

Center for Colorado
Policy Studies

University of Colorado at
Colorado Springs

with

Colorado Institute of
Public Policy

Colorado State University

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UNIVERSITY OF COLORADO
AT COLORADO SPRINGS



Colorado's Future: Can Affordable Health Care Be Quality Care?



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Pamela Shockley-Zalabak, PhD, is Chancellor and Professor of Communication at the University of Colorado at Colorado Springs. The author of five books and over 100 articles and productions on

organizational communication, Dr. Shockley's research interests include organizational cultures as they relate to individual employee values and overall organizational effectiveness. Prior to assuming Chancellor responsibilities, Dr. Shockley was Vice Chancellor for Student Success and the founding chair of the UCCS Communication Department. Dr. Shockley is the recipient of the University of Colorado Thomas Jefferson Award, President's Award for Outstanding Service, Chancellor's Award for Distinguished Faculty, the Colorado Speech Communication Association Distinguished Member Award, and the 2003 Colorado Springs Chamber of Commerce ATHENA Women in Business Award.



Daphne Greenwood, PhD, is Professor of Economics and Director of the Center for Colorado Policy Studies at the University of Colorado in Colorado Springs. She served two terms in the Colorado

House of Representatives on the Finance and Health committees and chaired the Finance Committee of Colorado Care. She has been a consultant to the Robert Wood Johnson Foundation on economic impacts of national health insurance, Honors Professor at the Naval Academy, visiting scholar at the U.S. Treasury Department, and corporate economist with Esmark, Inc. Dr. Greenwood has published articles on measuring quality of life through community indicators; health, education, and tax policy; and the distribution of wealth in the U.S.

Welcome to the 4th annual *Colorado's Future* conference, bringing policymakers and interested citizens together with top researchers from universities across the state. This conference is a great example of collaboration between campuses across Colorado and with the private and non-profit sectors. We know that if we spend our energies working together we can be part of building a better Colorado.

I want to applaud two new interdisciplinary centers that are building these bridges — across campuses, across disciplines and with elected and appointed officials. The Center for Colorado Policy Studies at UCCS hosted *Colorado's Future* conferences in 2002 and 2003, and the Colorado Institute for Public Policy at Colorado State University joined as a partner in 2004. We look forward to a long and productive relationship and are happy to have so many visitors from other parts of the state here today, along with members of the Colorado Springs community.

Most of us are worried about balancing budgets these days — but don't want to sacrifice quality to do it. Whether you are an individual dealing with a family budget, a business person meeting a payroll, a university administrator, or a part of state or local government, I know you realize the importance of health care costs in the budget equation. Welcome again to all of you who work in health care and all of you who are interested in finding solutions to the cost / affordability dilemma.

— Pamela Shockley-Zalabak, PhD
Chancellor, University of Colorado at Colorado Springs



This conference is about “win-win” solutions in health care. We come from different perspectives, but I suspect we all agree on the need to think out of the box to find solutions. Health care costs now absorb over 15% of U.S. national income and output compared to less than 5% forty years ago. To put this in perspective, over the same time period the share of income we spend on K-12 education has risen from just over 3% to around 4.5%. Yet many feel we are “throwing money” at education to spend so much.

While spending on K-12 has increased by 50%, spending on health care has tripled. Health is important — but every dollar we spend on health care is a dollar we can't spend on education, the environment, or other areas we also value. We know that good health comes from a clean environment and an educated population as much as it does from treatments and medications, so sacrificing them to pay for more health care may not be such a good deal. And despite having the highest health care spending in the world, we have rising numbers of our population without any — or adequate — insurance coverage. The pressures to expand access to health care are as strong as the pressures to control costs.

When you talk affordability or cost containment, this can raise hackles for practitioners — and patients — about quality of care. Calls for increased access or universal coverage make some think, “*This is going to cost me big — and I'm already paying too much.*” We often face trade-offs between cost, quality, and access. If we only cared about holding down costs and were willing to sacrifice quality or access, finding solutions in health care would not be so hard. Each of our speakers will address ways to get *true* increases in efficiency — holding the line on costs while increasing coverage, access, and quality of care.

— Daphne Greenwood, PhD
Conference Organizer, Center for Colorado Policy Studies

THE CENTER FOR COLORADO POLICY STUDIES, founded in 2000, applies economic principles and research results to critical policy issues at the state and local level. Papers on local growth issues, sustainability, quality of life, tax policy and education finance can be found on our website at <http://web.uccs.edu/ccps>.

Whatever the subject, there is rarely a shortage of opinion in Colorado. But timely, objective, high quality analysis can be in short supply. The Center was established to conduct and promote objective and timely research on issues facing Colorado and its communities.

The Center operates under all laws governing the University of Colorado, including the Rules of the Regents. Statements and publications issued from researchers at the Center or in its conferences do not necessarily reflect the views of the University of Colorado or members of our Advisory Board. Conferences and research are funded by contracts and grants, as well as tax-deductible private donations.

“ . . . several studies of HMOs show low satisfaction and inferior care for sick patients.

HMOs have actually increased Medicare costs.”



David Himmelstein, MD, is Chief of the Division of Social and Community Medicine at Cambridge Hospital and Associate Professor at Harvard Medical School. He graduated from Columbia University's College of Physicians and Surgeons and completed a medical residency at Highland Hospital in Oakland, California, and a fellowship in General Internal Medicine at Harvard. His research focuses on access to medical care, quality of care in for-profit settings, medical bankruptcy, the administrative costs of medical care, and the feasibility of national health insurance. Dr. Himmelstein has authored or co-authored more than 100 journal articles and three books. He co-founded Physicians for a National Health Program (www.pnhp.org).

“Government spending on health care in the U.S. exceeds total spending in any other nation.”

National Health Insurance: *Liberal Benefits and Conservative Spending*

Few would dispute that our health care system is deeply troubled. Forty-six million Americans are completely uninsured, and millions more have inadequate coverage. Employers' premiums are skyrocketing, workers are paying higher co-payments and deductibles, and seniors face soaring out-of-pocket costs. Yet government spending on health care in the U.S. exceeds total spending in any other nation. One reason — even as we deny care to many in need, we perform hundreds of thousands of unnecessary operations and procedures and too often prescribe useless or harmful medications.

In the 35 years since the implementation of Medicare and Medicaid, a welter of patchwork reforms has been tried. All have foundered on a simple dilemma: expanding coverage increases costs unless resources are siphoned from existing care. But with U.S. health care costs nearly double those of any other nation — and rising more rapidly — large infusions of new money are unlikely.

Recent health policies have encouraged an expanded role for investor-owned firms and private insurers. New layers of bureaucrats have invariably overseen the managed care “diet” prescribed for clinicians and patients. But several studies of HMOs show low satisfaction and inferior care for sick patients. HMOs have actually increased Medicare costs.

The fiscal case for national health insurance (NHI) arises from the observation that health care's enormous bureaucratic burden is a peculiarly American phenomenon. Our biggest HMOs keep 20% (even 25%) of premiums for their overhead and profit. Canada's NHI has 1% overhead while our Medicare takes less than 4%. Reducing our bureaucratic apparatus to Canadian levels would save 10% to 15% of current health care spending (at least \$200 billion annually) and fully fund both coverage of the uninsured and upgraded coverage for the underinsured through administrative cost savings.

While NHI would require new taxes, these would be fully offset by decreased insurance premiums and out-of-pocket costs. The additional tax burden would be smaller than is usually appreciated, since almost 60% of U. S. health care spending is already tax supported (vs. roughly 70% in Canada). In addition to direct payments for Medicare, Medicaid, and coverage of military and other government employees, we provide tax breaks worth over \$200 billion annually to private insurance.

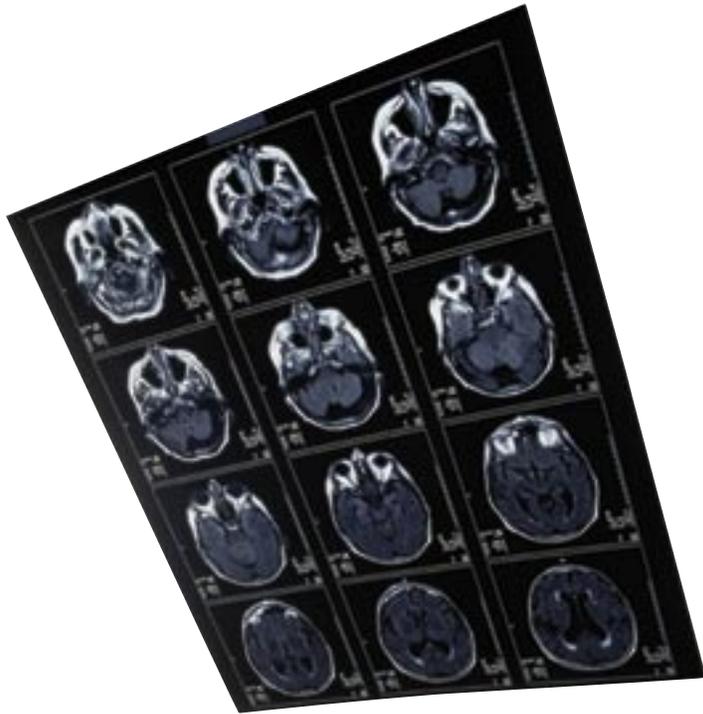
International experience proves that universal coverage is feasible and improves health. Every other developed nation assures health coverage for the entire population. Our infant mortality rate, among the lowest in the world in 1950, is now disturbingly high. We trail other nations on life expectancy and score poorly on measures of premature death.

Surveys have consistently shown wide popular support for national health insurance. Many physicians, including most medical school faculty and deans, now favor a single payer reform. Yet the policy debate is dominated by options that protect insurers and the drug industry rather than the health and wealth of the American people.

National health insurance could solve the cost-vs.-access conflict by slashing bureaucracy — now nearly 30% of our health care budget. It would reorient the way we pay for care and eliminate financial barriers to access. NHI could restore the physician-patient relationship, offer patients a free choice of physicians and hospitals, and free physicians from the bonds of managed care. How many more patchwork reforms must fail? How many more patients must be turned away? How many more trillions of dollars must be squandered on malignant bureaucracy before we adopt the only viable solution — a national health insurance system?

Like people in other nations, Americans want a system that assures care when we need it at an affordable price, that engenders trust and respect, and that affords patients choice. A universal, tax-funded, non-profit national health program organized like Canada's (but better funded) could achieve these goals. We need the liberal benefits and conservative spending that national health insurance would allow.

These remarks have been updated from a commentary in the *Archives of Internal Medicine*, May 13, 2002 (<http://archinte.ama-assn.org/>) by David U. Himmelstein, MD, and Steffie Woolhandler, MD. For more on national health insurance, visit the Physicians for a National Health Program website at www.pnhp.org.

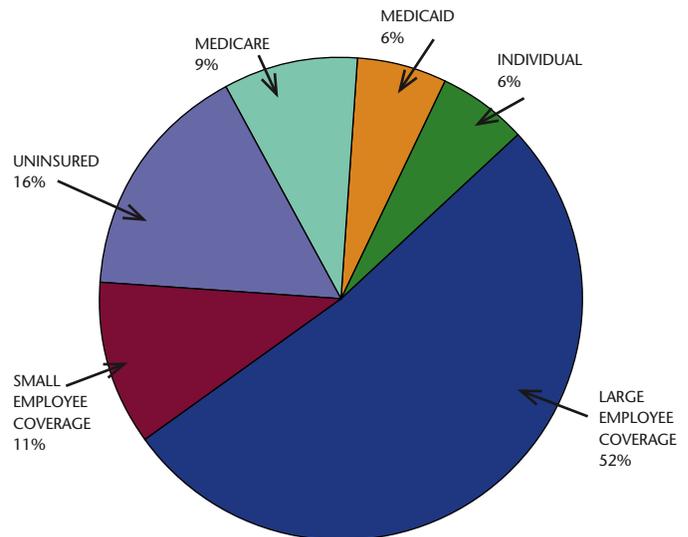


“No matter the kind of insurance system, we have to start making tough choices. New technologies enable extraordinary measures, but I believe that families will increasingly come to grips with quality of life issues and help us decide when it makes sense to take heroic measures and when it doesn’t.”

— Cherie Gorby, panelist

Issues and Choices in Colorado

Policymakers have relied heavily on private market forces to address the tripartite goals of quality, cost, and access to health care in Colorado. With the exception of frail elders and people with significant disabilities in need of on-going long-term care services, Colorado has one of the leanest Medicaid programs in the country. This leanness extends to other publicly funded health programs, including public health initiatives, the Child Health Insurance Program, and public subsidies intended to stimulate the small group insurance market. Since 1994, Colorado has enacted a series of regulatory reform initiatives to stimulate the small group health insurance market. Small firms (1-50 employees) are the market segment in Colorado and nationally that traditionally has experienced the highest rates of market failure. Colorado policymakers’ reliance on market competition has assumed that value (low cost/high quality) will result when insurers are able to compete in a market that is not overly encumbered by regulatory mandates and oversight. The chart below shows the source of health insurance coverage for Coloradans in 2002.*



Pamela P. Hanes, PhD, is President and CEO of the Colorado Health Institute (www.coloradohealthinstitute.org). She served as Executive Director of the Oregon Health Policy Institute; on the faculty of the Dept. of Public Health and Preventive Medicine at the Oregon Health and Science University; on the faculty of the University of Wisconsin-Madison; as a senior researcher at the Institute for Health and Aging, University of California, San Francisco; as a principal health and welfare consultant to the California Assembly; and as a Fulbright Senior Scholar in Krakow, Poland. She co-founded and was principal investigator to the National Consortium for Health Systems Development.



*Source: 2001-02 Current Population Survey; Medical Expenditure Panel Survey, 2002; Colorado Division of Insurance (DOI) annual small group survey, 2002; 2000 U.S. Census. The small group market includes only policies regulated by DOI, business groups of one, professional employer associations and small governmental entities.

A New Delivery Model for Early Intervention

Our current health care system is structured around illness rather than wellness. Depersonalization, excessive waiting periods, and costly time away from work are frequent road blocks to accessing the system.

In response to employee dissatisfaction and rising health care costs, Beth-El College of Nursing collaborated last year with El Paso County, Colorado (where we are located) to develop a clinic with a unique model of health care delivery for county employees and their families. Several months later, the City of Colorado Springs signed up its employees.

The model of care is one of “patient empowerment” and education. If patients can learn to understand their own bodies, illnesses, and the interventions that will keep them healthy, then their satisfaction will increase and the cost of their care will decrease.

Our clinic has a nurse practitioner structure of care delivery. The nurses staffing it are on our faculty. The medical office assistants are our students. Graduate and undergraduate students provide wellness programs. Our two local hospitals (Memorial and Penrose-St. Francis) provide laboratory, radiology, health promotion, and other services. The nurse practitioners work collaboratively with the patient’s physician to promote quality care. An important aspect of the model of care is that it maximizes how we utilize the skills and education of different health care providers in a cost-effective way.

A major success factor for the clinic is that the county and city are “self insured.” As a result, cost savings are realized immediately by the employer. Initial data analysis indicates that significant savings result from deferred office visits, deferred emergency room visits, and less time away from work. We expect that health of the employees will also improve due to our health promotion activities. But this will take a longer time frame to actually measure.

Although cost savings were an important goal, the greatest reward for all the project collaborators has been the high level of satisfaction. Patients evaluate their visit on a 1-5 measurement scale and provide written comments. Most evaluate the clinic at a 5 (the highest) level. Comments like “the best health care I have ever received” are not unusual. Patients who couldn’t get an appointment with their primary care provider for six weeks were able to walk into the clinic on the same day they had a problem.

As the project continues, more data will be available, and we will continue to analyze success factors.



Carole Schoffstall, PhD, is the Dean of Beth-El College of Nursing and Health Sciences at the University of Colorado at Colorado Springs (<http://web.uccs.edu/bethel/>). Dr. Schoffstall started the BSN program at Clayton State College in Georgia; initiated several new programs at Beth-El, including a health science degree program and an MSN; and facilitated the merger of Beth-El with UCCS. She serves on numerous local boards and task force groups promoting a healthy

Colorado Springs and has traveled to Tibet to pursue cross-cultural health care and traditional healing.

Improving Quality in Changing Times: Health Outcomes

Public opinion and research evidence support the perception that the quality of health care in the United States is sub-optimal. Efforts to improve quality can be directed at four levels, individually or in combination: the patient, the clinician, the practice or hospital microsystem, and the larger health care delivery macrosystem. Research at the Colorado Health Outcomes Program (COHO) of the University of Colorado Health Sciences Center (www.uchsc.edu/coho) is addressing quality at many of these levels.

Patients assert control over the quality of health care through their decisions to accept, modify, or ignore medical advice. COHO research emphasizes the role of information technology in helping patients make more informed decisions about their health. COHO investigators have shown that sharing medical records with heart failure patients increases self-efficacy and adherence, while direct email links with clinicians are used judiciously and improve satisfaction with communication. We are currently assessing a web-based patient portal to assist individuals with diabetes in setting their own goals for self-care.

Nationally, many efforts have been made to improve quality by changing the practice patterns of clinicians. Such interventions have been only modestly successful and are difficult to sustain, in large part because physicians are overwhelmed with myriad competing demands and expectations. For this reason, COHO research has not emphasized clinician interventions but has rather focused on interventions to improve microsystems of care. COHO is the data coordinating center for the National Surgical Quality Improvement program of the VA health care system and a comparable program in the private sector. Since this program began in 1994, surgical mortality has fallen by 45% and postoperative morbidity by 28% in the VA system. COHO has also conducted interventions at the practice level in both the public and private sectors to improve primary care and preventive service delivery.

Quality improvement at the macrosystem level involves policy efforts such as expanding health care coverage or using payment policies to improve care. COHO has evaluated one statewide effort to expand coverage for uninsured children in Colorado, the State Child Health Insurance Plan (SCHIP), and has found that accessibility, unmet needs for care, and patient ratings of overall quality improved after enrollment.

Such efforts to improve the quality of health care take place at the interface of biomedicine, public health, and health policy. The necessary tools encompass the sciences of individual behavior change, organizational change, epidemiology, economics, and informatics. COHO’s multidisciplinary approach is designed to apply these tools systematically.



John F. Steiner, MD, MPH, is Professor at the University of Colorado School of Medicine (www.uchsc.edu/sm/) and director of the Colorado Health Outcomes Program (www.uchsc.edu/coho), which conducts and evaluates interventions to improve the quality of health care and population health. His research interests include the design and evaluation of practice-based interventions, with a special emphasis on primary and secondary prevention of cardiovascular disease and disadvantaged and

medically underserved populations. He was a fellow in the Robert Wood Johnson Clinical Scholars Program at the University of Washington.

PANEL DISCUSSION



Marcy Morrison is mayor of Manitou Springs, on the Board of Directors of Memorial Hospital, and a consumer representative to the National Association of Insurance Commissioners. She earlier served on the Manitou Springs School Board, the El Paso County Board of Commissioners, and in the Colorado House of Representatives, where she chaired the House Committee on Health. She has been active in health policy and local environmental and land-use issues, served on a number of state commissions, and received numerous awards at the local, state, and national level, including the American Medical Association's Dr. Nathan Davis Award (2001) as the outstanding state representative from all fifty states.



"We ration health care for the chronically ill today. If you have the money or the insurance, you get it — otherwise you fall by the wayside. With all the resources our country has, we haven't figured out a way to provide quality care for all who need it when they need it."— Marcy Morrison, panelist



The **Hon. Betty Boyd** has represented District 26 in Denver in the Colorado House of Representatives since her election in 2000. She served eight years as a legislative advocate prior to being elected and is now Chair of the House Health and Human Services Committee and a member of its Judiciary Committee. She previously served on the House Finance Committee. She serves on the board of the Jeffco Action Center, the main provider of emergency services to the needy in Jefferson County (CO); and of the Lutheran Family Services of Colorado, an agency providing child welfare, foster care, and adoption services as well as services to seniors and refugees.



Cherie Gorby, RN, MSN, is Senior Administrator of Patient Care and Chief Operating Officer at Memorial Hospital in Colorado Springs, where she has also served as Administrator of Patient Care, Director of Maternal/Child Services, and Clinical Manager of Critical Care. She is an alumna of the Robert Wood Johnson Nurse Executive Fellowship Program, graduating in 2004, and was selected as one of Colorado Springs' Dynamic Women for 2003. She is an active member of several boards, including YMCA of the Pikes Peak Region, Beth-El School of Nursing Advisory Board, and Pikes Peak Integrated Solutions.



Dayna Matthew, BA (Economics), JD, is Associate Professor in the Center for Bioethics and Humanities and Associate Dean of Academic Affairs of the University of Colorado School of Law. She has written articles on fraud and abuse in health care, antitrust in health care, and Medicaid reform, and has taught interdisciplinary courses in bioethics and medical malpractice. As a litigator, she defended medical care providers and corporate manufacturers.

"All Americans contribute to funding medical research and education, developing new medical technology and constructing new facilities. As a result, we have available some of the highest quality care in the world. All Americans should have access to basic care."— Dayna Matthew, panelist

“For too long, insurers have driven us to focus almost solely on keeping costs under control.

But poor quality care is very costly. The recent focus on quality will actually help us control long term costs.

We need to continue in that direction.”

— Jeffrey Oram-Smith, panelist



Jeffrey Oram-Smith, MD, is Chief Medical Officer at Penrose-St. Francis Hospital in Colorado Springs. He has practiced general, vascular, and trauma surgery for 25 years and been involved in managed care as medical director for Total Care of Colorado Springs and on boards of other managed care organizations. In 2003, he became a consultant in the area of physician engagement and quality to both Centura Health and Penrose-St. Francis. He was appointed Medical Director of Quality & Clinical Effectiveness at Penrose-St. Francis before assuming his current position of Chief Medical Officer.



Gary VanderArk, MD, is Professor of Neurosurgery at the University of Colorado Medical School (www.uchsc.edu/sm) and Director of the Neurosurgery Residency Program (www.thecni.org). He started and continues to lead Doctors Care and the Colorado Coalition for the Medically Underserved. He received his BS at Calvin College and his MD at the University of Michigan. He spent three years at Walter Reed Army Medical Center in Washington, D.C. He started the neurosurgical program at Denver Health and Hospital and organized and continues to provide leadership for the Colorado Neurological Institute.



Lorez Meinhold has been the Executive Director of the Colorado Consumer Health Initiative (www.cohealthinitiative.org) since July 2001 and was a founding board member. She was previously with the Colorado Public Interest Research Group (CoPIRG) for 10 years and coordinated and developed CoPIRG's health care issue work. She sits on several boards including consumer representative to the National Association of Insurance Commissioners, Colorado Consumer Insurance Council, Padres Unidos, and Colorado Rural Health Council.

“A 2003 study by RAND Corporation showed patients receiving “best practices” care only 50% of the time. Many patients are not getting the right tests, medicines, and treatments. As providers of health care, we need to reduce errors and educate patients in order to be more efficient.” — Gary VanderArk, panelist



The Colorado's Future conferences bring together researchers from universities across Colorado with state and local policymakers and interested citizens. Our goal is to better link public decision-making with the valuable knowledge base in Colorado's universities. *Colorado's Future: How Can We Meet the Needs of a Changing State?* (2002) addressed topics ranging from quality of life and economic development to education finance and effectiveness. *Colorado's Future: The Challenge of Change* (2003) addressed the use of science in public policy formulation, as well as focusing on water and smart growth issues. *Colorado's Future: Economic Development and Public Policy* (2004) was held at Colorado State University- Fort Collins. Future conferences will alternate between the campuses. Information will be posted on the websites of the Center for Colorado Policy Studies, UCCS (web.uccs.edu/ccps) and the Colorado Institute of Public Policy, CSU (www.cipp.colostate.edu). Please contact us if you are interested in sponsorship or particular conference topics in the future.

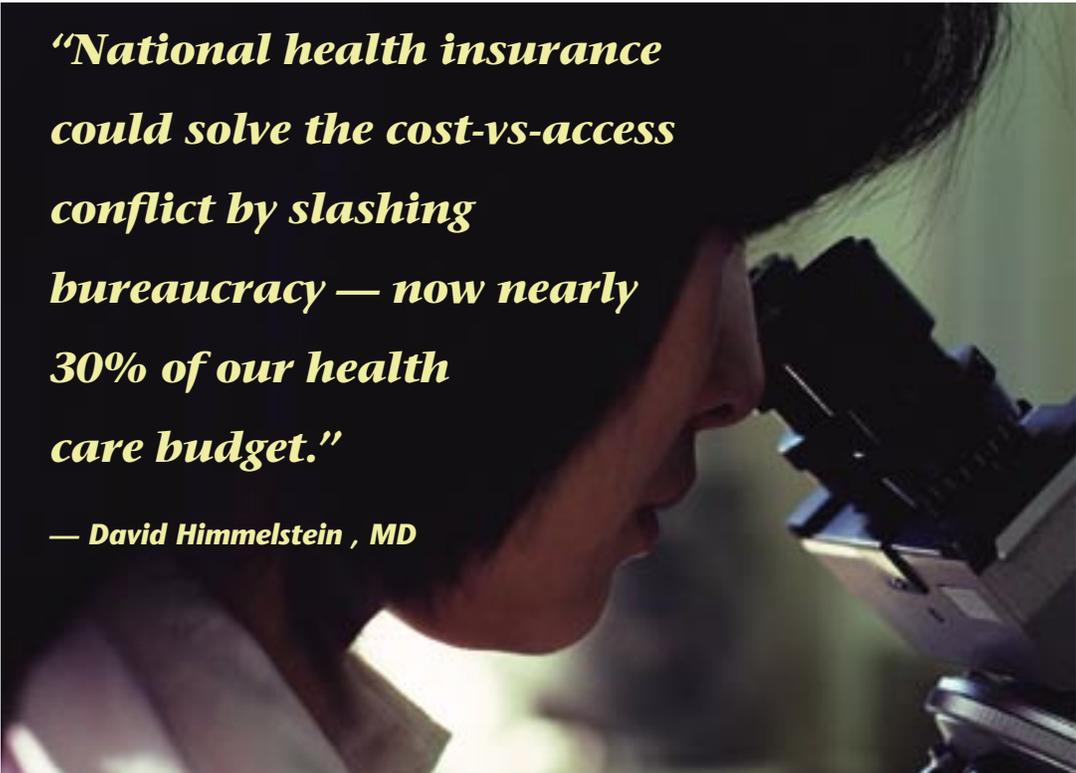


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“National health insurance could solve the cost-vs-access conflict by slashing bureaucracy — now nearly 30% of our health care budget.”

— David Himmelstein , MD



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