The health care industry has been grappling with new mandates for expanded coverage and cost containment, while also maintaining quality of care and profit margins. With both life expectancies and chronic illnesses on the rise, more and more people are in need of long-term health interventions and care. A healthy workforce is the very foundation of any economy, and in this podcast we will discuss some of the intersections between the health care industry and economic development.

Dr. Medows joined UnitedHealth Group in 2010. Before that, she was commissioner of the Georgia Department of Community Health. From 2001 to 2004, she served as secretary for the State of Florida’s Agency for Health Care Administration. Dr. Medows, thank you for joining me today.

Rhonda Medows: Thank you for the invitation. It’s a pleasure to be with you.

Bishop: The economic recession and changes in health care policies have brought new attention to nonmedical health care costs, including administrative costs. Indeed, a significant portion of health care expenses is related to administrative costs. What are some examples of these costs, and why are they increasing?

Medows: Before 1990, most administrative expenses were primarily focused on claims payments. In the more recent years, spending has focused on health improvement and care management efforts, as well as quality improvement, customer satisfaction, waste reduction, fraud prevention, consumer outreach, and education. Some examples would include things like nurse help lines, websites for patient education, self-management tools. In addition to those tools and materials focused on the consumer are materials and expenses that come with provider network management. So, there are additional costs that are associated with monitoring the access and the availability and the quality of providers that actually provide the care directly to our patients and members.

Quality improvement and assessment have become a much higher priority, particularly over the last year. So those programs and efforts that are used to focus on measuring things like health outcomes, performance metrics, and care delivery, efficiency, and effectiveness have also been added. In addition to quality, care, prevention, fraud and abuse, and efficiency costs that are associated with care delivery, there are also costs that come with building, with personnel. And for health insurance itself, there are also the costs that are included in administrative expenses from premium taxes, commission costs for sales forces. So you can see that there are additional costs and expenditures that go well beyond claims payment itself.

Bishop: Dr. Medows, the health care industry includes a large number of nonmedical occupations. What are some of these occupations, and what skills do they require?

Medows: There are clinical occupations, there are ancillary occupations, but there are also those occupations that focus on information technology as we move more and more into the IT world in the health care industry. Some of those positions and career opportunities are for technicians, engineers, software architects, security, computer programming. We have to remember that health care is an industry, and it is a business. So there are business operations that have to be addressed and met as well, and that includes people who have expertise in accounting, finance, actuary; specialists in risk management, general administration, medical secretaries, medical transcriptionists remain in demand; things like biomedical researchers, who are probably on the forefront of the health industry itself, as well as laboratory technicians, dental assistants, and hygienists.

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Bishop: Given current high unemployment in many job sectors, are these nonmedical occupations experiencing high demand and worker shortages?

Medows: Actually they are, and that's good news for many of us. If we were to look at the U.S. Bureau of Labor Statistics Career Guide to Industries for 2010, we would see that 10 of the 20 fastest growing jobs are health-care related. Looking at the top 25 on that list, we would actually see that, in addition to the five clinical or ancillary careers—like physician assistants, physical therapy, dentists, nurse anesthetists, occupational therapy, and ER physician—and there are another 20 that actually address the careers that I mentioned above. So that would be biomedical engineers, information systems, IT techs, software architects, database administrators, and software engineers. Management consultants in the health industry are in high demand. Actuaries, risk managers, product managers, and network operations all remain in high demand, particularly in the health care industry. Environmental safety and health specialists are also needed.

In addition to looking at the information provided by the U.S. Bureau of Labor, there was a very interesting article in the Wall Street Journal January 5th of this year that talked about the best and worst jobs for 2011. CareerCast rated 200 jobs based on income, working environment, stress, physical demands, and job outlook, and of those listed, 15 to 20 of the top 50 jobs are in health care, either specifically clinical, ancillary care, or in the areas that we talked about—information technology, in particular, risk management, biomedical research, and general administration, meaning back office for hospitals, doctors' offices, and the offices of other health care providers.

Bishop: So this seems like good news, particularly given these times.
The local prevalence of chronic illnesses, such as diabetes and hypertension, is emerging as a point of differentiation among regions as they compete for new businesses. Is this because employers recognize the increased costs associated with employees suffering from chronic illnesses? And why are employers more concerned about the relationship between chronic illness and worker productivity than they were, say, 10 or 15 years ago?

Medows: Employers have recognized the direct correlation of an employee's health, or the health status of their family members, and productivity, absenteeism; and that can be the absenteeism of the employee and absenteeism that's related to the illness of a child of an employee, or for those of us who are in the crunch in between having to take care of parents who are aging and children who need us still. There may be absenteeism because those individuals, those loved ones are ill, as well. So, a smart employer is going to look at those activities, at investments that they can make to improve the wellness of their workforce.

The employer share of the health care premium that they contribute for their employees is rising as a reflection of chronic illnesses worsening or increasing. If employers are still providing retiree health benefits, they will note that as the population ages, particularly since we are seeing this large increase in baby boomers aging out, that those costs will also rise if chronic illnesses are not effectively managed on the front end, detected early, and maintained. Employers who are looking toward future planning will note that with the health reform act and the employer mandate coming into play in January 2014, they will be responsible for providing if not health care coverage, then paying a penalty, which would then contribute to the cost of care for their employees. So they would see, as a reflection of chronic care that is not properly managed, higher costs.

Bishop: So, my last question is this. Many communities have improved their economic development appeal through healthy community planning options, such as developing walking trails. Dr. Medows, how might economic developers work better with the health care community to enhance the local business community and provide citizens with a better quality of life?

Medows: The developer that includes those community resources that can help with prevention and with wellness is already a step ahead. So walking trails, bike lanes, parks, recreational areas, things that actually allow people to exercise and be fit are extremely helpful. Include health care leaders, whether they be clinicians or public health leaders, for input during the planning process. There, they would learn about disease prevalence in a particular community, they would learn about resources available to a workforce that may be based in that community. The economic developers and the business community that invest in actually having an adequate pipeline of health care workers in the workforce are going to be much further ahead in terms of being prepared to meet the health needs of their workforce and the communities in which they wish to build and prosper.

Bishop: Dr. Medows, thank you so much for joining us today.

Medows: Thank you for the invitation. It's a pleasure to be with you.

Bishop: This concludes our podcast. We've been speaking with Dr. Rhonda Medows, chief medical officer and executive vice president for UnitedHealth Group's public sector programs. For more podcasts on this topic and others, please visit the Atlanta Fed's website at www.frbatlanta.org. If you have comments or questions, please e-mail podcast@frbatlanta.org. Thanks for listening.

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