

Executive Summary

OVERVIEW

President John F. Kennedy remarked that when the word crisis is written in Chinese, it contains two letters. The first stands for danger and the second for opportunity. The Engineering Society of Detroit and its Institute see our current environment relating to healthcare in this same vein.

FIRST, THE DANGER

Is there anyone reading this report who is not concerned about the cost and availability of healthcare now and in the future? If you work in the public sector, you see more cost with fewer benefits down the road. If you are employed in the private sector, you worry if your healthcare plan will continue to be offered by your employer down any highway. If you are unemployed, you see little if any hope at all.

And the numbers don't help our growing sense of anxiety. Since 1960, healthcare expenditures in the U.S. have gone up over 9,000 percent while our GDP rose only 2,500 percent. Clearly we are on the clock. Below is the chart that coldly provides the raw numbers for inflation and an unvarnished reality of our collective future:

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U.S. HEALTHCARE EXPENDITURES

Category of Expenditure	1960	1990	2000	2009	% Increase
National Health Care Expenditure (Billions)	\$27.3	\$724.0	\$1,378.0	\$2,486.3	9,007%
U.S. Population (Millions)	186	254	283	307	65%
Gross National Product (Billions)	\$526	\$5,801	\$9,952	\$14,119	2,584%
Hospital Care (Billions)	\$9.0	\$250.4	\$415.5	\$759.1	8,334%
Physician & Clinical Services (Billions)	\$5.6	\$158.9	\$290.0	\$505.9	8,934%
Prescription Drugs (Billions)	\$2.7	\$40.3	\$120.9	\$249.9	9,156%
Out of Pocket (Billions)	\$13.0	\$138.8	\$202.1	\$299.3	2,202%
Health Insurance Public/Private (Billions)	\$7.5	\$439.2	\$918.8	\$1,767.4	23,465%
Health Insurance Private Only (Billions)	\$5.8	\$233.9	\$458.2	\$801.2	13,714%
Medicare, per Enrollee (Dollars)	\$383	\$3,285	\$5,778	\$11,093	2,796%
Private Health Insurance, per Enrollee (Dollars)	\$102	\$1,305	\$2,321	\$4,237	4,054%

SOURCE: U.S. Department of Commerce, Bureau of Economic Analysis, and U.S. Bureau of the Census

NOW, FOR THE OPPORTUNITY

So, what are the answers and, importantly, how do we implement the best of the best? Or to say it differently, how do we enact many of the ideas that have been available to us for some time or discovered during our symposium?

Let's start with some tough questions:

- Aren't we in this all together?
- Has any industrialized country successfully controlled the costs of healthcare?
- How do we optimize healthcare delivery as a whole?
- What will 21st-century hospitals look like?
- Are hospitals as we know them today going the way of the dinosaur?
- How much clinical risk is too much and who decides?
- Is healthcare a utility or a growth industry?
- Can healthcare become a positive for economic growth?
- Can Michigan transform its healthcare systems into a strategic advantage to attract investments, jobs, and wellbeing to our state?
- How do we optimize integration instead of silos?

Those questions prompted us to ask targeted and fundamental questions that drove the hard work of our symposium. Modeled upon the National Academy of Sciences, we first asked an overarching Mega Question designed to bring diverse stakeholders together:

How can divergent stakeholders build a consensus to identify and reduce inefficiencies and waste on a sustainable basis within the U.S. healthcare delivery system?

Consensus is indeed the missing link to public policy transformation. And to achieve this elusive consensus, we ask workgroup questions to approach the solutions for different angles. Here are the four symposium workgroup questions:

1. If you were changing today's culture to create a healthcare delivery system that integrated providers, payors, payees, insurers, government, and other stakeholders to optimize patient care, what would it look like and how would you implement it?
2. If you were creating a legal framework for a healthcare delivery system to minimize unwarranted care, what would it look like and how would you implement it?
3. If you were designing state-of-the-art, sustainable best process improvement methods for a healthcare

delivery system, what would those methods look like and how would you implement them?

4. If you were examining incentives to sustain a healthcare delivery system, what would those incentives be and how would the incentives be implemented?

Notice that each of the above questions asks for an answer—we call this the response to the “What” question—but also asks for how an answer will be implemented, or the response to the “How” question. Each question is essential to implementation of any policy change and is a substantial factor at the Institute. It is, if you will, the driver that distinguishes us from a think tank and compels us to be a do tank consisting of diverse, creative, and sometimes conflicting constituents who come together to construct implementable and breakthrough solutions for the betterment of society. Simply put, it is all about quality of life. Invited stakeholders included:

- Hospitals
- Employers
- Labor
- Medical providers
- Insurance companies (nonprofit and profit)
- Doctors
- Nurses
- Administrators
- Government
- Nonprofits
- Academic
- Manufacturers
- Pharmaceuticals
- Legislators
- Taxpayers
- Patients
- Legal
- Financial





Perhaps the best starting point is a sample of the key solutions that were generated or confirmed during our symposium¹¹:

- Create a stakeholder collaboration framework
- Develop integrated medical informatics with clinical, operational, and financial information sharing (e.g., electronic medical records and health information exchanges)
- Increase capacity of, and access, to primary care
- Create national treatment standards based on evidence-based protocols to reduce variation in testing and treatment, including patient-safety incidents
- Create a repository for treatment guidelines
- Create a National patient registry portal similar to Facebook
- Have the Governor of Michigan convene an employer healthcare summit
- Examine current incentives of state public employee plans
- Incentivize transparency on cost data
- Research best practices in other states and countries

¹¹ We wish to share two significant studies from the Institute of Medicine & National Academy of Engineering of the National Academies, Washington, D.C. The first is entitled, “Engineering a Learning Healthcare System: A Look at the Future,” by Claudia Grossman, W. Alexander Goolsby, Leigh Anne Olsen, and J. Michael McGinnis (National Academies Press, 2011) regarding value-based, best evidence care. The second is entitled, “Finding What Works in Healthcare: Standards for Systematic Reviews,” by the Committee on Standards for Systematic Reviews of Comparative Effectiveness Research, Board on Health Care Services, Jill Eden, Laura Levit, Alfred Berg, and Sally Morton, Editors (National Academies Press, 2011) regarding standards for systematic review of comparative effectiveness research on health and healthcare.

Some of you may read those solutions and say, “Yes, but how do we get this done?” Or, “We are aware of these ideas and initiatives and are already trying to move many of these ideas forward. So what makes the ESD Institute different?” Those are great questions.

The ESD Institute was created in 2008 by an ESD Board directive not only to brainstorm ways to bring investment capital and jobs back to Michigan, but, more importantly, to move those ideas into action for economic growth. ESD is made up of 3,000 companies, over 50 unions, and reaches over 65,000 professionals. Grounded in a neutral-based methodology of problem-solving, we have a history of taking things a step further and insisting on answers to the “How” question through the endorsement and participation of fine people committed to actionable solutions.

The recommendation that follows is an answer to this critical and essential “How” question for our economic and social turnaround in Michigan. If meritorious, it will be an example for our country and many industrialized and developing nations that struggle with the common dilemma of serving the healthcare needs of citizens on a sustainable basis.

ESD INSTITUTE RECOMMENDATION

As we have reported in our past symposia work, a salient mission of the Institute is to focus on economic development looking for tax and fiscal incentive-free ways to attract investment and jobs on a sustainable basis in order to return Michigan to a globally competitive export state.

The work of our first symposium resulted in formation of a new form of investment zone that would be a creature of state statute enjoying its privileges and immunities by virtue of the U.S. and

Michigan constitutions. Unlike past investment zones, this zone would be virtual in nature, or, to draw on past Michigan authorities, floating without geographical boundaries except the state itself. The working details of the Zone are spelled out in our Green Enterprise Zone Report that has been benchmarked by Wayne State Law School.¹² The enabling legislation of the Zone is in Appendix G to this report.

In brief, the Zone would be a creature of state statute permitted under our constitution and would offer certain enumerated sovereign benefits. The purpose of the Zone would be to promote the economic and social advancement of Michigan and its residents.

As enumerated in the legislation, the Zone would enjoy key sovereign powers, including immunities, legal innovations, and collaborative labor management relations. Importantly, the Zone would have the power to offer medical, disability, and pension benefits to its participants. One of the key benefits would be to provide on a non-mandatory basis a first-tier level of medical coverage to every resident in Michigan who opts into its healthcare benefits.

In addition, the Zone would have the power to require quotes from third parties to provide administrative and medical services to those within it with companies—and not necessarily employees—paying premiums. It would also have the power to address workers' compensation, including an optimization of the various remedies available when someone is sick or injured in the workplace or elsewhere without distinction.

Due to its unitary ownership purchasing power and defined coverage responsibilities, the Zone could offer a first layer of coverage to those opting into its medical program at a dramatically lower cost with a second layer providing catastrophic coverage through the state funded in whole, or in part, federally. The Michigan Catastrophic Claims Association is useful as an explanatory tool for this second layer.¹³

To summarize, the Zone draws upon the best attributes of the private and public sectors and transforms the current medical delivery systems into an optimized two-layered system grounded in collaboration and best practices that could dramatically lower, on a predictable and sustainable basis, the cost of healthcare for all Michigan residents. By simplifying the delivery system, waste is reduced administratively. At the same time, implementation of

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fresh, more effective means of care are granted wide berth for adoption when fewer entities are required to embrace them in order to enjoy effectiveness.

We understand that within a few months, decisions may be made by the governor’s office regarding the Federal Health Exchanges under the Affordable Care Act. Recent rule changes have given states greater flexibility and the time and opportunity to innovate in this area.¹⁴ In our view, Michigan should initiate proactive steps now in crafting its own system to distinguish Michigan as the leader in cost-effective healthcare that optimizes patient care. Bottom line, if done inclusively with our healthcare stakeholders, we see this as an effective tool to bring investment, jobs, and well-being to Michigan.

We must take advantage of Michigan’s strategic advantage in healthcare resources that draw upon our administrative, education, clinical, and research capabilities..

Accordingly, the ESD Institute recommends that the Governor of the State of Michigan appoint an independent, nine-member blue-ribbon Waste in Healthcare Commission consisting of employer, labor, insurer, administrator, provider, physician, academic, governmental, and nonprofit stakeholders. Members of the commission would serve on a volunteer basis. ESD would serve as the administrator for the commission. The charge of the commission would be to present its finding to the Governor within three months of its formation.

Time is simply of the essence. A crisis is a terrible thing to waste, especially in healthcare.

¹² For the entire Michigan Green Enterprise Zone Report and the benchmarking research by Wayne State University Law School, see our website at <http://www.esdinstitute.net/greenzone/index.htm>.

¹³ Additional information relating to the Michigan Catastrophic Claims Association is available at <http://michigancatastrophic.com/>.

¹⁴ Vermont is a case in point. Regarding its healthcare initiative, see William C. Hsiao, Anna Gosline Knight, Steven Kappel and Nicolae Done, “What Other States Can Learn From Vermont’s Bold Experiment: Embracing A Single-Payer Health Care Financing System,” *Health Affairs*, 30, no.7 (2011):1232-1241 <http://content.healthaffairs.org/content/30/7/1232.full.html>.