BUSINESS ENGAGEMENT *in* BUILDING HEALTHY COMMUNITIES

WORKSHOP SUMMARY

Excerpt from full report

INSTITUTE OF MEDICINE
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Why Should Businesses Engage in Population Health Improvement?

A recurring theme across prior roundtable discussions has been that population health improvement requires multi-sector and multi-stakeholder engagement, said session moderator Andrew Webber, chief executive officer of the Maine Health Management Coalition. This workshop was focused on one particular stakeholder group—the business community—and speakers in this session discussed a variety of reasons business might or should engage in population health improvement. Michael O'Donnell, director of the Health Management Research Center at the University of Michigan, discussed the relationship of health to the federal debt and the creation of jobs. Catherine Baase, chief health officer at the Dow Chemical Company, used a macroeconomic model to illustrate how the current health scenario is negatively affecting the success of the business sector. Nicolaas Pronk, vice president and chief science officer at HealthPartners, described an initiative to develop the underlying rationale and business case for companies to invest in community and population health.

Webber reminded participants that there is not one homogeneous "business community," although all businesses are focused on remaining competitive in their market, and there is often a shared culture that informs how businesses determine whether there is a clear business strategy for engaging in an issue like population health and health care. Webber noted that although there has been a significant increase in worksite health promotion and wellness programs, engaging business at the broader community level has been more of a challenge (Webber and Mercure, 2010).

CREATING JOBS AND REDUCING FEDERAL DEBT THROUGH IMPROVED HEALTH

O'Donnell posed the question of whether improving population health could lead to reduced federal debt and to the creation of jobs. As background, he noted that in 1970 federal spending on health care (e.g., Medicare, Medicaid, Children's Medicaid, and exchange subsidies) was about 1 percent of the country's gross domestic product (GDP), and spending on Social Security was about 4 percent of GDP. In 2011 long-term budget scenarios from the Congressional Budget Office (CBO) suggested that federal spending on health care could reach 19 percent of GDP by 2085, with spending on social security projected to increase to about 6 percent of GDP

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(see Figure 3-1). Updated CBO projections in 2013 suggested that federal spending in health care might only reach 14 percent of GDP, and a recent short term projection suggests further reductions in predicted federal health care spending (CBO, 2011, 2013, 2014).

The current annual budget deficit is not the problem, O'Donnell said. Rather, it is the long-term federal debt.[1] If current CBO long-term budget scenarios hold true, by 2035 the U.S. federal debt could be 200 percent of GDP, O'Donnell said (compared with the current federal debt of about 75 percent of GDP). He suggested that such a situation would be a fiscal crisis for the United States beyond compare.

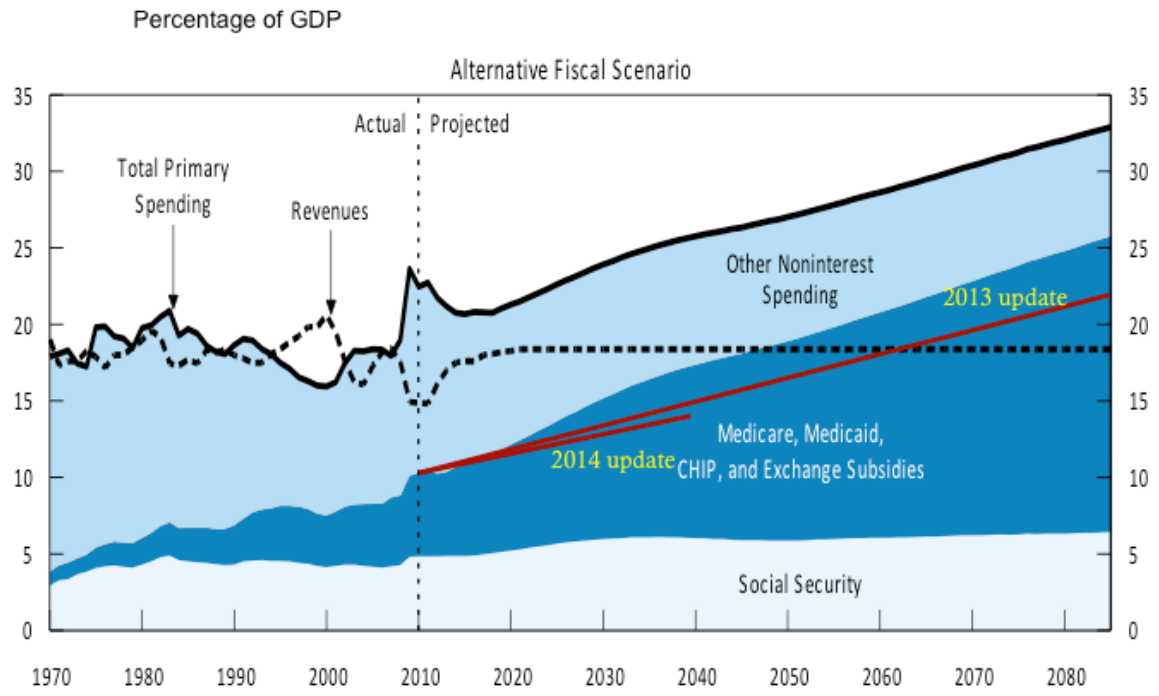

FIGURE 3-1 Primary spending and revenues, by category, under CBO's long-term budget scenarios through 2085.
SOURCE: CBO, 2011.

The Health-Related Contributors to the Federal Debt

O'Donnell listed four underlying health-related causes of federal debt: lifestyle, chronic disease, an aging society, and poverty and inequality (see Figure 3-2). For example, lifestyle can lead to increased chronic disease, resulting in increased Medicare or Medicaid costs for covered individuals and also in reduced tax revenues from these individuals because they cannot work. Poverty and inequality have a negative impact on lifestyle and health, and they are associated with increased Medicaid costs and decreased tax revenues.

[1] The annual shortfall between spending and receipts is the deficit. Borrowing to meet each year's deficit adds to the federal debt.

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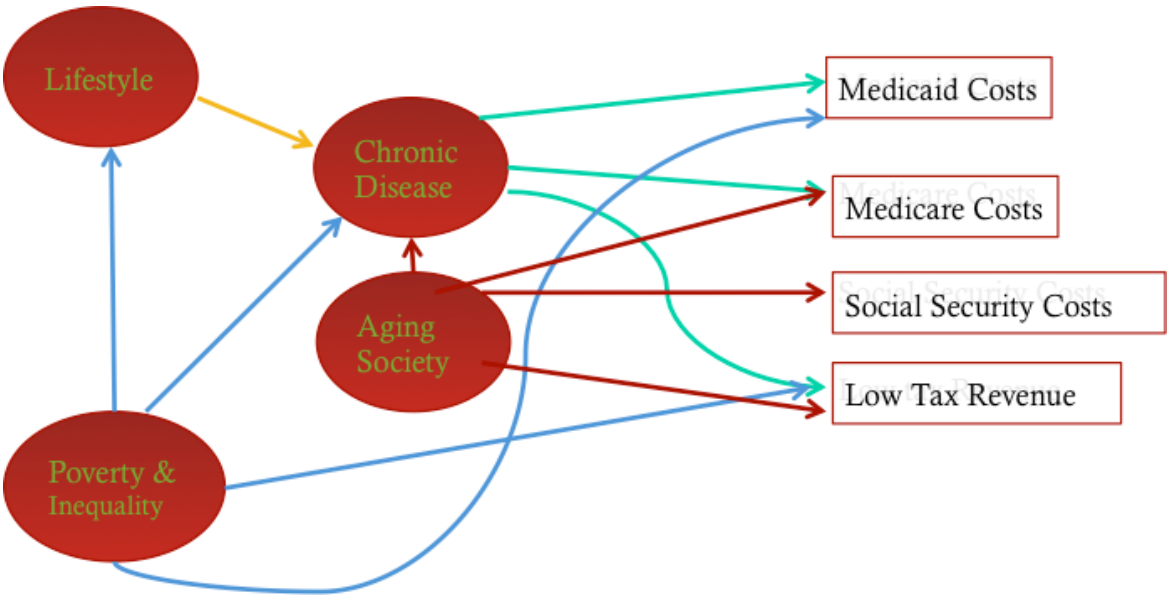

FIGURE 3-2 Underlying health-related causes of federal debt.
SOURCE: O'Donnell, 2012. Used with permission.

Opportunities Presented by Improved Health

Based on his own calculations, O'Donnell suggested that improving the health of the population can reduce the federal debt in various ways:

- Expanding the average years of working life by 5 months would reduce the federal debt by 1.6 percent.
- Expanding the average years of working life by 4.5 years would reduce federal debt by 16 percent.
- Expanding the average years of working life by 9 years would reduce federal debt by 32 percent.
- Reducing the annual rate of increase of Medicare by 0.1 percent would reduce the federal debt by 1.5 percent.
- Reducing the annual rate of increase of Medicare by 1 percent would reduce the federal debt by 15 percent.
- Reducing the annual rate of increase of Medicare by 2 percent would reduce the federal debt by 30 percent.

Improved health will, of course, also improve the well-being and quality of life of millions of people, he added. To facilitate these health improvements, O'Donnell recommended that funding come from organizations that can benefit from the improved health of the population, including employers and insurers, the U.S. Treasury (through the taxes it collects from employers), the Centers for Medicare & Medicaid Services, and state Medicaid programs, and then flow to organizations that can engage people in effective health-improvement programs where they live, work, learn, play, and pray (see Figure 3-3).

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A budget of $200 per person per year would provide approximately $62 billion per year, O'Donnell said (assuming 310 million[2] people). According to O'Donnell, this is about five times the current public health department spending per person (about $41 in 2005), about 30 times the spending of the existing workplace health promotion industry, about 2 percent of spending on medical care in the United States, and 0.32 percent of the liquid assets that non-farm, non-financial institutions have in the bank. This is definitely within our spending ability, O'Donnell asserted, and short-term costs may actually be covered by the short-term savings (in addition to reducing the federal debt in the long term).

In addition to reducing debt, O'Donnell said that growing the workplace health promotion field from $2 billion to $60 billion would create about 280,000 new health promotion jobs at about $75,000 per job (including benefits). He said that this would stimulate $4 billion dollars in new state income taxes and about $22 billion in new federal income taxes. These funds would be sufficient to fund health promotion programs for Medicare and Medicaid recipients.

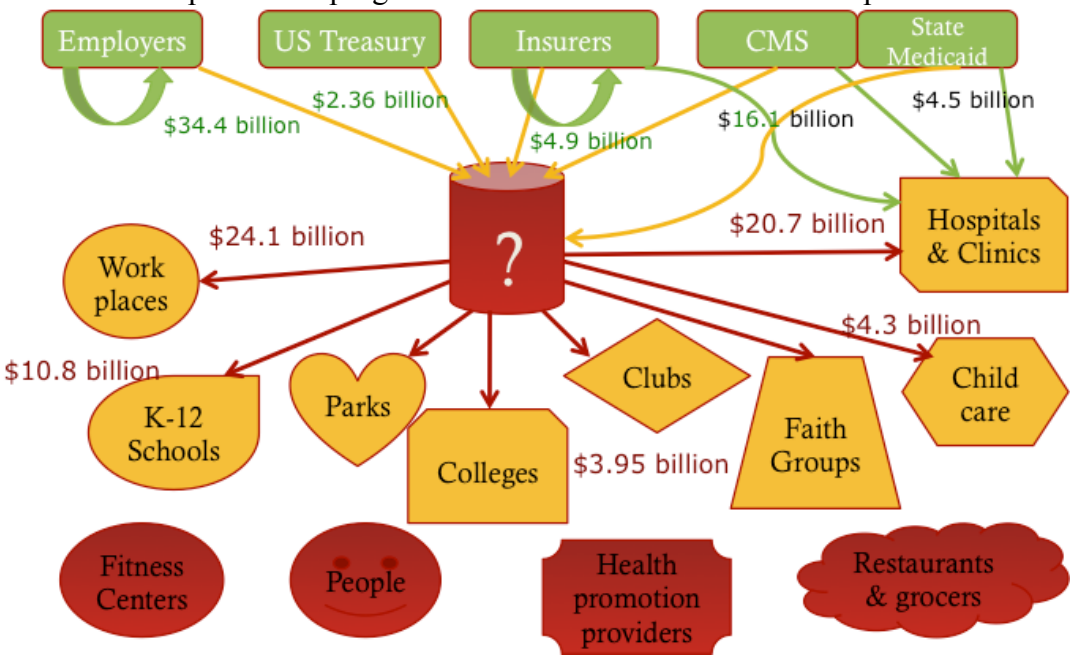

FIGURE 3-3 Funding flow from organizations that benefit to organizations that can engage people in effective programs. The majority of funding would come from employers. The U.S. Treasury would contribute funding from taxes. Estimates of funding allocations to recipient organizations are based on $200 per person per year. CMS Stands for Centers for Medicare and Medicaid Services.
SOURCE: O'Donnell, 2012. Used with permission.

[2] Latest Census figures show 317 million people live in the United States, but the figure of 310 was used as the basis for the speaker's back-of the envelope calculation.

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