

**SPEECH ON HEALTH CARE TO THE DETROIT ECONOMIC  
CLUB  
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I am pleased to have the opportunity to discuss health care policy with you today. I do so from the experience of leading a company, Pitney Bowes, that is both a payer and a provider of health care. In my remarks, I will draw some broad lessons from our experience that might give us useful guidance as we think about one of the most important domestic issues facing not only the United States, but the entire developed world.

The health care problem is large and growing: the United States spends far more in absolute dollars (over \$2 trillion), percentage of GDP (15.2% and rising) per capita costs (\$5,711), on health care than any other country in the world. However, in terms of overall health system performance, the World Health Organization would rate the United States only 37<sup>th</sup> out of 191 countries. For example, with life expectancy at 77.85 years at birth, we rank 29<sup>th</sup>, just below Bosnia-Herzegovina. In infant mortality, we rank 20<sup>th</sup> in the 2007 statistics, behind countries such as Spain, Portugal, Greece, and the Czech Republic.

More troubling is the fact that at least three kinds of health-related costs are skyrocketing:

- There is an epidemic of preventable chronic diseases like diabetes, cardio-vascular diseases, asthma, and emphysema. They comprise the highest percentage of our health care costs, and according to the

Centers for Disease Control and Prevention, they account for 7 of every 10 deaths in the United States and affect the quality of life for 90 million Americans. According to the World Health Organization, we have a higher incidence of obese adults over 15 years of age at 19.7% for males and 21.2% for females than most other developed countries.

- There is also a crisis with respect to infectious diseases. Besides the obvious broad problem of HIV/AIDS, we are also seeing a resurgence of tuberculosis and other infectious diseases once believed to be under control. The Global Health Council also points out that we are also seeing an increased incidence of deaths in hospitals from antibiotic resistant bacteria. Public health officials also tell us that we are at more risk than ever of a major flu pandemic.
- Environmentally-induced conditions like emphysema and other respiratory diseases continue to grow.

So what are the root causes of this divergence between what we spend and what we get? I would submit there are four root causes:

- We have defined the problem incorrectly and, as a result, we have a flawed strategy for attacking it. As a society, we should have two goals relative to health care:
  - To make all of our citizens as healthy and productive as possible; and
  - To provide affordable, effective health care when our citizens need it due to illness, injury or other conditions requiring medical attention.

Given these two goals, we do not invest sufficiently in the first, health improvement. In fact, many of our societal decisions make our citizens less healthy, such as the junk food and beverages we serve daily in our schools and the cutbacks in school physical education programs. I get frustrated when I watch government officials, business leaders, and health experts focus principally on access or shifting costs to the government or the individual and ignore the root cause issue of deteriorating health. That would be like a situation in which there was a widespread problem of automobile brake failures, and government officials defined the problem as a combination of access to brake repair services, affordability of brake repair insurance, and the system for negotiating with the repair service providers to insure access and affordability. Common sense would suggest that our first priority should be to fix the root cause of why the brakes are failing in the first place. Likewise, we need to find out why Americans are less healthy than they should be and attack that issue in parallel with the other important issues of access, cost, and structure.

- We are insufficiently concerned with promoting end-to-end health care system quality. We tolerate considerable amounts of system inefficiencies and fail to use basic fact-based tools to look at health processes end-to-end. For example, Medicare's reimbursement system treats virtually every visit to a physician as an isolated event, and regulates cost on an event-by-event basis, rather than looking at the total cost over the course of an illness or the treatment for an injury.
- We have not made informed, intelligent choices as a society on what we should and should not pay for as part of a health care coverage

system. Many of our decisions on health plan mandates that drive up the cost of health care are caused by legislators that overreact to special interest lobbyists or media frenzies that follow from a high-profile, but aberrational, case.

- Plans provided by private insurance companies and most governmental programs do not have incentives sufficiently aligned with long-term health, safety, and capacity improvement. Although our health plans are starting to improve, they are still too focused on disease treatment, not health improvement.

With this problem definition, let me turn to the Pitney Bowes story. First, let me tell you a little about our demographics. From a health benefits standpoint, our 26,000-employee U.S. population is really two different populations of roughly equal size. Population 1 resembles the demographics of a large employer, that is, all employees either work on, or report to, sites we control, and many of those sites have sufficient scale that we can support free on-site clinics, cafeterias, and fitness centers. Population 2 resembles the demographics of a collection of small businesses, that is, employees work in small concentrations on hundreds of customer sites as part of our Pitney Bowes Management Services facilities management business. For this population, we do not have sufficient scale to support clinics, cafeterias, or fitness facilities. Moreover, the second population is primarily lower-wage workers with a higher concentration of employees who come to use less educated about their health and how to use the system efficiently. Finally, we have recently acquired a variety of companies whose approach to health care is more traditional and whom we are just beginning to incorporate with our approach.

So how have we done with respect to health care costs in the areas that have been on this journey with us for awhile? In 1990, when I became chief human resources officer, our health care costs had been skyrocketing for five years. After a year in which we began a transition to having our employees share for the first time in the cost of their health care, we began to see progress. From 1992 through the end of last year, we have had a virtuous combination of high employee satisfaction and well-below-normal health care cost increases. In fact, for many years during the 1990's and in recent years relative to population in company facilities, our costs were flat from year to year.

Why have we been successful?

- We have invested heavily in improving health through illness and injury prevention.
  - In our large facilities, we not only serve appropriate portions of nutritious food and beverages, but our pricing, marketing and merchandising practices drive employees to eat the healthy food.
  - We have fitness centers in several of our facilities and subsidize exercise programs and outside fitness center memberships. We also give benefit premium discounts for employees that participate in fitness programs like the 10,000 steps-a-day walking program.

- We incent healthy lifestyles through reduced benefit costs. For example, if you are a non-smoker, you pay less for health care than if you are a smoker.
- We make valuable preventive screenings free or as low-cost as possible and do as much outreach as possible.
- We make immunizations free or as low-cost as possible.
- Our health plans are designed with certain objectives in mind:
  - To get early and appropriate diagnoses and treatment of illnesses and injuries;
  - To maximize adherence to treatment requirements, especially for chronic diseases;
  - To reward highest quality providers; and
  - To use rigorous data-driven Six Sigma analyses in the design and implementation of our plans.
- We make informed, data-driven choices about what we will or will not pay for, and how much we will pay. For example, we do not cover fertility treatments, high-risk procedures like gastric bypass, or experimental treatments that are unlikely to be recognized as effective and mainstream over the long term. We do cover certain kinds of alternative medicine treatments based on our judgment as to their efficacy. We also increase co-pays and deductibles for overused procedures like MRI's, to make sure our employees are making informed decisions about when to authorize the procedure.
- We look at multiple factors when we invest in health improvement, and try to create a culture of health among our employees, not just the return in terms of lower medical costs. We consider the benefits of

reduced absenteeism and “presenteeism” and reduced disability and workers compensation costs.

What are the broader lessons that can be drawn from our story?

- As a society, we must make an all-out effort to put Americans in a position in which they eat better, get more exercise, live healthier lifestyles, and live in healthier communities. Although this appears to position the government as a “nanny state,” there are many decisions that could be made differently to improve health:
  - Our schools should be serving healthier foods and beverages since they have a captive audience every day. Governor Schwarzenegger signed into California law in 2004 a bill that eliminates a considerable amount of the junk food and unhealthy beverages in California schools. Mayor Bloomberg in New York has retained his personal chef to create a healthier, but also more attractive, cuisine for New York City schools. The UK and France are zeroing in on changing the diets of students in their schools. In fact, childhood obesity is a crisis in the making. According to the Centers for Disease Control and Prevention, childhood obesity doubled in the 6-11 age group from 7% to 15.3% from 1980 to 2000 and tripled in the 12-19 age group from 5% to 15.3% between 1980 and 2000. Relative to total obesity in our U.S. population, the number of states that had successfully kept population obesity rates below 20% dropped from 28 in 2000 to 4 in 2005.

- Our institutional food providers that serve employees of companies and hospital patients need to think about how to make their offerings both healthier and more attractive. We have worked very effectively with Host America to change the eating habits of our employees, and have a highly-satisfied employee population.
- Schools and communities need to have more places for students to exercise. We also need to get adults to adopt simple programs like the 10,000 steps-a-day program to increase their fitness even if their schedules or financial situation do not enable them to join a fitness center.
- We need to continue our relentless effort to reduce smoking and other lifestyle behaviors that significantly add to our health costs. We have been exceptionally successful over the last 30 years in reducing smoking among adults, but we need more targeted programs relative to specific populations where our efforts are not successful, such as young single women who see smoking as an appetite suppressant and way to keep their weight down.
- We need to make screenings and immunizations as widely available and as low-cost as possible. Beyond the well-publicized seasonal flu shot, we need to get parents to keep up with the immunization schedules for their children.
- We also need to emphasize the importance of basic sanitation behaviors, such as hand-washing and keep social distance when a person has a communicable disease to reduce the spread of infectious diseases.

With respect to health plan designs, we have been quite successful in increasing adherence to chronic disease treatment plans by reducing the cost of maintenance drugs to virtually zero and by assigning care advocates to patients to help them manage complex treatment programs. It costs us money in the short run, but it saves significantly on emergency room and hospital visits, particularly for chronic diseases that have no symptoms like hypertension, where adherence is more challenging. Government and private insurance health plans need to be designed to incent the most sensible behaviors by chronic disease patients to reduce long-term cost, not simply to reduce the plan cost for a specific patient interaction like a maintenance prescription. Since we redesigned our plan to reduce our maintenance drug costs over the last several years, our total diabetes treatment costs have declined 6% and our costs for asthma treatments have declined 15%.

For behavioral health conditions, we provide eight free consultations through our employee assistance program to give employees incentives to work with us to find the appropriate provider rather than having them automatically look for the most expensive and fastest treatment plan. This is particularly important for substance abuse treatment, where the most expensive program is not always the most effective. We believe that using “gatekeeping” programs like this is most effective when it is made financially more attractive, not when plan providers eliminate choices for patients. We have also reduced behavioral health costs over the last several years as well.

Finally, we believe strongly that there needs to be a permanent, portable, private electronic health record controlled by the patient that has a comprehensive medical history and record usable everywhere. I have recently accepted the position of chairman of Dossia, an initiative founded by six major employers, and initially led by Craig Barrett, the chairman of Intel Corporation. Health providers need to know as much as possible about patients and we need to eliminate needless duplication of medical procedures, treatment errors, adverse drug interactions and the other inefficiencies associated with lacking a complete medical history at the point of patient interaction with a health provider.

If we can tame this beast of rising health care costs, we will make its consequences less daunting. There will be fewer uninsured Americans because premiums will be lower due to lower cost. The burden of retiree health will be lower because the projected actuarial cost increases will be lower. Americans will be more productive if they are healthier and have a higher quality of life, and we will have more competitive American businesses.

I have appreciated the opportunity to share my views on health care policy with you today. I would now be happy to take your questions.