid for those services for our employees and their dependents.

I recognize I am dating myself, but I remember when health care benefits were part of what management referred to as fringe benefits—an ancillary cost to providing competitive wages to our employees. In those days, with inflation and wages going up at 13 and 14 percent each year, we barely kept our eye on the ball in this area. Then a funny thing happened—wage inflation slowed down, but medical inflation did not. It suddenly hit our radar screen that this fringe benefit wasn't so fringy anymore. That trend has continued, with the cost of providing health and retirement benefits now consuming a huge part of most organizations' talent acquisition and retention costs, especially in the public sector.

There are a number of factors that cause the US to have one of the highest cost and lowest efficiency health management and health care delivery systems among industrial societies. We spend well over 17 percent of our GDP annually delivering health care, and that number continues to move up—not down.

By contrast, Switzerland spends 11 percent and Taiwan 7 percent.

Some of the factors behind that difference include technology, distribution, and inefficiency. There are a lot of other contributors, too. Bluntly, over 60 percent of our health care expenditures are directly related to patient/consumer behavior. As a society, we do a poor job of managing health and involving consumers in a meaningful way in the management and responsibility for their own health.

Our outcomes aren't particularly spectacular either. It's true that if you can afford it, some of the best care in the world is available in America, but measured by average mortality and morbidity, US results are pretty mediocre.

We are consistent. A recent study by the International Federation of Health Plans examined the costs of 23 different medical procedures, ranging from routine checkups to MRIs to Lipitor, and found that the costs for the services were higher in the US than in any other participating country for 22 out of 23 services. No other participating country currently spends more than 12 percent of GDP in providing care. That means we are spending 41 percent more than the least efficient of those other countries.

In a recent piece in the *Journal of Healthcare Management*, the authors indicated that there are two primary vehicles to "fix" health care delivery—the competitive marketplace and government intervention.

As I read that article, a couple of thoughts occurred to me:

- That deals with health care delivery or access, kind of.
- That seems to let a lot of other potential stakeholders off the hook.

A few weeks ago, I had the opportunity to hear a health care executive*, who is also a trained physician, present a couple of key themes that resonated with me.

- First, if we continue to consume health care and deliver it in our current system, it is depleting an ever-increasing percentage of our economy.
- Second, upwards of 60 percent of health care issues are not genetically predisposed, but rather lifestyle related—a fact which the current solutions don't address.

How long can we continue to give up that kind of competitive positioning and remain viable as an economic power?

*Keynote Address by Dr. Mark R. Chassin, President of The Joint Commission at the Arizona Health Care Association Annual Meeting, August 2010.

Chapter Two: The Political Solution

The Supreme Court recently debated the constitutionality of the Affordable Care Act. I'm concerned that their exercise was an academic one.

It dealt with the legality of the issue. The court has no responsibility or intent to address the underlying issues surrounding the availability or efficiency of our current approach to managing health and health care.

Much of the current debate and anguish about health care reform legislation centers around costs, access, and responsibility for funding. But there's an even more fundamental issue. If asked, the average American believes that every citizen has the right to at least a basic level of health care. The sticky point seems to be what is defined as basic.

While most of us agreed that the current model wasn't working, our arguments centered around who to blame, not the best way to fix it. The way we deliver health care in the United States, both systemically and individually, is inefficient. It presents substantial opportunities for improvement.

Some of that improvement is well under way, such as organizational efficiency, innovative techniques for rendering care, and the application of record-keeping technology. Better yet will be a long-overdue system in which medical professionals are paid for outcomes rather than according to services provided. This is just common sense where I come from, in the manufacturing and operational environment.

However, we as Americans have unwisely called on politicians to find solutions to the health care crisis. Politicians have no appetite or expertise to create meaningful solutions. Real solutions are going to come from a different place.

Great thinkers like Bill Gates, Jeffrey Pfeffer of Stanford University, Michael Porter of Harvard University, and a lot of other people much smarter and more accomplished than I am have said the same thing.

Chapter Three: Hidden Costs of Health Care

In addition to the alarming costs of providing health care and the meteoric rate at which those costs are consuming our GNP, there are indirect costs that need to be discussed and addressed. These are costs to employers over and beyond the cost of providing coverage to their employees and their dependents.

The American Mental Health Association estimates that employers in all sectors lose $200 billion annually to a phenomenon called "presenteeism." It refers to people who are at work but not performing well because of a physical, emotional, or mental ailment, most often caused by stress. Some of those costs are embedded in the $44 billion employers spend annually on depression through absenteeism as well as reduced productivity.

Other costs are represented through the 400 percent higher accident rate, 300 percent higher rate of absenteeism, 500 percent higher rate of injury, and 300 percent higher medical claim rate for employees with substance abuse issues. Substance abusers also typically operate at productivity levels 34 percent lower than their sober counterparts.

These costs are not premiums paid to providers; they are costs to the employer community. These are in addition to increased premiums from increased use of health care by an aging population, increased premiums because of uncompensated care, and other direct costs.

Much of this expenditure is related to the estimated 60 percent of health care conditions that are lifestyle-based rather than hereditary or "organically-based." What I mean by this is that studies indicate our nutritional or personal decisions around health management are responsible for these conditions, not genetics. These costs were calculated prior to the latest recession. Current studies indicate that worker dissatisfaction is at an all-time high, so I rather doubt these costs will be lowering anytime soon. Health care delivery consumed 17 percent of GDP in 2011.

There are also significant costs to the system because of inefficiencies with health care delivery, information sharing, and other issues resulting from our societal focus on process rather than outcome-based medicine. Two elements are driving factors:

- Costs to the employer over and above premiums that they pay (and have now been effectively mandated by legislative reform). This addresses a key question of "what is in it for me" to resolve these issues. If we want employers to fully embrace participation in making changes to our current system, we need to provide them with financial reasons as well as social responsibility imperatives to do so.

- In order to stem these causes at the root, they need to be addressed before they present in the doctor's office or emergency room.

In some ways, US businesses perpetrated our own mess through the creation and funding of highly codependent, rich, and entitlement-oriented fringe benefit offerings that defined

employees as consumers rather than partners in their health and health care. It was only when the cost of these benefits began to rival those of other critical operating factors that employers took note, and when we did, we used our old historical approach: squeeze your supplier. We pressured health care providers to keep premiums down and chose insurance plans based on cost. When that approach didn't work, we began reducing benefits. What we accomplished was the transfer of costs to the government, the provider community, and society.

Health care providers can address the problem of poor health, but they have to do that largely by treating those who are already ill or injured. They are not positioned to address the codependency or entitlement issues that increase costs and undermine overall health of the patient/employee. When we wait to address an issue until it presents, we are inspecting quality in rather than building it in. Instead of identifying and preventing a problem, we are passively letting it occur and then trying to correct it. The second way is more expensive.

The current health care "reform" legislation managed to convey two primary messages: 1) government is not capable of fixing the problem, and 2) the provider community, insurers, and employers are stakeholders willingly or unwillingly. At a minimum, they will be the funding source. Alternatively, we could use this legislation as a foundation for collaboration, stewardship, and partnership to systemically address the issues.

Chapter Four: Framing the Issues

Health and health care, like education and poverty, are societal issues, and we are all stakeholders. Society and business need to look for opportunities to involve and hold all of our stakeholders accountable for their roles in the process.

As I mentioned in my introduction, a couple of years ago I became intrigued with the concept of personal competency. Personal competency, as reflected in the famous phrase, "life, liberty, and the pursuit of happiness," was one of the principles embraced by the Founding Fathers when they crafted the Declaration of Independence, the Bill of Rights, and the Constitution. Liberty implies self-reliance. If the individual must depend passively on a lord (as in ancient feudalism), a government, or even a corporation for sustenance, shelter, protection, and more, that person is not free. When the individual has the liberty to pursue happiness, it means the individual also must exercise the responsibility for developing the skills and wisdom to make decisions crucial to that quest.


IN CONGRESS. JULY 4, 1776.

The unanimous Declaration of the thirteen United States of America.

The idea of personal competency codified the right and responsibility of each citizen to define themselves and their future without regard to their heritage or lineage. It was an attempt to remove the shackles of the feudal model of lord and serf. We lost much of that as our society became more industrialized. People left the farm and their small towns in exchange for the "security" of employment in large companies, who in return for compliance provided a certain degree of security.

It would be simplistic to assert that employers willingly wrapped the employee in a cocoon of fringe benefits. Early in the Industrial Revolution, they did no such thing, but employees, lacking economic alternatives, became dependent nevertheless—dependent and largely helpless. Many

of the battles over the collective bargaining process, waged by labor organizers from the late 1800s through the mid-1900s, resulted from a need to balance the scales so that the employee (or at least "employees," plural) had some leverage in striking the employer-employee bargain. Working conditions improved. Hours improved. Pay rose. But multiple generations of Americans also grew up in a system where their employer provided for their health and welfare thorough generous health and retirement benefits. Most employees then and now remain remarkably ignorant of the costs and complexities of those systems. The insurance industry grew out of a pooling model that allowed employers to reinsure costs. In the early days, cost containment was rare, and even today's employees see the provision of high value health and retirement benefits as an entitlement. Nowhere is that better represented than in the public sector, where you see jurisdictions threatened with or in an actual state of insolvency because of these contractual entitlements. The typical funding solution is to reduce services and reduce the workforce.

On the private sector side, management used a more efficient solution. First we shifted the costs, and then we reduced or eliminated benefits. The more enterprising companies moved to alternative jurisdictions, either domestically or internationally, to reduce or eliminate the obligation altogether.

Health care providers took similar steps. They shifted costs to the insurer and the health care professionals themselves. Health care has become big business. Employers dropped or reduced coverage, and government programs picked up more constituents while much of the population became underinsured or uninsured. The problem with that is obvious. The need hasn't gone away; it's simply not being met.

Perhaps, however, the "crisis" provides us with a catalyzing recognition—"fixing" health care isn't a health care provider or government or employer issue; it is a societal issue and requires a societal solution.

My view represented an anomaly in the employer sector even years ago. I saw our organization (the employer) as a stakeholder and partner in health and health care in the eighties. We looked to apply the same methodologies to our health care expenditures as we would to any other significant operational costs—build a better process. We partnered with our employees, their dependents, and our provider to attempt to identify what the potential causes of our health care costs were and what they would be, and we proactively focused on reducing them. We did this in both the occupational and non-occupational side. We found there were two outcomes: we increased the level of engagement on the part of our employees, and we saved a lot of money. It wasn't rocket science.

Fast forward to today. American businesses are in worse shape than we were almost 30 years ago. We spend $5 trillion dollars annually on turnover and another $200 billion is attributed to the costs of presenteeism. Those are costs related to heavy health care utilization, absenteeism, and lost productivity from employees not fully engaged in their work. Employee dissatisfaction is at historic highs.

Another article in the *Journal of Healthcare Management* discussed the implications of increased

unionization activity in health care because of the crisis I described above. Our collective bargaining infrastructure, especially in the public sector, fought very hard to provide these benefits to their membership. They see employer efforts to reduce health benefits or revert to an individual mandate which shifts responsibility to the employee as a significant take away.

One apparently effective strategy employed by collective bargaining groups is using negative public opinion strategies to galvanize both employees and communities in support of their efforts.

Many of the issues we face in delivering high quality health care outcomes are not being well addressed by the current models. These include:

- A national shortage of trained health care professionals, which is especially pronounced in rural areas.

- A seeming lack of dialogue or collaborative solutions between providers, insurers, employers, and consumers.

- Lack of integrated initiatives targeted at education, intervention, and personal competency at the consumer level.

- The 60 percent of health care issues that are lifestyle related. We can treat the result, but are we addressing the causes?

In short, we are addressing the issue serially rather than systemically. The article I referenced advocated for "accountable care organizations." Publications targeted at health care professionals often raise the issue of engaging the provider community, but I don't see much about engaging the non-provider employee base, the employer base, or the communities the organizations serve.

Chapter Five: Delivering Health Care Versus Managing Health

The current approach to health care problems seems largely focused on handling the issue by managing access to care and applying technological solutions.

That approach fails to address some of the key causes of our issues, like lack of trained professionals, the cultural implications of entitlement, a lost sense of personal competency, failure to adequately engage the consumer, and more.

It is also highly compliance-based. I will explore this issue in a chapter of its own.

This situation isn't new. In a 2009 *Harvard Business Review* HBR IdeaCast, Dr. Richard Bohmer succinctly posited that there are three major issues with our health care system:

- How we define a service.
- How we finance health care.
- How we deliver health care.

He also gave a great explanation of the difference between *managing health care*, which deals with defining and delivering services, as opposed to *managed care*, which he refers to as an insurance or financing model. I recommend this 13-minute interview, still available in the HBR IdeaCast archives.

Bohmer sees health care delivery as a series of separate events, beginning with diagnosis and proceeding through treatment and follow up. He argues that health care delivery and cost should be based on outcomes rather than the way we currently track and price it. It should be approached as we do lean manufacturing or total quality: success is determined by outcome, not process.

The Affordable Health Act attempts to address some of this particular issue, but the issues surrounding things like capacity (the number of health care professionals) and individual behavior are minimally addressed.

Before you interpret my comment as a criticism of the current administration, I want to be clear; the Affordable Care Act is trying to address some of the problems I have identified. I haven't seen any of the proposals coming from candidates seeking the president's job in 2012 addressing any of them

All of Bohmer's points are focused on delivering health care. Except, almost incidentally, in how we (government and payers) define a service (prevention versus treatment potentially)—we leave those other areas essentially unchanged. So in summary, we can continue to manage delivery and costs, or we can manage outcomes. To manage outcomes, we have to step up and address root causes, not just the effects of lifestyle decisions and personal actions.

In our society, and especially in the worlds of business and government, issues that involve people and how they behave make us uncomfortable. Accountants and MBAs much prefer the world of numbers and systems to messy things like relationships and emotions. Political solutions that attack numbers and move money and physical things around are far more attractive to officialdom than those designed to motivate or challenge the public. In politics, the winning strategy often involves promising something for nothing. It rarely includes a call for personal accountability.

Taking things away from people is very unpopular, especially in an election year.

Chapter Six: The Entitlement Mentality

Much of the legislation that defines the rights and responsibilities of management and labor was crafted between 1933 and 1945 during Franklin D. Roosevelt's three-plus terms in office. In that period, Congress defined what many HR practitioners today believe to be a very adversarial model, a model which persists to this day in many aspects. The United States has one of the most limiting legal structures regarding the process of interactions between employers and employees in the industrial world. Let's examine this model as it relates to health care and retirement.

We saw the greatest proliferation of fringe benefits like health care, retirement, and pay for time not worked (vacations, holidays, etc.) in two periods during the twentieth century: World War II (America was in the war from 1941-45) and the Nixon administration (1969-74). In both periods, the government stepped in regarding the payment of direct compensation (wages) to prevent these costs from impacting the war effort and, in the case of Nixon, to stem inflation. Management and labor got together and found something else to trade: fringe benefits. The costs of these things at that time were relatively small, thus the name.

Employers ended up in the health care business because it was usually as part of a union contract that the employer would provide these benefits, typically at little or no cost to the employee. Employers who wanted to remain nonunion and create parity with their nonunion staff extended these benefits as well. It became a significant competitive disadvantage not to offer the benefits. In the process, we unwittingly took away the rights and expectations of personal competency by creating codependency.

Over the decades, medical technology, lifestyles, and other factors have caused the cost of providing benefit coverage to escalate alarmingly. The ability of medical care to prolong life has exacerbated the problem. People are living longer and benefits are extending over a longer period of time. Advances in medical care are often very expensive as well. In addition, most employees had no idea of the cost of providing care to themselves and their dependents and saw it as an entitlement; this situation still prevails in many cases today.

In the public sector, the combination of costs spiraling upward and employees oblivious to the employer's subsequent bind has devastated municipal, county, and state budgets. Cities and even states face bankruptcy because of their obligations under collective bargaining agreements to provide levels of health care and retiree benefits that are out of touch with reality.

This also became a huge issue for employers in the private sector in the early 1990s when the government changed the model for accounting for the future cost of care. Until then, the cost of retiree and employee medical plans was handled as a current liability—essentially, you pay as you go. When the change required that responsibility for those obligations, much like pensions, become an expense that has to be funded at the time the employee becomes *eligible*,the cost for providing those benefits at that time caused huge issues. Essentially, it requires employees to set aside dollars in trust to fund future expenditures based on actuarial calculations, including considerations like the life expectancy of the employee and assumptions about medical inflation. We are taking about billions of dollars in current expenses that hit their balance sheets.

Organizations that provide defined benefit retirement and health care plans for their current and retired employees suddenly were faced with conducting actuarial studies and putting dollars in reserves and trusts to meet those future liabilities. You saw corporations taking billions of dollars in write-offs and, in many cases, dropping retiree coverage and moving to defined contribution (we agree to a set funding amount) rather than defined benefit (we guarantee a service or amount) plans.

The difference is significant. In a *defined benefit plan*, I, the provider (who is usually an employer or government agency or association) essentially guarantee you access to a certain income or level of care. In a *defined contribution* arrangement, I guarantee a financial contribution but am not obligated to provide the level of care or guarantee an annual payout to you from your retirement plan. The individual absorbs that responsibility.

This transfer of risk from the institution to the individual is a factor many employees find both highly complicated and frightening.

Although most private employers have made transitions from defined benefit to defined contribution programs in the health and retirement areas, the same is not true in the public sector.

Many collective bargaining contracts still firmly embrace the defined benefit model. This is one of the biggest factors contributing to the financial insecurities of thousands of municipalities, counties, and even states. They have contractual obligations to provide these benefits, in some cases for the lifetime of the employee.

Public sector unions are very reluctant to bargain these rights away, and politicians are very uncomfortable taking on this issue. Many public sector employees feel that they traded more lucrative salary opportunities to serve the public and these generous benefits in some ways bridge that gap. The concern is that they are financially unsustainable.

When we talk about things like social literacy and adverse selection, the potential implications of this will become even clearer.

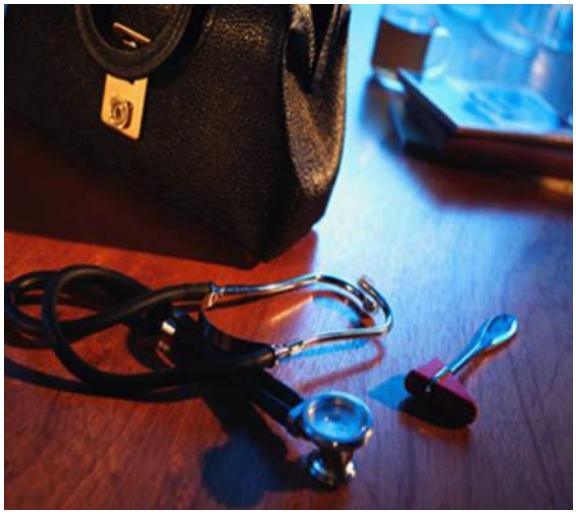
My point in this chapter is that we have multiple generations who grew up with someone else making these decisions with little or no involvement on their part.

Chapter Seven: The Caregiver Shortage

I spent over twenty years in the state of Oregon. One of the issues there that you almost never hear discussed is the growing shortage of physicians, especially primary care physicians, as well as other caregivers. Oregon has only one medical school, and more than 50 percent of the graduates of that program leave the state. In some cases, it is a lifestyle choice to return home. In other cases, it is because Oregon is not an easy state in which to practice medicine. When this information was shared with a group of business executives in 2007, we were initially stunned, and then concerned.

The problem becomes exacerbated in rural communities. Despite the fact that half of Oregon-trained physicians leave the state, most of the other half tends to locate near where they did their residency. Oregon's only medical school is in Portland, the state's largest city, which is situated in the state's far northwest corner. This does not bode well for the availability of medical care in southwestern Oregon. In as short a period as ten years, Oregon could be facing a critical shortage in trained health care practitioners because of retirements, new graduates moving out of state, and other related issues. In much of the state, the shortage is already being felt. There are similar issues with nurses and other health care practitioners.

It would probably take a decade and at least a billion dollars to build a new medical school—and that's a pre-recession estimate.



Now I live in Arizona, which likewise has limited health care education capacity and may be facing the same issues soon. I suspect we could see this issue repeated in a number of other parts of the country as well, especially in those less densely populated.

To an extent, the shortage of health care practitioners is exacerbated by the market model of delivering health care. Medical professionals tend to congregate in larger markets where there is greater economic opportunity. They also tend to migrate toward certain specialty practice areas, both for economic and legal liability issues. This puts an even bigger strain on areas like primary

care and OB/GYN. Primary care loses out because it pays less well and OB/GYN suffers because of the liability issues.

These issues are converging with the aging of baby boomers. As this huge population bubble enters the stage of life in which they will need the most care, the shortage may hit crisis proportions. If we expand coverage, as planned under the current law, demand will not diminish; it will increase, at least for a time.

A 2010 study* estimated that 46 million people, 25 percent of the US population under the age of 65, do not have continuous access to health insurance coverage, and it is estimated that even with the coverage proposed under the Affordable Care Act, potentially half of that number (23 million) will still be unable to afford needed health care services.

The solution is not likely to be found by trying to manage health care delivery. We must address the subject of health itself. Healthy people have less need to see a doctor.

Even if we are able to expand the physical capacity of our health care education system, there is a shortage of faculty—no one to staff the new educational organizations. Leaving private practice to teach is typically not an attractive economic choice.

Managing demand by managing the supply and further reducing reimbursement levels, making it less financially attractive to enter the health care field, feels a bit counterintuitive.

One further point: I would go out on a limb and bet that the average citizen or business owner/executive doesn't even have this issue on his or her radar screen. When we discuss the health care crisis, we generally refer to it in financial terms. Rarely do we discuss it in terms of access to care and caregivers.

*Hsieh, Clement, and Bazzoli, *Health Care Management Review,* 2010.

Chapter Eight: The Social Literacy Issue

Like the caregiver issue, this is one that often slips under the radar screen.

I first learned about social literacy from Dr. Mark Chassen, CEO of the Joint Commission, the organization that provides accreditation to hospitals and health care organizations, in an address he delivered in the summer of 2010.

Social literacy is essentially our ability to understand and process information. Most of us have heard that newspapers are written at an estimated eighth grade literacy level. Anyone who has had the opportunity to interact with the health care system recognizes that its use of language is nowhere near so accommodating.

The language and processes surrounding the management and delivery of health care are opaque, murky, and mysterious to most consumers. As someone who has worked in the system, I can tell you that I think part of this is deliberate—not just with health care, but with the insurance industry as well.

Things like deductibles and out-of-pockets are just the beginning of the specialized, hard-to-grasp vocabulary. As an executive negotiating health care contracts for my employer, I found it necessary to inform myself about things like pooling points (where our claims were pooled with the total group), per-claim transaction costs or PCTs (the cost for recording your expenditure or claim), and sending the explanation of benefits (EOB) that we get from our insurer telling us what is covered and not covered.

I think our friends in financial services and air transportation have learned from their counterparts in medicine and health insurance that there are all kinds of interesting places to assess charges and recoup revenues.

Even as a practicing human resources professional with years of experience and training in the field, I found the process of learning this new language and decoding it pretty daunting. For the average American, who I hope participates in the system peripherally, this is incredibly confusing.

The problem with an individual mandate is that employers, providers, and insurers haven't provided any context for the average consumer to understand and navigate this process, and to the best of my knowledge, there is no proposed infrastructure to do so.

This is a huge issue. The process of managing the maze of health care is daunting. The number of players, the language, and the deliberate use of vocabulary that is foreign to the average person makes it very scary.

Studies indicate that more than 75 percent of Americans read and comprehend at an intermediate level or below. The language involved with the delivery of health care can turn a PhD into a

puddle of confusion.

If we are truly going to require/allow consumers to take responsibility for making informed decisions about health care, we need to rewrite the language and create infrastructure to make it user friendly. I will admit I have not read the entire Affordable Care Act, but I will bet that chapter is missing.

I would like to share what I think represents a similar situation from earlier in my career.

Years ago, when I was a young human resources professional, 401(k) retirement plans first emerged.

Accountants, MBAs, and consultants loved them. They terrified the average employee. They made the employee responsible for determining the security of their retirement. Bad decisions could mean you had no retirement.

Most employees ignored them and held tight to their defined benefit pension plans where their employer made the decisions and they had an annuity they could count on. They weren't all that interested in assuming risk, even given the potential upside. A market correction (can you say "The Great Recession"?) could put your entire retirement plan in jeopardy.

The entitlement mentality is also at work here. The average American doesn't want to think about the complications of managing their health and health care. I want to eat and drink what I want and in the event I experience health issues, I want the best health care available—funded by my employer, the government, or someone else, of course.

Chapter Nine: The Issue of Adverse Selection

Adverse selection is what the principle of insurance tries to mitigate or correct across a group. At its most simplistic, it means that we only want to pay for a service when we need it rather than preventively. Given a choice, only sick people or people who anticipate a need for a medical service want to pay for it.

A great illustration can be found in COBRA, which is the acronym for health care obtained under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985. It allows Americans who have lost or left a job to continue coverage under their old group plan but without employer-paid premiums. They have to pay most of that part themselves. Most people who look into COBRA experience sticker shock. Suddenly faced by a number much closer to the real cost of health insurance than anything they've encountered as an employer-covered patient, they often decide they don't want to pay what it costs.

Yet, COBRA, because it is group coverage, provides better coverage at a more reasonable rate than most individual health insurance policies. Individual policies offer much more limited coverage and much higher rates. Prior to the Affordable Care Act, insurers used preexisting condition exclusions to prevent high-risk individuals from enrolling or getting coverage for medical conditions they had that are expensive to treat.

To illustrate the effects of adverse selection even more graphically, the sickest 5 percent of our population account for 50 percent of the total health care expenditures. All the premiums collected from all of these individuals probably would not pay the complete cost of their care. By broadening the pool, we do in fact underwrite their costs, providing those individuals with the care they require. We have made a decision as a society not to leave those individuals out on the ice to die.

We have actually added to the difficulty of adverse selection through the contraction of the economy. As more Americans lose employer-based coverage, the solution in many cases is to do without. As a result, much of our health care delivery has shifted to emergency rooms to treat ailments that have hit critical mass. To compound that issue even further, much of that care is delivered by not-for-profit organizations or public institutions, so the provider is not reimbursed. As a result, those costs get shifted to those people with insurance or to paying patients—just like the costs of shoplifting gets passed along to the paying customer.

The 2010 study conducted by the International Federation of Health Plans indicated that this spreading of costs from those who can't or won't pay to those that can and do is one reason why Switzerland and other countries, after experimenting with an individual mandate, opted to reject it. According to the study, it actually increases costs and decreases the quality of care provided.

The Affordable Care Act is attempting to mitigate some aspects of this issue. Banning health insurance companies from rejecting individuals with preexisting conditions is supposed to help get those people, and their needs, into a broader insurance pool better able to absorb the additional expense of caring for them. But once again, the government imposes its solutions at the site of financing and delivery.

In the current economic recession, millions of Americans who have lost their employer-based coverage must face decisions like whether to make the house payment, buy groceries, or purchase health care for themselves and their families. Anyone who has been unemployed or self-employed has likely experienced this phenomenon.

In the language of medical diagnosis, this societal symptom is already presenting.

Chapter Ten: The Point-of-Delivery Issue

Sick people don't go away; we just deliver their care in a less efficient setting.

I remember hearing the story of the $250,000 splinter from an emergency room physician in a health care organization I support. A homeless man, in his meandering, managed to get a splinter in his foot. Being homeless, he didn't have great access to a means to deal with it, so he did what most homeless people do—he ignored the splinter and hoped it would work its way to the surface and out of his foot. Unfortunately, that didn't happen.

His foot became infected—in fact, so badly infected that by the time he presented in the emergency room, his leg was gangrenous to above the knee, requiring amputation, hospitalization, rehabilitation, and a prosthetic leg. The health care organization that treated him was forced to write off the costs of that treatment, including the prosthetic.

In our current environment, with unemployment mounting, we have shifted the site of delivery of care for millions of Americans. They can no longer afford to seek preventative treatment or get their checkups. They seek care when it hits a critical stage, typically at the least efficient and most expensive site of treatment.

Currently there are many individuals who are covered by plans that were enacted when the Affordable Care Act was passed. Under the requirements of the Emergency Medical Treatment and Active Labor Act, hospitals are required to treat individuals needing acute care without consideration for their ability to pay.*

These individuals are typically receiving their care in emergency rooms. As the number of uninsured continues to grow, this issue continues to accelerate. Arizona had the most progressive medical safety net in the United States until recently, covering single individuals as well as families up to a multiple of the poverty level.

I say *had* because the state had to remove many of those people from basic coverage because of costs. Effectively, what that did is move their site of care back to the emergency room.

Again citing the International Federation Study, the United States consistently had the highest cost of providing 22 out of 23 services ranging from routine physicals to MRIs and drugs when compared to other industrialized countries. Point of delivery is a significant factor. The market does not do a great job of addressing that issue.

There are many who believe that a system based exclusively on an individual mandate, a choice to either carry coverage or pay a fine—which are essentially the options under the Affordable Care Act—would actually increase that problem.

Then I find myself in a situation where I require significant and expensive medical care that my family and I do not have the means to pay for. The caregiver initially, and then eventually those individuals who do carry insurance, end up absorbing the cost of providing that care.

I don't think about it because I haven't been educated or expected to fully understand the issues.

*P. Cunningham, *Harvard Health Policy Review,* 2008.

Chapter Eleven: The Role of Personal Competency

I recognize that much of this particular chapter is redundant to things I discussed earlier, but I think it is very important to understand this concept as part of the law of unintended consequences. It bears repeating. Over two hundred years ago, as they were acting on the ideas that inspired the American Revolution and the drafting of the Constitution, some of the Founding Fathers fixed on two related concepts that had to do with how this new, egalitarian society was to distinguish itself from the ancient feudal system—a system in which people belonged either to a ruling or ownership class or to a serving class, as determined at birth. Feudalism was a system that we supposedly had left behind.

One of those concepts is one that we have held onto with a passion ever since, declaring it to be among the cornerstones of the American experiment. This is the idea of personal property ownership: the idea that, through your own achievement, you should have the ability to accumulate and own property without regard to your prior economic or social status.

Fundamental as it is to our capitalist system, we hear this principle invoked every day. America was a place where no class system or government defined who you were or what you could achieve. You could reinvent yourself. You could own property, build a business, and leave it to your heirs. Our largely agrarian society and vast frontiers, with what seemed to be an inexhaustible supply of land, fit this idealism. This continues to be a loud shout in public discourse.

Far less audible has been, until recently, the other of these two principles: personal competency—the right to build your skills, express yourself, and sell your products and services as you see fit. This concept includes not only an implied right, but also a responsibility.

As our country shifted from an agrarian society to an industrial one, we moved from the fields to the factories during the Industrial Revolution. This dynamic produced a new version of master and serf. In the feudal system, the serfs were bound to the land. They cultivated the master's crops on land that would always belong to the master. In exchange, they might get a meager share of what they harvested or merely the privilege of working a tiny plot for their own families' sustenance. Prior to the labor reform legislation passed in the late 1930s and early 1940s, Americans created a kind of industrial serfdom of their own. This was when collective bargaining was formally or informally outlawed. The miner or factory laborer, with little choice but to work as hard and as long as required for as little as the boss cared to pay, lost the rights of personal competency.

Under this semi-feudal thinking, people couldn't be trusted or expected to make good decisions. The business community believed it needed to dumb things down. This was the advent of white collar (those who "think") and blue collar (those who "do"). That model did not go away after reforms brought better working conditions and living wages. In fact, it became more deeply embedded in corporate-industrial culture.

This model assumed that employees would do what they were told, and in return the "nobility" (we in management) would take care of them, and we did. Over the decades, we took better and better care of them. We promised lifetime employment. We provided for their health care and retirement. We cannot say we did it willingly; organized labor played a huge role in providing these things as well as industrial safety, limitations on work hours, and other rights and benefits. Along the way, we lost the equality factor; we began to "take care of" employees. They began to expect it.

The 1960s-1980s saw international competition that forced changes in the US business model. The Japanese and Germans, rebuilding their economies after World War II, were eager to learn about the latest techniques for managing employees to achieve maximum efficiency. They found such techniques being taught at US business schools. Among them were ideas that brought some of the concepts of personal competency back into the workplace.

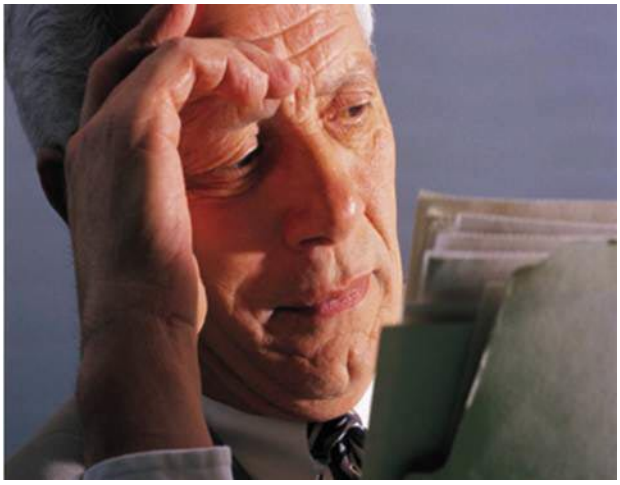
At the same time, there were forces driving American management further away from promoting personal competency. Reacting to rising costs and government regulations, we began using outsourcing and moving production offshore—hardly investing in personal competency.

We also begin to notice that some of the costs of taking care of our employees were becoming a problem. This was the beginning of employers recognizing the challenge of rising health care costs, thus experimenting with managed care, cost shifting, reducing benefits, and trying other strategies.

We saw organizations that had practiced "no layoff" policies begin to downsize their workforce and aggressively outsource and move jobs offshore. We saw the advent of newly defined contribution programs like 401(k) plans replace defined benefit pension plans. We also saw organizations reduce or eliminate retiree health benefit programs. The government, meanwhile, required corporate health care programs for retirees to be primary rather than secondary to Medicare.

Employment attitudes shifted in response. The social contract had been broken and employees became less trusting and less subservient.

Management was not or could not hold up their end of the bargain. We saw parents and grandparents who had been promised lifetime employment lose their jobs. Capitalism and personal property remained, but often at the expense of the American worker as we outsourced, downsized, and offshored to protect profit margins. People became a cost rather than an investment, and the new generations responded with a social contract of their own.



When I was new to the game, my employers used the standard solutions to address many of these issues:

- Beat up the providers and carriers.

- Begin a long and arduous process of cost sharing with our employees, ranging from higher deductibles and co-pays, elimination of services formerly covered, and reduced coverage for retirees, dependents, and other groups.

- Cutting out the middle man and moving to self-insurance to gain administrative savings.

Some enlightened employers embraced managed care pretty aggressively. By managing health care delivery more efficiently, we could affect costs

This feudal model, however, reflects a paternal and disrespectful view of the relationship between not only employer and the employed, but between doctor and patient as well. It represents one of the last bastions of that unhealthy and imbalanced relationship, and employers had a significant role in both creating it and facilitating its continuation.

Meaningful solutions simply have to address this issue. Study after study has indicated that much of the cost of managing health is related to environmental factors and individual behavior—as high as 60 percent—but the current solutions avoid dealing with that driver of health care costs.

My experience has been that individuals can and will step up and play a bigger role in management of their health *if* we provide them with the appropriate context and tools to do so.

This applies not only to the management of their health, but also to other important dimensions of the relationship between the employer and the employed.

It also only makes common sense. If 60 percent of the costs of something are not being meaningfully addressed, then we are leaving significant opportunity on the table to both reduce costs and improve quality of life.

Chapter Twelve: Why an Individual Mandate Fails

As you can tell, I am not a fan of a simple individual mandate. I have a number of reasons why, but I am going to focus on just a few, some of which we have already discussed. They are:

- Failure to address root causes.
- Social literacy.
- Adverse selection.
- Care provider supply.

Failure to Address Root Causes

As I mentioned earlier, studies demonstrate that 60 percent of health-related issues can be tied directly to consumer/patient behavior. An individual mandate requires you to have insurance, but there is no inherent vehicle to either educate you about or incentivize you to change your behavior.

We see studies every day about the relationship between obesity, smoking, and other lifestyle-related activities and individual health and health care expenditures.

Jeffrey Pfeffer, an internationally renowned professor of Organizational Behavior at Stanford University, points out that much of our health care costs are directly related to stress. Employees are stressed out about work, their finances, and a host of other issues. The current economy makes it worse, not better, to lose your job and lose your benefits. Unemployment insurance is relatively short-term as well.

The American Mental Health Association estimates that $200 billion is lost annually to presenteeism and absenteeism because people show up sick, take up work time dealing with personal problems, or just miss work altogether. Employers pay those costs directly and indirectly.

Another major factor is education. How many of us, as employers, even talk to our employees about health care costs? I do not mean premiums; I mean costs. This goes to personal competency. For generations, organizations like corporations and government agencies, especially under collective bargaining agreements, have provided employees and their families with high cost, high value benefit programs with little or no information about what those programs cost or how personal behavior contributes to those costs. We tell our employees that we are reducing benefits, increasing cost sharing through higher deductibles, or use similar tactics, but do we actually talk about how to reduce costs through prevention and a healthy lifestyle?

Individuals need to participate in the management of their lifestyles and in the costs of providing health care solutions. Employers can participate through education and partnership with health care providers.

The most commonly prescribed medications in the US are anti-depressants. Drugs treating people for ADHD and others are in the top 10. Viagra and other erectile dysfunction drugs are still booming. It is too easy to blame it all on the insurers, the medical community, and the government. As a society we have to hold all stakeholders accountable. As the employer (payer), we are in a role to communicate and set behavioral expectations for our employees in a way that health care providers can at best manage indirectly.

Social Literacy

As I mentioned before, this is a huge issue. The process of managing the maze of health care is daunting. The number of players, the language, and the deliberate use of vocabulary that is foreign to the average person make it very scary.

More than 75 percent of Americans read and comprehend at an intermediate level or below. The language involved with the delivery of health care can turn a PhD into a puddle of confusion.

If we are truly going to require/allow consumers to take responsibility for making informed decisions about health care, we need to rewrite the language and create infrastructure making it user friendly.

Adverse Selection

Adverse selection is one key reason why Congress elected to force the individual mandate. Their concern is that if people have a choice to opt out, they are likely to do so because of economic reasons, because they are healthy, or because they just don't see a reason to spend discretionary income on purchasing health insurance.

The principle of insurance is spreading the risk and the cost across a broad group. This is the primary reason why group insurance plans are both more comprehensive in their coverage and more affordable on an individual basis for group participants. The insurer knows that sick people will have their costs subsidized in part by healthy people who are minimal users of the coverage and/or exercise good judgment and personal health management habits. By distributing the costs in this way, we reduce the per capita costs. It is also a reason why insurers have imposed pre-existing condition exclusions; they know that people with pre-existing conditions are more likely to require care.

Provider Shortages

The individual mandate does absolutely nothing to address this. Neither does changing the laws regulating insurance and allowing large insurers or cooperatives to more easily operate in multiple jurisdictions.

The individual mandate speaks to a market-driven model and could provide for some uptick in efficiency, which I believe is sorely needed. However, it only addresses delivery (kind of), and none of the *cultural* issues that we face. It is purely a systemic model.

For an individual mandate to be successful, we need to address the cultural as well as the systemic and provide the appropriate infrastructure.

Chapter Thirteen: Why a Pure Market Model Doesn't Work

Philosophically in the United States, we have always been very committed to the concept of personal responsibility, opportunity, and allowing the market to sort things out. I am a capitalist. I think there are many areas in which the market is a great arbiter. I even think that the market offers advantages with regard to certain dimensions of delivering health care.

If you do not follow best practices and your efficiency and quality suffers, I think your reimbursement levels from both social insurance (Medicare and Medicaid) and private insurance should incentivize you to correct those practices.

If our health management and health care issues were limited to delivery, as Dr. Bohmer indicates, that could be a solution, but the issues aren't just about delivery.

Let's go back and examine some of the issues I brought up earlier.

If you look at things like shortage of caregivers, adverse selection, social literacy, the entitlement mentality, the impact of individual behavior, etc., the market doesn't address those at all.

If anything, you could say that the market model exacerbates them. Remember that the cost of 22 out of 23 procedures performed in the United States is higher than in any of the other countries, according to the study from the International Federation of Health Plans. Not lower. Higher.

Also remember that we are not seeing better outcomes. Insurance companies and health care providers in the market model are incentivized and rewarded almost exclusively at the delivery level. The current model does not incentivize or encourage them particularly to focus on managing health. Neither do they have the infrastructure for it.

If we believe the literature and research that 60 percent of health is related to lifestyle and behavior, then how does the market adequately address that? The principle of insurance is based on aggregation, or spreading risk. In individual insurance policies for life insurance, we can adjust premiums for health and lifestyle, but societally, are we prepared to do that for medical conditions over which an individual has no meaningful control because of heredity or other factors? Are we prepared to deny someone basic coverage because they lack the financial means to pay for it?

We also have the issue that more and more Americans are losing access to their health insurance, making their treatment center the emergency room, the least efficient and most expensive way to treat any medical condition. How does a market solution address that?

There are multiple reasons why I don't believe a pure market solution works, but for the sake of simplicity, here are my big three:

- It doesn't address root causes and focuses almost exclusively on delivery of care versus management of health.

- It assumes an equal playing field geographically and demographically, which we know is untrue.

- It excludes a role and responsibility for what I believe to be major stakeholders in a societal issue. Specifically, I refer to consumer/employees and employers.

Beyond that, the single biggest reason is that it has failed.

The United States is giving up a 40 percent competitive margin on our GDP on a model that is delivering mediocre results. That number is growing, not shrinking. When we leave millions of Americans with no coverage or inadequate coverage, the costs don't go away, they just manifest themselves in other ways or get redistributed.

It also applies a purely systemic solution to an issue that is both systemic and cultural. This has been our propensity for the last one hundred-plus years, and the research shows that it is one reason we are wasting billions of dollars of lost opportunity from people issues like lack of engagement, presenteeism, and employee turnover.

Part Two: The People Part

As I illustrate in the previous chapters, I am concerned that solutions that do not recognize and proactively engage employees and consumers in the management of their own health and well-being will have limited success.

As a human resources professional, I also feel that the current relationships we have with our employees and consumers in this area are codependent and more than a little disrespectful.

In these next few chapters, I will explain why I feel this way and provide some reasons why it is not only critical, but advantageous in the long and short term to partner with consumers in addressing this as an issue.

Chapter Fourteen: Systems Versus Culture

Something I learned very painfully a number of years ago is that culture eats systems.

This is the stuff that makes accountants, scientists, and MBAs squirm.

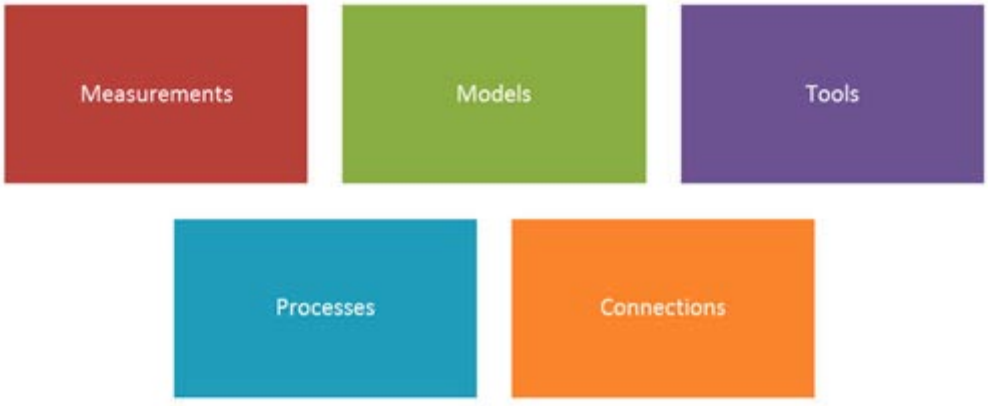
Studies show that we tend to operate on three levels: the "I think," the "I feel," and the "I am."

Psychologist Abraham Maslow explored this in his famous hierarchy of needs. Studies also demonstrate that when the "I think," our rational side, is in conflict with the "I feel," or emotional side, the "I feel" will prevail 85 percent of the time!* If your "I think" is in conflict with your "I am," what author Seth Godin refers to as our "lizard brain," we are doomed!

Social literacy and the entitlement mentality we created over generations play right into this trap. So does the fact that 60 percent of health-related issues are attributable to behavior and we are not addressing them, either. When we apply system thinking without consideration for the cultural dimension, we ignore significant resistance to change.

Dealing with cultural/emotional/entitlement issues is political kryptonite. I think, to a large extent, it is why solutions, especially those coming from government, are so focused on delivery and provider rather than individual behavior changes.

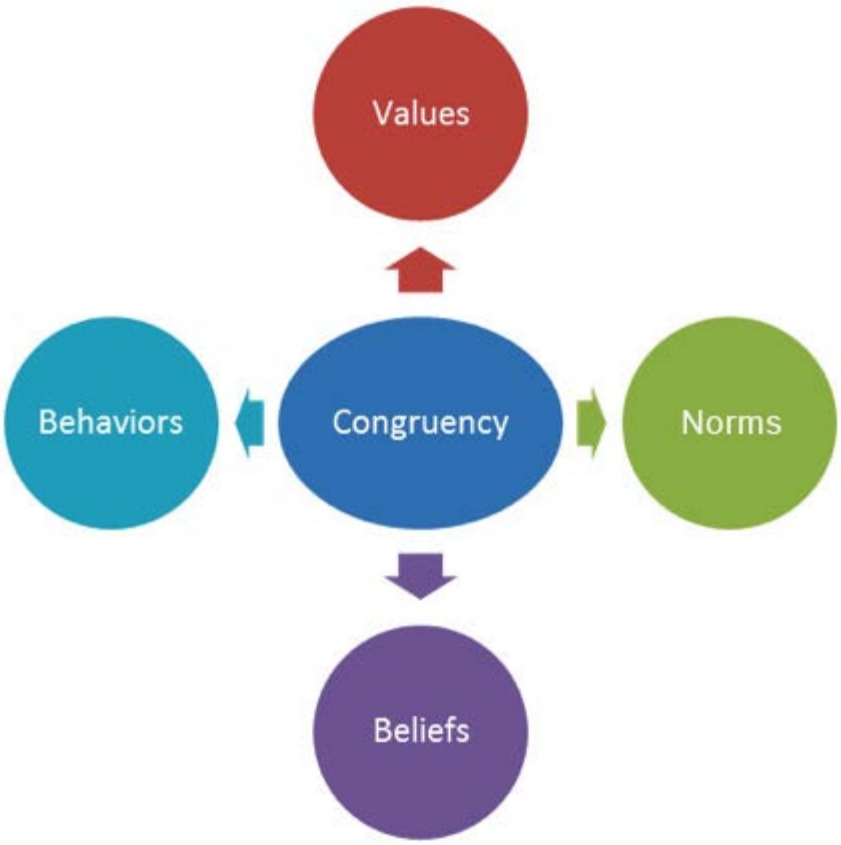
Let's examine the dimensions of a system:



These are things that we are comfortable with. We can track them, build best practices or templates around them, and then replicate those templates. That is much of what the Affordable Care Act, managed care, and other prior models attempt to do.

I want to be very clear here that I am not dismissing the efficacy and importance of systems; I am just pointing out that they do not address these emotional triggers.

Now let's take a look at culture:



Things like social literacy, the entitlement mentality, and, to an extent, even personal competency live in this space.

I think this explains some of the reason why the average American believes everyone should have access to health care; they just resent a mandate to pay for it.

Similarly, if my values and beliefs have been conditioned for generations, leading me to believe I am entitled to my personal lifestyle and that I will not be held accountable for any resulting costs and consequences, then I am not likely to be swayed by a mere intellectual argument telling me that I must change.

Before we can impose a purely systemic solution, we need to address some of the long-embedded cultural norms. Where in our health and health care delivery models is the best place to do that?

The other issue with the individual mandate is that it is compliance-based rather than commitment-based. We don't try to impel you; we compel you. We don't invite you to participate in the solution; we impose it on you.

Compliance is essentially fear-based. When people stay with an organization or support an objective only because they are afraid of the consequences, you will not get their best effort. In

so many cases, compliance models are based on, "Do this or you will be terminated," or compensation or advancement is withheld—a win-lose model. You simply do not get sustained excellent performance by using fear or sanctions.

I could make the same argument with regard to health. If the reward is that you don't get punished and there is not a clear line of sight between consumers changing their behavior and a positive outcome, it is tougher to get sustained positive results.

If you don't provide a perceived personal upside for the change, at least in the short term, it is a push, not a pull.

* Ron Willingham, *Integrity Selling*.

Chapter Fifteen: Change is Hard

Change is a threat when done to me and an opportunity when done with me.

—Rosabeth Moss Kanter

Change is hard, whether as an individual or as an organization. Studies indicate that 90 percent of people resist change. People have many different reasons for resisting change, but the two biggest reasons are that people are unable to make changes without outside assistance and that they don't want to make the change. As you might suspect, there are lots of sub-reasons for both those positions. The problem with most change modalities is that they tend to be one-size-fits-all rather than personalized.

The other irony is that if you do the math, we have met the enemy and he is us—we are part of the 90 percent. It is kind of hard to be an effective change agent when you haven't resolved your own issues. Most of us have a natural resistance to change. Asking others to "do as I say, not as I do" isn't terribly effective role modeling.

Being resistant to change is one of those things to which very few people will openly admit. The status quo has a certain twisted security to it. Change involves risk and ownership.

I have been a change agent for over thirty years and I can't tell you how many times I have been brought in to fix organizations or people. It is not usually a welcome revelation when you share with a manager or leader that they are part of the issue.

We also really like the idea of magic solutions that don't involve any meaningful changes on our part or any work.

Some of my colleagues, especially KeyChange Institute founder Reut Hebron Schwartz, have embraced creating and evangelizing a different model that shows some intriguing results. Their approach involves a combination of brain science, personalization, and congruency.

The 90 percent number representing the change resistant may sound pretty high, but there is significant data that shows many organizations' unwillingness to explore a new way to relate to their stakeholders, including customers, employees, and communities. Add to that the nation's entrenched political gridlock, in which being right seems more important than doing the right thing, and you get a better explanation for why we can't overcome inertia.

Change isn't easy, as an individual or as an organization. The alternative for most organizations isn't very attractive either. I don't think most of us are so invested in the status quo that we want to see our organizations fail or people fail.

As Seth Godin and others have said, change—like other critical initiatives—involves not only acknowledgment of the need for change, but also a willingness to embrace that need and do the work.

We cannot achieve meaningful solutions to today's problems using yesterday's tools. The only way we can successfully change the way we manage health and health care today is by involving all the players; all of them must make changes.

- Individuals need to change their behavioral patterns.
- Health care suppliers need to understand that we need a model based on managing health, not simply delivering health care. They both have a place, but the current model is tilted towards reacting, not pro-acting.
- One of the biggest roadblocks to achieving better overall health and more effective health care is that consumers lack the social literacy to adequately manage their own wellness or to understand and negotiate the health care system. Conversely, institutions haven't given sufficient effort to transparency. The language of health care is byzantine and complex. Most of the governmental interventions are about access and delivery. They don't do much about addressing personal responsibility.
- We still don't have a great systemic solution which identifies a meaningful role for consumer, provider, employer, and government in a collaborative rather than a competitive manner.

We are, in fact, trying to do change *to* rather than *with* people in most of the models I have seen proposed.

Chapter Sixteen: The Recruitment-and-Retention Issue or Opportunity

Among the many things I learned as a human resources manager and executive, these two stand out in the context of this book:

- We hire and retain whole people.

- Increasingly, discerning candidates and employees look at not only the job, but the community and surrounding environment when evaluating whether to take a position or stay with an organization.

The old perception of the company man who would relocate anywhere to advance his career is, if not dead, largely an endangered species. This is especially true with the emerging generations who are more aligned with their personal and career goals than those of the organization.

Very early in my career, I worked for a business in the extraction industry; we mined copper and other metals. As you might suspect, our location was not on the top 100 places to live. My first assignment was in the area of recruitment of the professional technical talent we needed to run our operations. At that time, the competition for top talent was very heated. We didn't have a great hit rate in getting candidates to accept our offers. Some root cause analysis yielded an interesting data point—in many cases it was the spouse who was causing the rejection. We were doing a good job of recruiting the employee, but it was very common to ignore the spouse. It wasn't intentional; it was cultural.

What we found was that the spouses often saw both the fact they were ignored and the fact that they were not well equipped to explore the surrounding community and get a perspective on the available housing, education, health care, transportation, shopping, and recreation. As a result, they developed a negative impression. We found this to be true not only with recruitment, but retention. We would successfully recruit a candidate, only to have the individual terminate employment with us because of the spouse's dissatisfaction with the community.

By recognizing this and changing our model to welcome and accommodate not only the employee, but the family, we saw both our recruitment and retention go up significantly. Interestingly enough, I learned this model as a military brat where frequent relocation was part of my reality.

My point is that if you are in a community that has what is considered to be inferior infrastructure in important dimensions like education and health care, you are in fact at a competitive disadvantage.

I spent much of my youth in what was essentially an agricultural community in Arizona. When I graduated high school there, the "metropolitan" population was probably under 30,000. We took a lot of ribbing from the more cosmopolitan suburbs of Phoenix.

Shortly after I graduated from college and relocated, a high-technology firm was evaluating sites to locate a new production facility—a billion dollar investment. My understanding is that as part of that process, company executives had some very involved conversations with the community leaders about things like transportation, health care, education, and housing.

That community was Chandler, Arizona, and the high technology employer was Intel. Largely because Chandler city officials successfully reached an understanding with Intel back then, Chandler has grown to a population of better than 250,000. The city also enjoys a budget surplus and has been described as one of the best managed municipalities in the country. A recent magazine article described it as the "Silicon Valley of the southwest." Chandler's health care infrastructure and educational infrastructure typically score in the top quartile, if not the top decile, nationally.

Intel recently announced plans to build yet another fabrication facility in Chandler over the next five years or so. The new Intel fabrication plant will bring the number of facilities to three in Chandler and represents an additional $5 billion in investment, not counting the benefits to the community of the direct and indirect employment it will create.

Smart organizations look at these issues systemically. Employees will not relocate or stay in communities with inadequate health care or educational infrastructure.

Studies by the Department of Labor, the Society for Human Resources Management, and others project that over the next decade or so the supply of experienced talent is expected to decrease by 15 to 20 percent while the demand increases by a similar margin.

Relying on your human resources department, social media, or a hip advertising campaign to make up deficiencies in core infrastructure seems pretty ill advised.

A different model can save employers a lot of money and can change people's lives.

The reality is that the issues around health care are, and always have been, societal as well as systemic, and the employer has always had a stakeholder role.

Chapter Seventeen: Exploring a Commitment Model

Since before the Industrial Revolution, we have always been very attached to what I will call a compliance model. In fact, much of our management modeling is based on it. It is what we teach in business schools and in most management and leadership training.

We create expectations, set guidelines, measure, provide feedback, and correct. It is all very linear and precise.

Companies within the health insurance industry are absolute masters of compliance. They have more rules, regulations, and forms than almost any other industry, except insurance or government.

Compliance allows us to ratchet back our expectations around things like social literacy and personal competency. We have rules that explain all that stuff.

But when we apply compliance to health management and health care, we have a kind of schizophrenic relationship with it.

We used the provision of welfare benefits as a means to gain compliance, as I mentioned in a previous chapter, and largely created codependency with our employees around the administrative activities and personal responsibilities of managing their health and health care.

In fact, the insurance industry and human resources profession have seen a great deal of their growth from this model.

I am not singling them out. It is still the primary employee/employer relationship model in use in almost every industry. I would point out, however, that as in the discussion of change models in the last chapter, the compliance model has some inherent flaws.

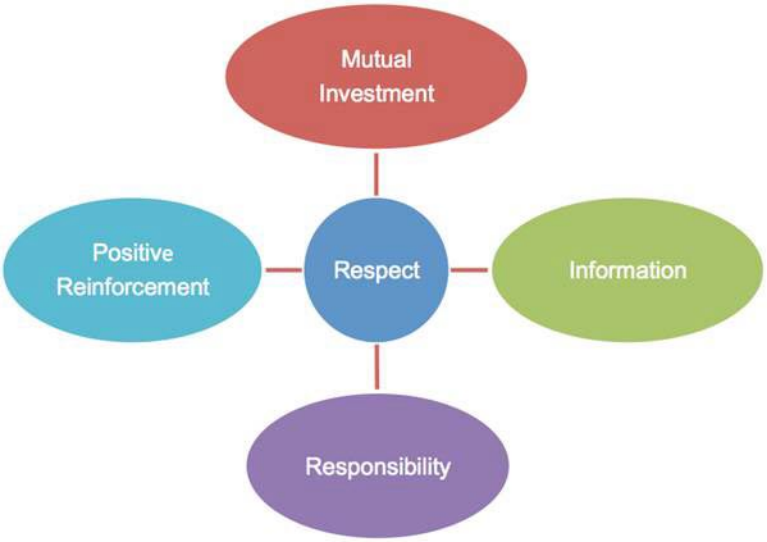
Compliance is essentially fear-based. When people stay with an organization or support an objective only because they are afraid of the consequences, you will not get their best effort. In so many cases, our models are based on withholding compensation or advancement and threatening termination. This is a win-lose model. You simply do not get sustained excellent performance by using fear or sanctions.

In many ways that is how we are approaching the management of health and health care delivery.

- If you don't sign up, we will fine you.
- If you don't follow certain best practices or procedures as a health care provider, we will reduce your reimbursements.

A number of years ago, I began experimenting with a different approach to managing relationships that I refer to as moving from Compliance to Commitment™.* I intuitively believe that if you provide employees, and people in general, with a less adversarial-based model and give them a positive reason to do what you ask and clear infrastructure to use in doing it, you will get and sustain better results.

My model is based on five elements:



The foundation of the model is respect and personal competency. I treat you and expect you to operate like an adult. We may not be organizational peers, but we have equal standing as people. Based on that equal standing, I will provide you with clear expectations, constructive feedback, equitable rewards, context, and all those other things that lead to a productive relationship.

In the event I am forced to introduce change into your environment, I try to do it *with* you rather than *to* you. At minimum, I provide you some type of context.

I am not going to spend a lot of time on this model here. If you feel it is something worth exploring, my website is replete with more information, and I have published a couple of other books on this topic.

The net result of this kind of a model is that it creates an environment that we now refer to as *employee engagement*. Unless you have been living in an underground bomb shelter, you have been unable to avoid at least some contact with the theories and information regarding the benefits of high employee engagement versus a moderately or under-engaged workforce.

We have failed in applying these principles to managing health and health care. That is a significant missed opportunity.

By not providing and requiring employees to play a meaningful role in the management of their health, I think we have been disrespectful. By not providing them with information about things they can do to participate in managing their own health and contributing to the overall benefit of

the organization, we have withheld information. By not holding them accountable to take those actions and by creating entitlement and codependency, we have withheld responsibility. By not endeavoring to solve root causes, reduce costs, and improve quality of life and work environment, we haven't equitably rewarded them.

The sum of all these things is that we have not made mutual investments in them as individuals rather than as human capital or an asset.

I despise the terms "human capital" and "human assets." They seem very impersonal and cold to me. On the other hand, I also deplore the waste of human potential. It seems to me that we have an opportunity to explore a different paradigm and to see ourselves as stewards of this particular resource as much as we care for clean water, air, and other precious resources.

Maybe I am being overly simplistic, but I believe that examining the way people and organizations work together allows us to contribute to sustainability as much as green building and other methodologies.

* Mark F. Herbert, *One Man's Journey–Managing Whole People*.

Part Three: Exploring Alternatives

There are different ways to address this issue in a more systemic fashion—ways that have been successfully embraced by progressive organizations that have not only helped them reduce their expenditures in the costs of providing health care to their employees and dependents, but also yielded other ancillary benefits.

The common characteristics of these programs are that they are systemic. The employer has embraced both the program's role and the role of the employee/consumer in the process. The employer has also recognized that it is a continuous process rather than a singular event.

These successes are not limited to large organizations nor do they have to be prohibitively expensive.

This section deals with some proactive actions that can be taken by organizations.

Chapter Eighteen: Applying What We Learned from Total Quality Management

There is an opportunity to apply systemic and cultural solutions to the way we manage health care. The key is to apply both.

Reimbursement for outcomes is superior to payment for processes. I learned this working in a manufacturing and operational environment.

We were taught those lessons by international competition, which resulted in many of the innovations represented by total quality management (TQM). Interestingly, some of those concepts involve a shift from vendor to partner in key relationships, the recognition of customers as the real definers of quality, and the significant role that employees could play in identifying and improving processes and outcomes—a stakeholder model.

Dr. Bohmer, in his IdeaCast from Harvard Business Review, mentions some of these lessons that I think have application on the supplier side.

Health care currently is delivered and defined, in his opinion, as a series of separate events beginning with diagnosis and proceeding through treatment and follow-up. He argues that health care delivery and costing should be based on outcomes rather than the way we currently track and price it. It is kind of like lean manufacturing or total quality; success is determined by outcome not process.

There are significant opportunities for improvements in efficiency and outcomes there, but that isn't my area of expertise so I won't spend a bunch of time there. The current debate around health care is largely focused on this perception, and in my opinion, it is overheated and fueled

by tremendous blame and frustration on the part of almost everyone involved.

The public and much of the government have embraced the notion that our delivery system is overpriced, inefficient, and rewarding insurers and providers at inappropriate rates for less than optimal outcomes. They may be right.

The employer sector has historically played the role of payer to a great extent. Employers see themselves as being peripheral to the actual health care/health maintenance process. Many public and private employers have stated, "We are not in the health care business." I would disagree.

When we are giving up a 40 percent GDP advantage and many organizations indicate that providing for health care related benefits are impacting profitability and sustainability, how can we pretend we aren't a significant stakeholder?

After unsuccessfully trying to minimize increased competition from postwar Japan and German through tariffs and trade restrictions, we began doing the work of improving our processes and building better products.

The amusing thing is that what we referred to as "Japanese management techniques" were largely created in the United States in the 1940s, but we didn't adopt them because we didn't have a compelling need to be more efficient then. The Japanese and Germans built these techniques right into the fabric of their processes as they rebuilt their factories.

One of the most compelling concepts of TQM is the necessity to address root causes. Don't inspect quality in; build it into your process and your product.

That is a big part of the issue I have with focusing our energies almost exclusively on health care delivery. We are ignoring root causes and leaving 60 percent of the opportunity (behavior and health management) on the table.

Is it just me, or does that seem dumb?

Chapter Nineteen: My Personal Experiences

Over thirty years ago, as a young human resources manager, I saw this play out. Organizations had just begun to recognize the opportunity costs of unmanaged health care expenditures on both the occupational and non-occupational sides of delivering health care.

My employer had previously implemented a gainsharing plan for our employees. Also referred to as a Scanlon Plan, these plans are a kind of suggestion/cost-sharing program where if you are able to reduce the costs of production over historical performance, then a portion of those savings are distributed to employees. My boss and I decided to take a radical step and introduce the idea of costs savings from accidents and injuries as well as health care expenditures into the bonus pool. To be sure, it required some education—not only with employees, but also their dependents—but the results were great.

Employees and their dependents actually bought into the program and began questioning bills and procedures, checking for mistakes and other things that reduced our expenses, and reducing our need to shift costs by increasing co-pays, raising deductibles, and other compliance-style solutions.

Across town were a number of very traditional firms, including Stanley Works, Fafnir Bearing, and other manufacturing organizations. They were, of course, heavily unionized.

Their approach was to announce to unions that changes to the health care benefits were going to be required as part of cost reduction. The net result was that both those organizations experienced their first work stoppages (strikes) in over a decade.

I still remember the Chairman of the Board of Stanley Works asking me how we managed to make our changes and looking at me incredulously.

Their approach was exclusively systemic; ours took culture into account as well.

Fast forward almost ten years later and I found myself working on the other side of the country with a technology firm. Like many other organizations, we found that our expenditures for health care on both the occupational (worker's compensation) and non-occupational sides were becoming a significant line item.

At that time, conventional wisdom was that a way to deal with at least the non-occupational side was to move to self-insurance, which allows you to capture administrative efficiencies (cut out the insurer) and move yourself beyond the jurisdiction of the states regarding certain kinds of mandated care—the most typical being substance abuse and mental health.

If you have a large, sophisticated infrastructure and the right numbers, this can be a good strategy.

There are also risks. When you move to self-insurance, you become a fiduciary. In layman's terms, it means you become legally responsible for things like adjudicating claims and complying with the myriad regulations. The problem with dropping coverage is that the underlying issues that cause the need for those treatments don't go away.

We took a risk and decided to take a different approach. Because we were essentially in one location, we opted to partner with our health care providers through our insured relationship and apply some of the same process improvement techniques from TQM that we used in our manufacturing processes.

The results were pretty compelling. By identifying root causes and targeting high-risk areas in our manufacturing processes, we were able to reduce our expenditures for occupational related costs by hundreds of thousands of dollars in a twenty-four month period.

Similarly, by identifying the top medical issues for not only employees, but also their dependents, and carrying out an aggressive campaign of education and ongoing communication with those employees and dependents, we saved hundreds of thousands on the non-occupational side.

This was before the advent of electronic medical records (EMR).

We did not invade our employee's privacy or gain illegal or unethical access to their medical records or conditions. We identified behavioral risk/lifestyle changes and we worked with the health care infrastructure to educate our employees and their dependents.

To put it in perspective, at a time when medical inflation (and health care premiums) was accelerating at rates of 13 to 14 percent annually, we enjoyed minimal or no rate increases without reducing coverage, increasing co-pays, or implementing other typical strategies. It gave us a significant competitive advantage and gained us national recognition.

As with the previous example, it was not done in a vacuum but rather as part of a broader strategy to engage our employees before that phrase became a popular part of the vernacular.

Chapter Twenty: Other Significant Employer Successes

Beaumont Health System has seen annualized reductions in per capita health spending ranging from 5 percent to 14 percent in a three-year period.

Johnson & Johnson saw similar results with a health care spending reduction of $250 million between 2002 and 2008, a return of $2.70 for every dollar invested in integrated wellness.

A study conducted jointly by the University of Michigan and Summit Health care systems in 2008 demonstrated the ROI (return on investment) from a well-integrated health management/wellness strategy can approach three dollars to every one invested. That's a 300 percent return.

I have seen other information provided by WebMD from organizations representing multiple sectors of the economy with similar results.

The key in each case is that the employers saw themselves as stakeholders in the process and typically embraced a strategy that combined five distinct elements:

- Education about health and healthier lifestyles for employees and dependents.
- Changes in nutritional and eating habits.
- Exercise and movement.
- Ongoing consumer/employee engagement and reinforcement.
- Financial and other incentivization programs.

Other significant factors include work environment, quality of management, and some non-health care causes.

Studies from the American Medical Association indicate that in 2010, 17 percent of the costs of health care delivered in the US, or $178 billion dollars, were directly or indirectly associated with obesity. That's obesity as a function of lifestyle, not from organic causes

The American Mental Health Association indicated we lose another $70 billion to emotional health issues, depression, and substance abuse.

Don't forget the:

- 400 percent higher accident rate.
- 300 percent higher rate of absenteeism.

- 500 percent higher rate of injury.

- 300 percent higher medical claim rate for employees with substance abuse issues.

All of the above are attributable to emotional health issues and the fact that substance abusers also typically operate at productivity levels 34 percent lower than their sober counterparts. These are costs largely beyond health care premiums.

Health care delivery does not address these issues. Instead, they get dealt with in your workplace or the emergency room.

The other key is that the models are *integrated*, not serial.

Much of this data and several of the solutions I describe have been addressed in a series of webcasts available from WebMD. They maintain an excellent website with an abundance of solutions and materials, including archives of previous webcasts (https://webmdhealthservices.webex.com).

Chapter Twenty-One: Solutions for Small Employers

Many small businesses, almost feel helpless about the escalating costs. If you aren't a decent-size group, you probably feel like you have little or no impact on your health care costs and premiums. Many smaller employers have had to substantially increase the cost share that their employees are paying to have coverage for themselves or their dependents. Some even examine dropping coverage altogether. I know employers who are considering dropping coverage not because they want to, but because they feel they can no longer afford to provide it.

Here are some things you can do as a small business:

- Educate your employees. We have been providing employees with health care for years. In many cases they have little idea about how it works and how much it costs, and they don't care! If I have never had to participate in the costs and have no idea how much premiums go up or if they do, why should I care?
- If you had a production or quality issue, you would in all likelihood ask your employees for help in fixing it. (If you aren't already doing this, you should be). Why not do the same with health care?
- Contract with an employee assistance plan (EAP), preferably one with a wellness component. Employee assistance plans have been around for years. Originally, people thought of them as kind of an in-house school nurse or therapist. Good ones are way more sophisticated than that.
    - A good EAP can help your employees and their dependents address stresses such as alcohol and substance abuse much more cost-effectively than your insurance provider can. In many cases, the EAP can act as a gatekeeper to get your people the right intervention. Most are funded in such a way that they are motivated to do this efficiently. They provide services for a set fee, not an open check book. Many EAPs today also include wellness programs. These are programs that involve health care screening, exercise and diet, and other lifestyle management interventions that help your employees and their families catch and address issues before they become problems. A gym membership is way cheaper than a bypass surgery. In fact, estimates say that 60 percent of our health care costs are lifestyle related rather than organic disease-based! EAP counselors can also help you identify hot spots in your organization. If a disproportionate share of your employees or dependents use their services, you can look for root causes. If a particular supervisor or manager has extremely high turnover or other issues cropping up in one department or division, the problem may not be the employees.
- Look at incentives. It may sound crazy, but incentivizing your employees to utilize things like discounted gym memberships, smoking cessation programs, weight loss, and safety campaigns can save you big bucks. When employees understand that health care costs affect the dollars you have available to pay wages, make investments in technology and capital, and give pay increases, it makes a stunningly positive difference. Once you have successfully explained to them how they can help themselves by helping you, they

become your partners, not your dependents.

- Hire and train good supervisors. I have been a practicing human resources professional for decades, and we have a truism that "people join companies and leave managers." Poor supervisors and managers cost businesses millions every year in turnover and lost productivity. Make sure that when you hire or promote someone they have the right skill set. This doesn't have to be horribly expensive. You can either hire these skills or, in many cases, provide excellent supervisory training available through your local chamber of commerce or community college. Executive coaching is great, but most of your employees don't work for an executive. Poor front-line supervision is relatively cheap to fix.
- Engage your employees. Engaged employees see themselves as being in partnership with you. They care about your organization, your customers, and your goals. They are committed, not compliant. Engagement isn't a big company phenomenon. It requires trust, respect, responsibility, information, rewards, and mutual loyalty.

Chapter Twenty-Two: The Sustainability Factor

Employers of all sizes say that continuing to provide health care to their employees with costs rising at triple the rate of wage inflation is not sustainable. I agree with them, but I have to question how pushing delivery of care to the least efficient point of delivery represents a meaningful solution.

Research tells me that integrated health and wellness strategies can result in savings as high as 5 to 14 percent annually per employee and have ancillary benefits like increased personal and job satisfaction, as well as increased productivity.

Remember, Johnson & Johnson *recovered* $250 million over a five-year period. That represents a quarter of a billion dollars available for *redeployment* to other parts of the organization.

If we were to apply that methodology to communities and address not only access to care, but the costs of delivering care, isn't that an indirect form of increasing sustainability?

It is estimated that we lose $200 billion annually to presenteeism, people performing at less than optimal levels because of job-related stress, dissatisfaction, etc.

Other studies say we have a 4 percent productivity drain based on accidents and injuries, absenteeism, and other behavioral health issues. What if we could recover all or part of those opportunity costs? Isn't that a form of sustainability as well?

The key word in these solutions is *integrated*.

The effectiveness of health management and wellness programs go up exponentially when you incorporate *all* of the elements.

Education and information only go so far. In many organizations, the participants in stand-alone wellness strategies are the healthiest employees. They already get it. They are believers. They watch their diet, exercise, and see their physician annually.

Most communication strategies consist of a health fair coincident with annual open enrollment in the employer-sponsored benefit program. Some organizations may take it so far as to send a quarterly health care publication. I am not knocking that; I actually applaud it. I just think we need to go further.

Why an *integrated engagement* approach? A study by WebMD of 36,000 employees indicated that a wellness strategy that includes both wellness and incentivization resulted in 70 percent of survey participants indicating a high likelihood of participation. Wellness + communication + financial incentives increased participation by 78 percent.

Full integration isn't just additive; it is exponentially more effective.

I have spent over three decades as what we call in the business a "change agent." I can tell you that one of the most difficult things to overcome in any organization is inertia. We have embedded behavior in individuals for generations. Simply announcing a change isn't going to cause it to occur.

Remember my old friend the entitlement mentality? We have generations who have grown up believing it is their right to smoke, that obesity should be a protected class, and that what I do on my own time (drugs and alcohol) are my business.

I recognize that there are indeed individuals who experience obesity as part of a medical condition, but I would submit they do not represent the majority. Similarly, much of type 2 diabetes is caused by lifestyle, not genetics.

I smoked for over twenty years. It was stupid. The packaging clearly says, "Yo dumbass, this will kill you." As I became a parent, among other things, I recognized and embraced lifestyle changes.

Research shows that the average American benefits from financial incentivization to change their behavior. The research also shows that those incentives must eventually provide both positive and negative reinforcement. In simple English, that means the best incentivization includes both the carrot and the stick.

Great incentives reward the behavior change initially, but they also build in consequences for choosing not to participate in the management of your health. This speaks to my incorporation of personal competency and responsibility back into the equation.

I think there is a significant difference in saying to someone, "We will not cover you because of a genetic predisposition or health condition you have no control over," and saying, "If you choose to smoke, avoid exercise, and generally contribute to long-term deterioration of your health, you will be given an opportunity to more fully share the resulting costs."

As a human resources executive, other than people who were affected by economic conditions or poor hiring, I never "fired" an employee. Employees who were provided with clear expectations, feedback about necessary changes in their behavior or performance, and elected not to make those changes were making a cognitive choice. I just facilitated their opportunity to find an environment that fit their choices better.

Examining the way that people and organizations work together allows us to contribute to sustainability as much as green building and other methodologies.

If you believe the data I shared with you earlier, we are giving up a sizable part of our GDP (17 percent versus 11 percent) to other industrial countries. That represents a 40 percent advantage to them. If we examine it a little more closely, it is even worse. The 6 percent between the US and Switzerland isn't an apples-to-apples comparison in actual dollars. I would daresay our GDP is a bunch bigger, so what we are conceding is even more significant.

How do we believe we can continue to yield this kind of competitive advantage or think we can address it by outsourcing or offshoring our production capacity and maintain our economic efficacy?

This is kind of like saying that the stock market is up and C-level compensation is increasing at over 20 percent per annum so we don't have any issues. That is the current thinking of our distribution methodology for health care. "The market will take care of it." The market hasn't.

Top-performing organizations have recognized that by using integrated methodologies, they enjoy enormous competitive advantages both domestically and internationally. Not only do the savings directly and indirectly contribute to their bottom line, they also reap ancillary benefits in employee engagement, retention, recruitment, and other factors. The employees see themselves as partners in the equation.

Chapter Twenty-Three: Exploring a Societal Model

When we look at some of the issues facing health and health care reform, I find myself concurring with renowned physician, scientist, and philanthropist Dr. Leroy Hood and his thought partner Valerie Logan, who identified several key parameters to frame their vision of scientific education in the State of Washington.

They stated that the solutions must be:

- Strategic
- Systemic
- Sustainable
- Societal

In exploring the societal dimension, Hood spelled out the importance of recognizing stakeholders in the educational system and process.

Hood's parameters are no less relevant or applicable to health and health care.

Health and health care are indeed societal issues. The poor and the sick don't just go away. The issues are also much broader than just "who pays". We are experiencing critical issues in our ability to deliver health care both now and in the future because of shortages of trained health care professionals. Over the next ten to fifteen years, those shortages could become acute if they are not addressed in the near term.

If you look at some of the issues we have explored in earlier chapters, no one dimension of our society is well positioned to address all of the issues we have identified.

The provider community can certainly address some of the issues around system delivery, and government can go a long way to define outcomes versus process.

The issues around things like social literacy, the entitlement mentality, consumer/patient education, and creating behavioral and financial incentives are going to require collaboration with employers and the educational sector.

This week, I read articles in the *Journal of Healthcare Management* that further reinforce my thinking.

An executive with a significant health care provider described the fact that most of the proposals for Accountable Care Organizations (ACOs) are coming from hospital or health care organizations.

One of his cautions to organizations considering such a move is that while implementing best practices and procedural changes can indeed affect costs and outcomes, they do not address patient behavior. Simply put, if the patient doesn't follow the caregivers' instructions, either because of social literacy issues or simple apathy, their health is unlikely to improve.

My research tells me that upwards of 60 percent of health-related costs are directly or indirectly related to patient/consumer behavior. Accountable care simply doesn't address that.

A better model, in my opinion and those of many health care professionals, is the medical home model. This parallels the primary care physician model some of us may remember from the old managed care plans.

A health care provider, typically a primary care physician, acts as a gatekeeper/guide to channel your care. They have a comprehensive view of your health and required health care interventions. Once again, however, this model is based on proactive contact between consumer and caregiver. How many of us really follow through with the recommended annual visit to our physician, especially those with a high deductible or no health insurance at all?

The upside of this model is that it incorporates relationship and partnership. The literature would tell you that although employee/consumers like getting information from multiple channels, their most preferred channel is their health care provider.

One of the challenges of this model is the growing health care provider shortage, especially in areas like primary care. Another is the situation that arises if, because you have lost coverage and your primary care provider, your primary care physician becomes the attending doctor in your local emergency room. They don't usually have a lot of time to discuss a health management strategy with each person they treat.

A secondary issue is access to primary care providers for rural residents. At least in that particular arena, some of the advances we have made in telemedicine and other technologies make virtual connection possible. It has also done some amazing things with allowing connection points between facilities providing limited or critical access and facilities providing tertiary or specialized care.

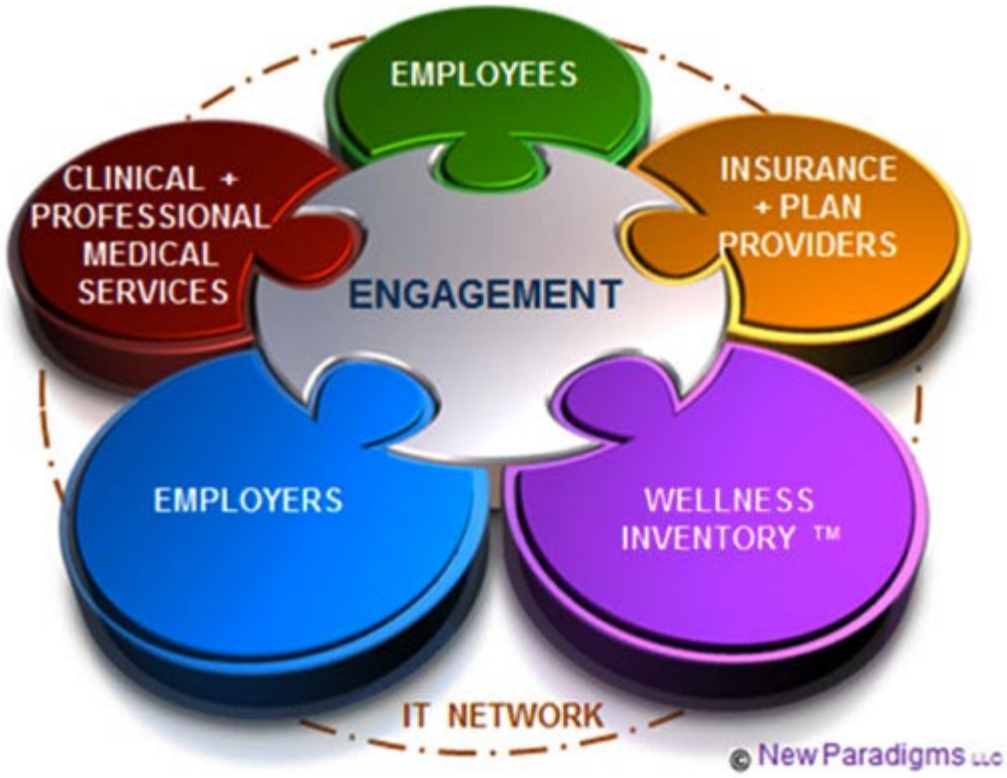
When it comes to disseminating information, the employer is definitely in the best position. We can, or at least should, interact with our employees on a regular basis—much more frequently than their health care provider.

I am not suggesting we get fully into the health care business, although there are large employers that are offering on-site clinics for routine care, but rather we can facilitate the flow of information and definitely play a significant role in education, reinforcement, and incentivization to change behavior.

We can also provide key insights from our experiences in developing strategic partnerships with vendors and key suppliers to build quality in rather than inspect it in, a process in which the

health care community is behind.

A fully integrated health care model could look something like this:



Most of the current models are heavily technology- and compliance-based. These are important elements, but they do not address the consumer/patient behavior accounting for 60 percent of the costs for delivering health. Sustained behavior modification is essential.

This action plan model is based on two key paradigm changes:

- Recognition and integration of the role of all the stakeholders in the process.
- Transforming employees from a compliant to a committed mindset.

This thinking also incorporates a fundamental shift from a compliance to a commitment mindset, as I describe in my management model, Compliance to Commitment™.

- Respect
- Responsibility
- Information
- Shared Rewards

- Mutual Investment

It also addresses the elements identified in Dr. Hood's recommendations:

- Systemic
- Societal
- Sustainable
- Strategic

Why we would want to walk away from at least exploring a solution with the kind of demonstrated financial returns that an integrated strategy offers—not only singularly, but collectively as a society—when we are yielding such a significant competitive advantage to other industrialized countries?

Chapter Twenty-Four: Other Implications

In a lot of ways, issues that I have discussed here relative to health and health care management are illustrative of much bigger issues we face as a society.

A 2008 study by Cigna provided some pretty startling statistics:

- US workers reported that they spend two to five hours per week resolving personal issues at work, a productivity loss of 5 to 12 percent.

- Sixty-one percent of US workers have reported to work while they were ill or dealing with personal matters.

- Of that group, 62 percent felt that they were noticeably less productive or attentive to their duties.

- Forty-six percent missed at least one day of work in the preceding six months, with 22 percent of those absences related to family matters.

Eric Allenbaugh, a management consultant based in Lake Oswego, Oregon, published an article in 1994 describing the three primary cultures represented in corporate America. He summed them up as:

- **The Glazed Eye Group.** This group is most recognizable through their lack of spirit and vitality. They are adept at explaining why something can't be done, make excuses, and avoid taking risks or being accountable at all costs. Here is the really bad news: Allenbaugh estimates this population at 54 percent of the American workforce, ranging from neutral to mildly negative, they don't take proactive action to improve their situation. Specifically, they don't leave under their own power; they stay and drain the energy out of your organization.

- **The Beady Eyed Group.** This is the group that is actively disengaged. They are your corporate terrorists. They actively seek out the flaws and the negative and spread the wealth, sharing their negative energy and disenchantment with everybody. Although they represent only about 17 percent of the workforce, their impact is disproportionate as they consume huge amounts of managerial energy and investment. They are not interested in finding solutions and improving things. By the way, they are also significantly less likely to seek alternative employment either. Since life sucks, they figure it's all the same. Why go through the work of changing?

- **The Bright Eyed Group.** This is the group you want, period. These folks are engaged and buy into your mission, values, and vision. They embrace change, look for opportunities to improve their skills and aptitudes, and embrace personal accountability. The unfortunate part is that they represent only about 29 percent of the current workforce.

In 2008, a study conducted by international consulting firm BlessingWhite found less than 30 percent of employees were engaged. The same study identified 19 percent as disengaged. But it gets worse; disengaged workers are not the most likely to leave—they "quit and stay."

The same study found that only 27 percent of organizations globally have a formal program or strategy to increase employee engagement, and 19 percent don't even have it on their radar screen.

The studies I have cited here are all from before our current Great Recession. Does anybody believe that the numbers have gotten substantially better as unemployment has increased and the gap between C-level compensation and the compensation of the average worker has grown?

I can assure you they haven't. A 2012 survey reported that over 75 percent of employees surveyed expressed dissatisfaction with some element of their job, their employer, or both.

As an alternative, let's discuss the positive implications of engaging the workforce.

- Hewitt Associates reported that organizations with high engagement showed shareholder returns 19 percent higher than the mean level of performance in 2009.

- Gallup reported that organizations with higher levels of employee engagement were much less likely to see erosion in earnings per share (EPS), even during the recession that began in 2008. In fact, Gallup stopped just short of drawing the conclusion that "…workplace measures like employee engagement might be even more important in predicting organizations' long-term economic success than EPS."

- In examining the best places to work, the Wharton School indicated that high levels of employee satisfaction generate superior long-horizon returns. Other studies from organizations including SHRM, Towers Watson, and Manpower demonstrate the same correlations.

- In 2010, the Hay Group reported that high engagement can improve revenue growth by 250 percent and reduce turnover by as much as 40 percent.

- Seventy percent of organizations with high engagement exited the downturn with higher levels of employee motivation than pre-recession.

- A 2008 study by Development Dimensions International (an international training and consulting firm) indicated that moving an employee's level of engagement from low to high represented a 21 percent increase in individual performance.

- Employees at the highest levels of performance have per capita productivity of 20 percent higher than the average across industries, and offices with high levels of engagement are 43 percent more productive according to studies by the Society for Human Resource Management and the Hay Group.

We are giving up significant competitive advantages in how we manage and deploy our talent.

You will notice that I deliberately refrain from using either "human capital" or "human assets" to describe our employees. I do this because they are people, not an item on a balance sheet.

My experiences is that the same issues that in large part are affecting our expenditures in managing health and health care are being replicated in other parts of our relationships.

We have a huge opportunity to recapture and redeploy literally billions of dollars by using different frameworks for how we work together with other elements of our society and our employees.

I don't say this from an academic perspective; I have actually spent the better part of my career proving these theories out.

So I leave you with some questions to ponder:

- Can we really continue to give away a minimum 40 percent competitive GDP advantage to our competitors in the international marketplace?*

- Do we really want to pass up recapturing a 21 percent productivity increase from 70 percent of our workforce and the $200 billion annually we are giving up to presenteeism?

- Do you really want to give up a potential opportunity to gain 5 to 14 percent of what you are spending on health care annually in just hard costs?

For the judicial "gang of nine" and for the politicians, this is largely an academic exercise. For the rest of us, it is not.

We have a huge opportunity to fix this. Let's stop looking to Washington and create our own solutions collaboratively with our employees and other stakeholders.

*The International Federation of Health Plans, 2012.

About the Author

Mark F. Herbert is a speaker and author with over thirty years of combined C-level executive and management consulting experience in high technology, financial services, healthcare, ecotourism, and non-profits. He is currently a principal in the management consulting firm, New Paradigms LLC, where he specializes in helping organizations effectively and successfully embrace change and engage their workforce.

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Designer: Greg Carter

Editor: Courtney Enzor

Editor-in-Chief: George Schlukbier

Publisher: Bob Butler