

Prevention: The Keystone of Healthcare Reform

Commentary

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key.stone n

1. the stone at the top of an arch. It is the supporting element for the entire arch — without it the arch would collapse. An arch built without a centering keystone is called a *corbella* or false arch.



Note: *The keystone supporting the arch of healthcare reform is Prevention. Specifically, the prevention of early onset disease and disability associated with unhealthy lifestyle choices. Of course, prevention is not the only segment of the arch supporting healthcare reform. The “solution” to the healthcare crisis is horribly complex and involves many areas of concern. HHS Secretary Mike Leavitt’s value-based “Four Cornerstones” approach focusing on information technology, performance measures, transparency, and payment reform is without question a key segment. Likewise, so are issues of access and affordability (subsets of prevention), out-of-control malpractice judgments, and escalating medical liability premiums. From Congress to state houses many are working passionately, eloquently, and tirelessly on these issues. However, fundamental to the solution mix is the need to address and correct the attitude of differed responsibility (personal, corporate, and community), and the sociological, economic, and educational conditions that foster lifestyle choices that adversely impact our healthcare system.*

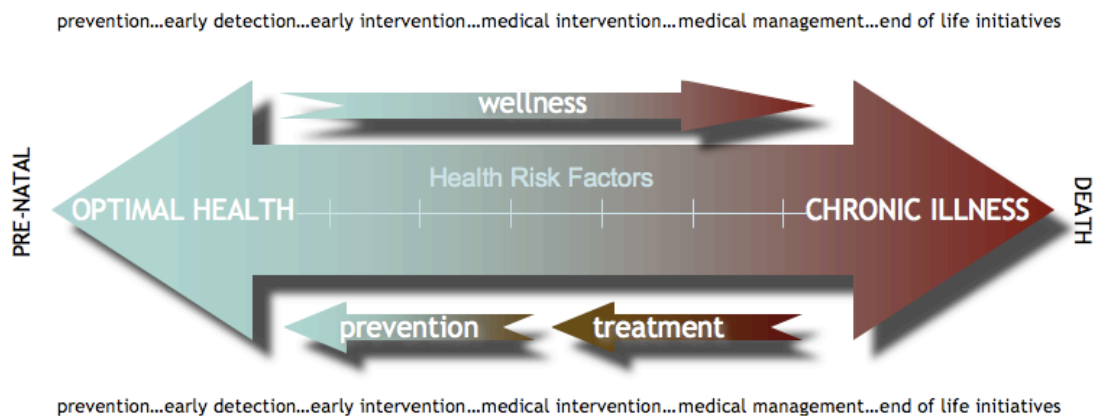
The Treatment Model: Busted, Broken, It Doesn't Work

It doesn't work—our current healthcare system—it doesn't work. No secret, everyone is talking about it, our current healthcare system, it doesn't work. Given an annual bite of \$2.3 trillion in 2007 on a pace to hit \$4.3 trillion by 2012, the U.S. healthcare treatment model is economically unsustainable. People are getting sicker earlier and staying that way longer, productivity at the worksite is down while employer healthcare costs are rising out of control. Teen smoking is creeping back up, obesity is epidemic, and 10 year-old kids are being diagnosed with “adult onset” diabetes. The current healthcare system isn't just breaking, it's broken. So, whom do we blame and who's going to fix it? After all, finger pointing is a national sport, so let the blame begin (continue)! Actually, when judicious identification, removal, and replacement nets positive change, seeking and finding blame is both logical and helpful. In this case, however—our national healthcare crisis—who takes the rap? Who do we kick out? And, whom do we charge with solving the problem: The employers? The pharmaceutical companies? The physicians? The medical centers? The health insurance companies? The lawyers? The government? The answer is: Yes! Anyone else? Did you say, “us, all of us?” Well, if the plural is “us,” the singular must be... ME! What? Me? Now, wait a minute, not me! Sorry, but once again we realize that Pogo was right when he said to Porky, “Yep, son, we have met the enemy and he is us.” We did it and now, we (us, I) have to fix it.

What did I do? Nothing. And, that's a big part of why we are now facing a crisis, a crisis that demands immediate and, some would argue, radical attention. We, as a nation, do nothing or next to nothing on the prevention side of the wellness/sickness continuum while we continually and consistently support the supply side of the treatment industry. We consciously made and make choices that created, sustain, and grow this \$2.3 trillion business. For most Americans, quality healthcare is a given, a birthright, an entitlement program where we are passive participants. For decades we have chosen one role in the healthcare game: To get sick. Fixing and paying? That's

someone else's problem, someone else's responsibility, and someone else's dime. It's been that way since FDR, through Truman, Eisenhower, Kennedy, Johnson, and so on, right up to today. No more. Why? Easy... no more money. Besides, the current system is busted, broken, it doesn't work. Don't believe it? Take a look...

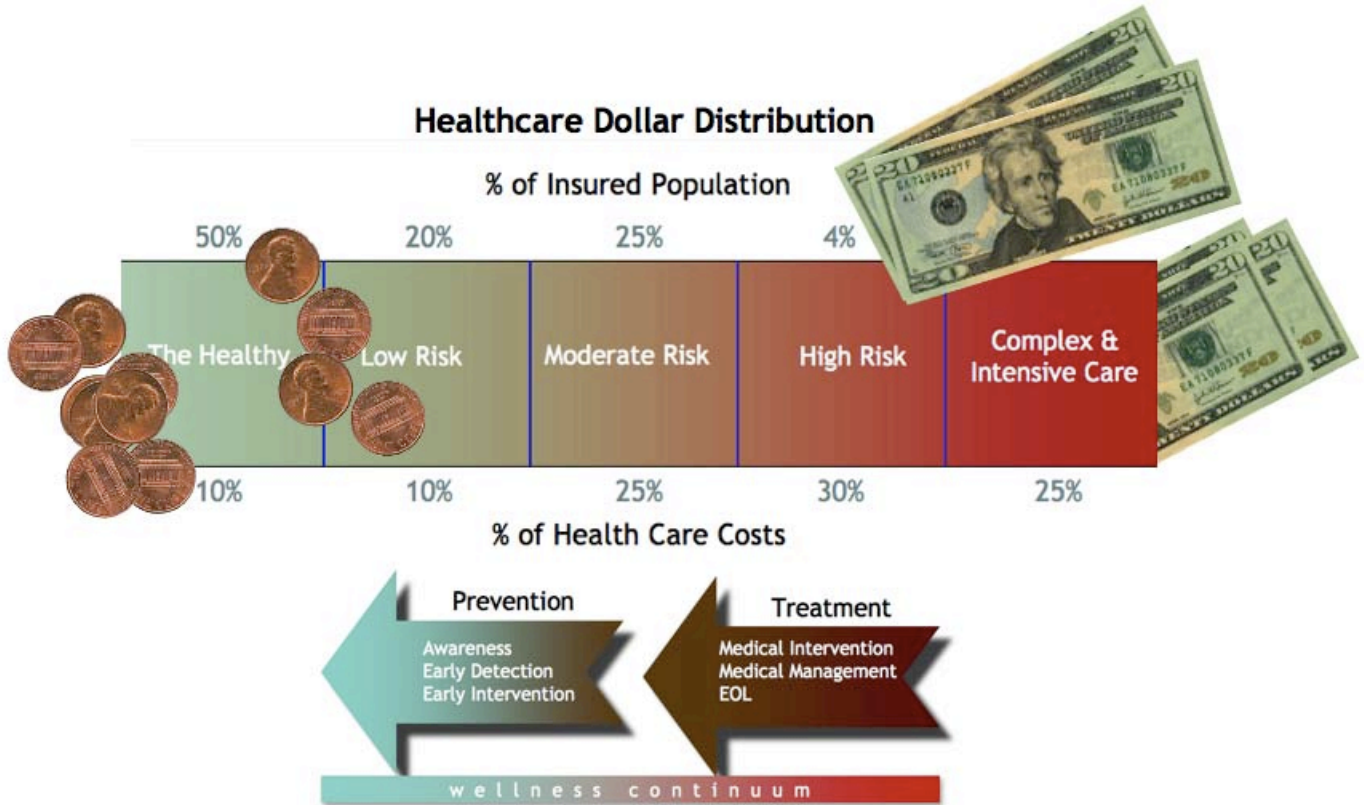
Follow the Money: The Cost & Reward of Doing Business Right of Center



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Ninety-eight percent of the annual \$2.3 trillion (and growing) spent on U.S. healthcare kick-starts and grows dramatically as you move right of center on the above graph. Certainly, everyone vested in the healthcare business espouses the value of keeping and/or driving people left of center toward optimal health (intellectually and morally, how could you not take this position?). The reality, however, is that the status quo—the treatment model—is sustained and advanced due to the enormous power, money, and influence held by those who live and work in the treatment world. Follow the money and you will find centers of excellence (cancer, diabetes, heart, arthritis, stroke, etc.), treatment-focused research grants, enormous malpractice judgments (and corresponding liability insurance rates), practitioner incentives skewed toward quantity vs. quality, medical device hardware and software, specialty pharmacy, and all things curative. Where are the dollars for prevention? Good question. Here are two more good questions: Where are the economic incentives for prevention? How do you shift

the momentum of massive amounts of money, power, and influence to the left on the resource distribution continuum? Answer these questions and you've solved the prevention-funding question.



Prevention: Compressed Morbidity, Economic Relief, & Expanded Quality of Life

Invariably, when discussing prevention, someone will present the argument that disease is inevitable, that you can *manage* but you cannot *prevent* all disease. Assuming a “natural” death, something—heart disease, stroke, cancer—is going to get you in the end. No argument. The issue isn’t *eventual* disease; the issue is *avoidable*, *early onset*, or *premature* disease associated with elected behavior. An extension of that is expanded quality of life for the individual and, if you are an employer, enhanced worker productivity. There was a time when disease had a predictable and fairly uniform path.

In 1935, when President Roosevelt signed the Social Security Act, a newborn baby girl could expect to live until the age of 63, a baby boy, 59. As for infectious illness and disease, once it struck, there was little science to combat the quick advance of tuberculosis, cancer, diabetes, pneumonia, hepatitis, polio, influenza, and heart disease. Same for life extending/saving organ transplants. The first, a kidney transplant, didn't occur until 1966. Today, science and technology are such that—foregoing certain cancers, congenital catastrophes, and dramatic events such as war, homicide, and accidents—a child born in the US can expect to live to 79 or 80. Even with a lifetime of unhealthy habits, most people can expect to live well past the age of 70. Organ transplants, kidney dialysis, bronchial dilators, insulin, gastric bypass surgery, full spectrum antibiotics, chemotherapy, and other assorted machines, drugs, and procedures can counter or delay much of the damage caused by tobacco, poorly managed stress, poor diet, obesity, and sedentary lifestyle. The result is a life characterized by compressed quality and expanded morbidity. On the other hand, wise lifestyle choices fostered and practiced in healthy work, home, school, and community environments results in expanded quality of life and compressed morbidity. Not a great deal of difference in years but how about in the cost of sustaining those years gained since 1935? Huge. So, who pays for the \$300,000 lung transplant, the \$200,000 liver transplant, the \$250,000 heart transplant, the \$20,000 gastric bypass, the \$100,000 specialty drug bills, and the \$28,000,000,000 (billion) annual cost of type II diabetes in the U.S.? Of course, you know the answer: All of us, independent of how we live our lives. The treatment model may not work for some people; however, for those who earn their living on the right side of the healthcare dollar distribution continuum, it is working VERY well, indeed.

A Shift to the Left: A Formula for Chronic Disease Prevention

pre.ven.tion n

1. an action or actions taken to prevent something from taking place.



It is arrogant and presumptuous to suggest that there is a simple solution to a problem of this magnitude. The psychology, sociology, neurobiology, politics, law, and pure economics of the sickcare industry (you know as well as I do that we do not have a *healthcare* system) are horribly complex. However, if there was a silver bullet it would come wrapped in prevention. So, what are we trying to prevent and how do we do it?

Goal: *The prevention of avoidable disease and disability associated with lifestyle choice.*

The Prevention Formula Mix



We often make the assumption that everyone knows the importance of healthy living and the consequences of poor choice. Advertisers will tell you that the simple knowledge of a product or concept is not enough. In the world of product marketing, there is a direct relationship between customer sales and number of distinct product impressions. The more you see or hear about a product the more likely you are to buy it. Same goes for healthy living and the world of social marketing. While it's a sad truth that the average child sees over 40,000 television ads each year, it is also true that during the critical early years leading up to the teens, the most influential people surrounding that child are his or her parents, teachers, and siblings. Positive messages and positive modeling of healthy behavior is critical. As for the physical buildings, homes

must foster healthy choices and schools absolutely must remove high-fat and high-sugar foods from vending machines and cafeterias.



Data shows that even the most affluent and educated among us has challenges when it comes to preventive medical screenings, prescription drug compliance, and comprehensive health insurance coverage. Also, given the high cost of eating well, fewer and fewer households are able to keep cupboards and refrigerators stocked with fresh fruits, fresh vegetables, whole grains, lean meats, fresh fish, and low-fat dairy. Unfortunately, the knowledge that fast food is not the healthy choice is trumped by wallets that are thinning as fast as waistlines are bulging.

It is deplorable that 46 million Americans are uninsured and that among that number are over 8 million children under the age of 18. Not surprisingly, lack of insurance is much more common among people with low incomes. Some 24.4 percent of people with incomes below \$25,000 were uninsured in 2005, almost triple the rate of 8.5 percent among people with incomes over \$75,000. The percentage of Americans who are uninsured rose largely because the percentage of people with employer-sponsored coverage continued to decline, as it has in the past several years.

Table 1. Health Insurance Coverage, 2001 to 2005*

	Uninsured		Medicaid/ SCHIP	Employer- sponsored Insurance	Individually- purchased Insurance	Medicare	Military Health Care
	Number (millions)	Percent	Percent	Percent	Percent	Percent	Percent
2005	46.6	15.9%	13.0%	59.5%	9.1%	13.7%	3.8%
2004	45.3	15.6%	13.0%	59.8%	9.3%	13.6%	3.7%
2003	45.0	15.6%	12.4%	60.4%	9.2%	13.7%	3.5%
2002	43.6	15.2%	11.6%	61.3%	9.3%	13.4%	3.5%
2001	41.2	14.6%	11.2%	62.6%	9.2%	13.5%	3.4%

* Based on Current Population Surveys. Percentages do not sum to 100% because some people have more than one type of coverage.

Table 2. Health Insurance Coverage of Children, 2001 to 2005*

	Uninsured		Medicaid/ SCHIP	Employer- sponsored Insurance	Individually- purchased Insurance	Medicare	Military Health Care
	Number (millions)	Percent	Percent	Percent	Percent	Percent	Percent
2005	8.3	11.2%	26.7%	60.5%	5.5%	0.7%	3.1%
2004	7.9	10.8%	27.0%	61.0%	5.8%	0.7%	2.8%
2003	8.4	11.4%	26.4%	61.2%	5.3%	0.7%	2.7%
2002	8.5	11.6%	23.9%	63.0%	5.3%	0.7%	2.9%
2001	8.5	11.7%	22.7%	63.9%	5.0%	0.6%	3.3%
2000**	8.6	11.9%	20.9%	65.6%	5.0%	0.7%	3.5%
1999	9.3	12.8%	20.3%	64.8%	5.6%	0.5%	2.9%
1998	11.1	15.4%	19.8%	63.3%	5.1%	0.5%	3.1%

* Based on Current Population Surveys. Percentages do not sum to 100% because some people have more than one type of coverage.

** The Census Bureau changed how it determines who is uninsured in 2000, so data before that year are not fully comparable to more recent estimates.



Affordability and access are closely linked; however, even when coverage is available from Medicaid and Medicare, it's not always accessible. In one example, Medicaid enrollment among children is expected to decline in the coming year because of changes enacted earlier in 2006 as part of federal budget-cutting legislation (the Deficit Reduction Act enacted in February, 2006). In particular, one provision of that legislation requires U.S. citizens who are enrolled in, or applying for, Medicaid to document their citizenship by producing documents such as birth certificates or passports. Analyses based on a national representative survey suggest that one to two million U.S. citizens covered by Medicaid, including poor children, pregnant women and mothers, could have their coverage delayed or denied because they do not have these documents readily available. This new requirement is just beginning to be implemented by states, and its impact is not yet known.



The notion that your health is your business and nobody else's may apply to the specifics of your personal health information; however, unless you are paying the full healthcare bill with your

own personal dollars, this notion is out of date, dangerous, and wrong. The financial and social impact of unhealthy lifestyle choice impacts all of us and, therefore, it is all of our business. The days of “I get sick and someone else pays” are quickly coming to an end. Increasingly, a significant portion of costs tied to unhealthy choices will shift to the individual. Similar to auto insurance where premiums are a product of a person’s claims history and driving record, individuals will pay or benefit according to how well they take care of their body (prevention screenings, medical treatment compliance, lifestyle-related illness and disability). Continuing with the analogy, we have one healthcare road, period. Should you choose to drive a semi down that road, that’s your choice. However, at some point (now) those who drive smaller, more fuel-efficient vehicles are going to get tired of paying for the damage and waste caused by your choice. You’ll still be able drive your big car or truck, but you’ll also have to assume your fair share of the bill. Actually—moving back to the real world of healthcare—companies are already beginning to make healthy living a requirement for obtaining and keeping their jobs. Weyco, Inc., a benefits administrator located in Okemos, Michigan, is one of the more frequently referenced examples of this trend toward dictating healthy worksites and workers. Beyond a no *smoking* policy, they have a no *smokers* policy. If you smoke, don’t bother to apply for a job at Weyco, and, if you were a smoker at Weyco beginning in January, 2005, you were given the choice of quitting smoking or losing your job. Michigan, with 1.9 million smokers and one of the highest cigarette taxes in the nation, has no “smoker’s rights law” found in 29 other states, so there isn’t much that employees can do. “We are saying people can smoke if they choose to smoke. That’s their choice,” said Gary Climes, Weyco’s chief financial officer. “But they just can’t work for us.” Other companies are following Weyco’s lead.



A Personal Case History: The Importance of Early Detection & Early Intervention

To the best of her ability—and for as long as I have known her (37 years)—my wife, Hillary, has exemplified healthy living. She does not smoke, maintains a healthy diet, practices good stress management, and exercises regularly.

Because she was diligent with her age-related screenings, she was diagnosed and treated for Lobular Carcinoma In-Situ (LCIS) of the left breast in the spring of 2005. LCIS signals an increased risk for developing invasive breast cancer later on in life. As a result, her screenings went from yearly mammograms to an alternating yearly schedule of MRIs and mammograms. In May of 2008, the MRI led to a needle biopsy and a diagnosis of Ductal Carcinoma In-Situ (DCIS) of the right breast. DCIS is an uncontrolled growth of breast cells and is the earliest stage of breast cancer. The good news is that DCIS is a cancer that doesn't behave like most cancers. DCIS hasn't started to break through normal tissue, which means it's not a life-threatening cancer. It does, however, require fast and aggressive treatment.

In June, 2008, Hillary had a lumpectomy and a sentinel node dissection. Sentinel node dissection is a method of identifying and removing only the lymph nodes that are likely to contain cancerous cells. As expected and prayed for, there was zero node involvement, and the lab results indicated clean margins. A clean margin is a medical term referring to the attempt in surgical oncology to resect a tumor with no portion of the malignant growth—on microscopic examination by a pathologist—extending past a set delineation known as the tumor margin.

Given Hillary's excellent general health, favorable family history, and the early stage/treatment of her cancer, she elected to forego radiation therapy. She made this decision after consulting with her physician and after a great deal of research. However, due to the fact that her tumor was estrogen positive, she is now on Tamoxifen, an anti-estrogen therapy prescribed as a prophylactic/preventive measure. This is a somewhat controversial drug with documented risk for uterine cancer and blood clotting; however, in Hillary's case the risks are minimal. AND, OF COURSE, she will continue to be diligent with her breast self-exams and her annual screenings!

Summary...

Health Management: A Social Contract

Let's be very clear. Society (government, healthcare providers, employers) must take the lead role when it comes to responsibility and accountability. This is a partnership, a social contract whereby—we, the people—voluntarily subjugate the freedom of action we have under the natural state (a state of existence that is not contingent upon man-made laws or beliefs) in order to obtain the benefits provided by the formation of social structures. Building on the philosophy of John Locke, who said that "no one ought to harm another in his life, health, liberty, or possessions," Thomas Jefferson et al, framed our government's responsibility under the umbrella of securing inalienable (natural) rights including "life, liberty and the pursuit of happiness." By obeying man-made laws and complying with accepted standards and mores, we implicitly agree to our part of the social contract. In turn, we have the legal, moral, and ethical ground to demand that the custodians and protectors of our natural rights—our elected officials, medical providers, and employers—be held accountable. This speaks directly to the issue of healthcare access and affordability.

In its simplest form, our social contract requires that society provide:

- awareness of the consequence and benefits of lifestyle choices
- education needed to initiate and sustain healthy living
- access to affordable primary, secondary, and tertiary healthcare
- evidence-based medicine and prevention measures
- supportive infrastructure (city planning, parks, healthy worksites, recreation, green, etc.)

and, when provided with all of the above, individuals representing themselves and their minor dependants are responsible for:

- making healthy choices
- self-exams (paying attention to changes in personal health)
- keeping up with recommended clinical screenings

- seeking timely and appropriate medical attention
- complying with evidence-based recommendations and directives involving lifestyle habits, medications, lab work, and, rehabilitation protocols

Health Management Social Contract

Contract Parties: Society (Government/Medical Providers/ Employer) & Individuals

Responsibilities	
Society (Government/Medical Providers/Employer)	Individual
<ul style="list-style-type: none"> • Awareness • Education • Access • Supportive Infrastructure • Evidence-Based Medicine and Prevention 	<ul style="list-style-type: none"> • Healthy Choices • Self-Observation/Care • Evidence-based Screenings • Timely & Appropriate Attention • Compliance
Penalties	
Society	Individual
<ul style="list-style-type: none"> • Removal from Public Office (Government) • Fines (Employer) • Reduced Reimbursements (Medical) 	<ul style="list-style-type: none"> • Increased Financial Obligation • Compressed Quality of Life/Expanded Morbidity • Potential Criminal Charges (re: care of minors)
Rewards	
Society	Individual
<ul style="list-style-type: none"> • Re-Election (Government) • Tax & Insurance Rate Credits (Employer) • Higher Reimbursements (Medical) 	<ul style="list-style-type: none"> • Expanded Quality of Life/Compressed Morbidity • Favorable Insurance and Co-Pay Rates • Happier/Healthier Dependents

Future Commentaries...

Future commentaries will take a closer look at healthcare reform as a transformational process. Five separate commentaries will focus on the key “What?” questions:

- What? – Detailed Look at Current U.S. Healthcare Status
- So What? – Short and Long-Term Consequences of a DNA Approach (Do Nothing at All)
- What Now? – Short-Term Strategy Recommendations
- What Difference Will it Make? – Showing Quantifiable Results
- What’s Next? – A Long-Term Sustainable Strategy

For more information...

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