

Is Equity an Attainable Health System Goal?

Grantmakers In Health Annual Meeting on Health Philanthropy

Baltimore, Maryland

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National Academy for State Health Policy

Health Care Costs

ANNALS OF MEDICINE

THE COST CONUNDRUM

What a Texas town can teach us about health care.

BY ATUL GAWANDE

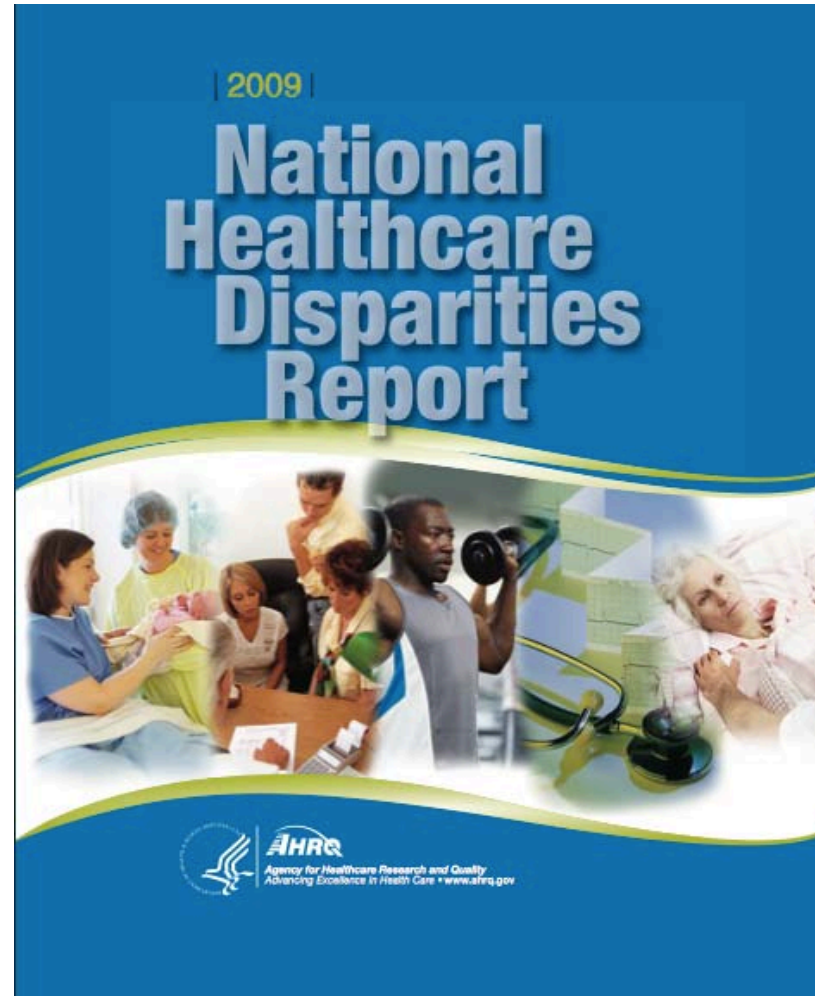
JUNE 1, 2009

It is spring in McAllen, Texas. The morning sun is warm. The streets are lined with palm trees and pickup trucks. McAllen is in Hidalgo County, which has the lowest household income in the country, but it's a border town, and a thriving foreign-trade zone has kept the unemployment rate below ten per cent. McAllen calls itself the Square Dance Capital of the World. "Lonesome Dove" was set around here.

McAllen has another distinction, too: it is one of the most expensive health-care markets in the country. Only Miami—which



Health Care Disparities



Presentation Outline

- Framework for addressing health disparities
- Reasons for optimism
- Unfinished business
- Role of philanthropy

Framework for Addressing Health Disparities

- Layer 1 – Micro system level
- Layer 2 – Health system level
- Layer 3 – Societal level



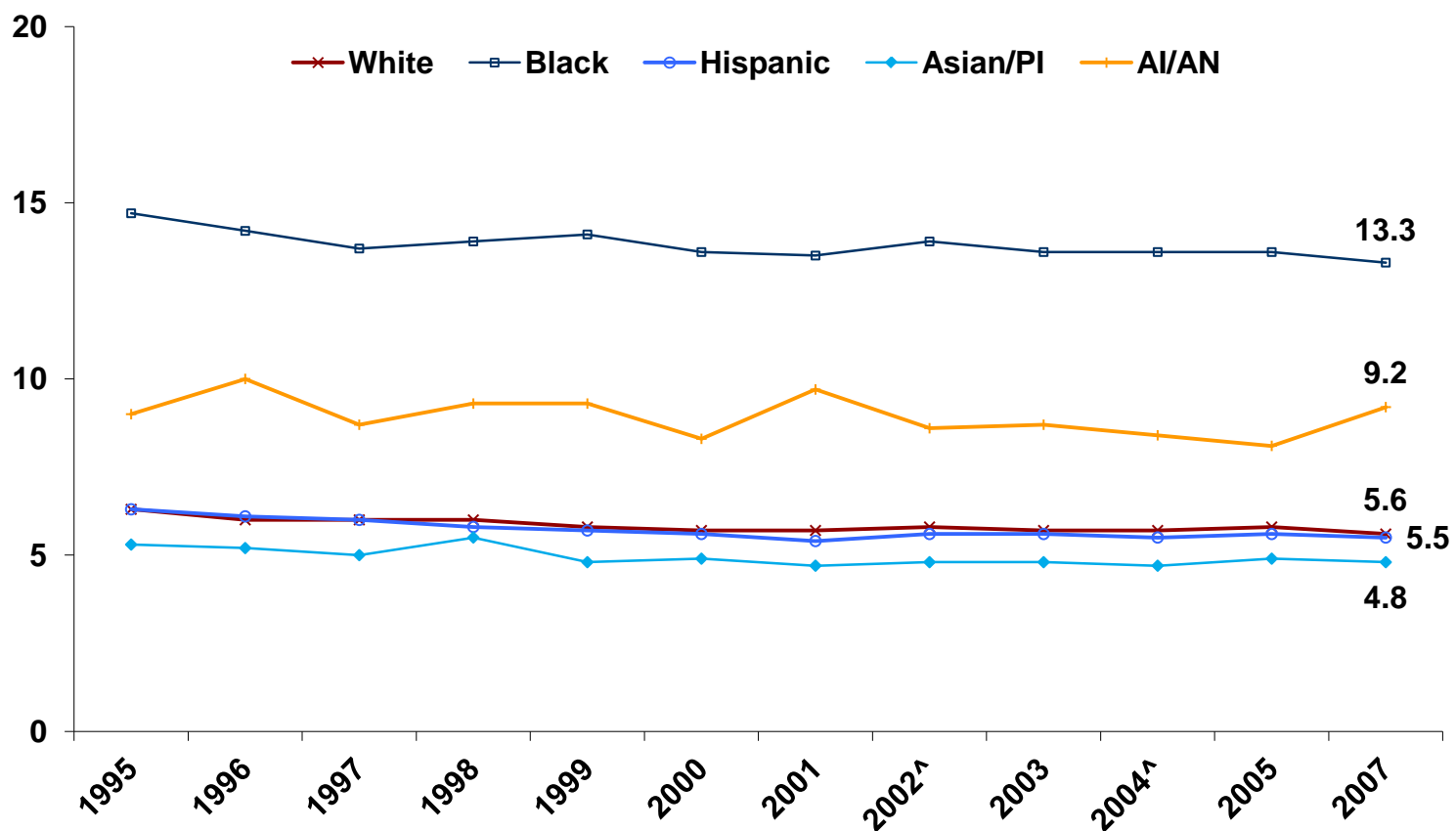
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Infant Mortality

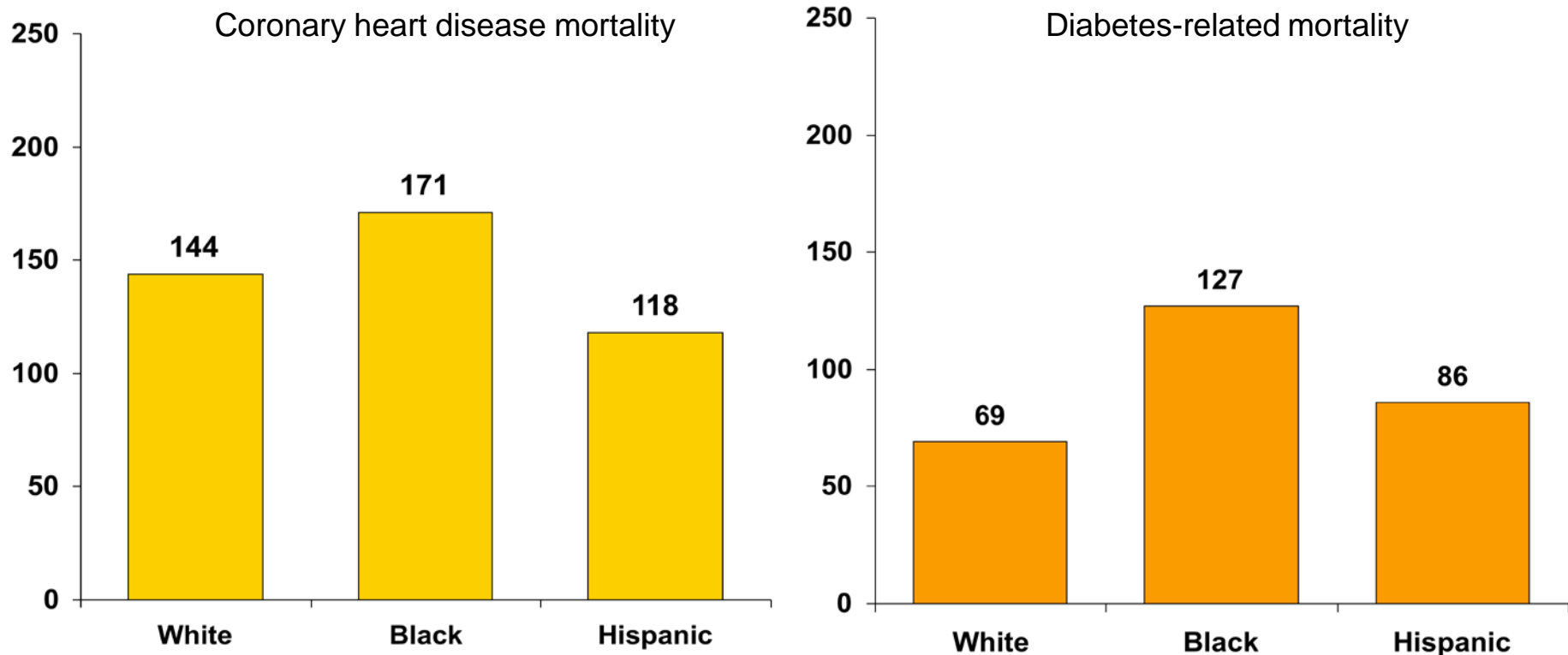
Infant deaths per 1,000 live births
By race/ethnicity, 1995–2007



Source: Adapted from The Commonwealth Fund National Scorecard on U.S. Health System Performance, 2011.

Coronary Heart Disease and Diabetes-Related Mortality, by Race/Ethnicity

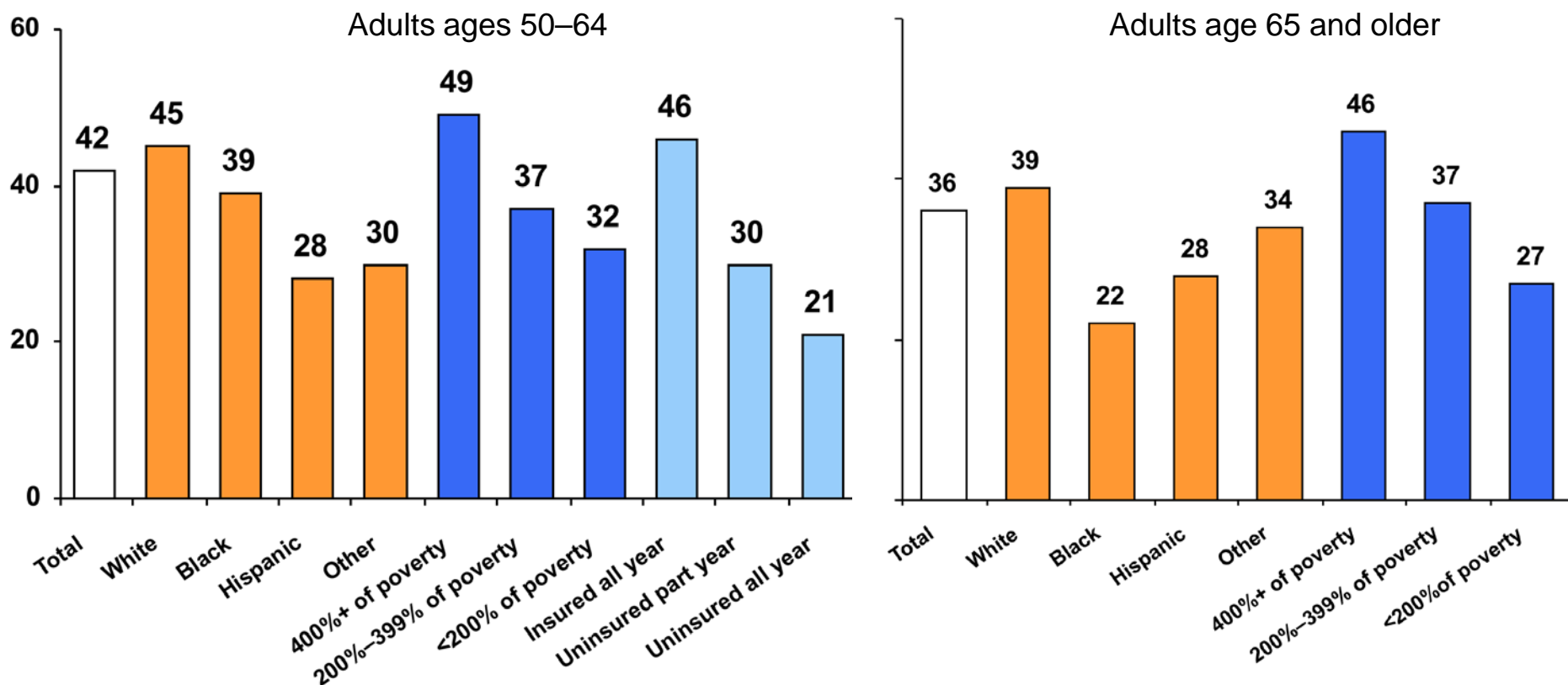
Age-adjusted mortality per 100,000 population



Source: Adapted from The Commonwealth Fund National Scorecard on U.S. Health System Performance, 2011.

Receipt of Recommended Preventive Care for Older Adults, by Race/Ethnicity, Family Income, and Insurance Status, 2008

Percent of older adults who received all recommended screening and preventive care within a specific time frame given their age and sex*

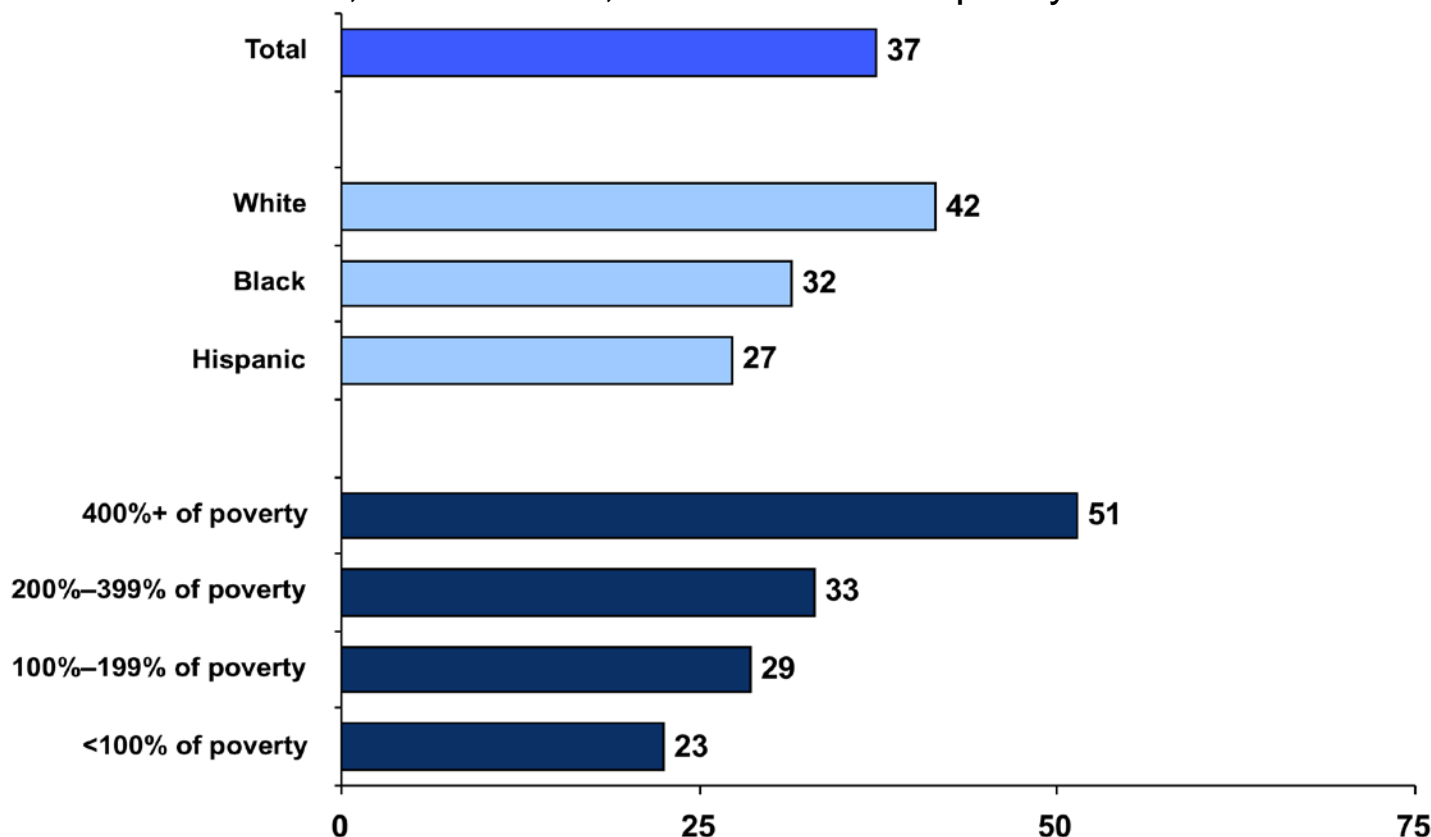


* Recommended care includes at least six key screening and preventive services: blood pressure, cholesterol, Pap, mammogram, fecal occult blood test or sigmoidoscopy/colonoscopy, and flu shot. See report Appendix B for complete description.

Source: The Commonwealth Fund National Scorecard on U.S. Health System Performance, 2011.

Receipt of All Three Recommended Services for Diabetics, by Race/Ethnicity and Family Income

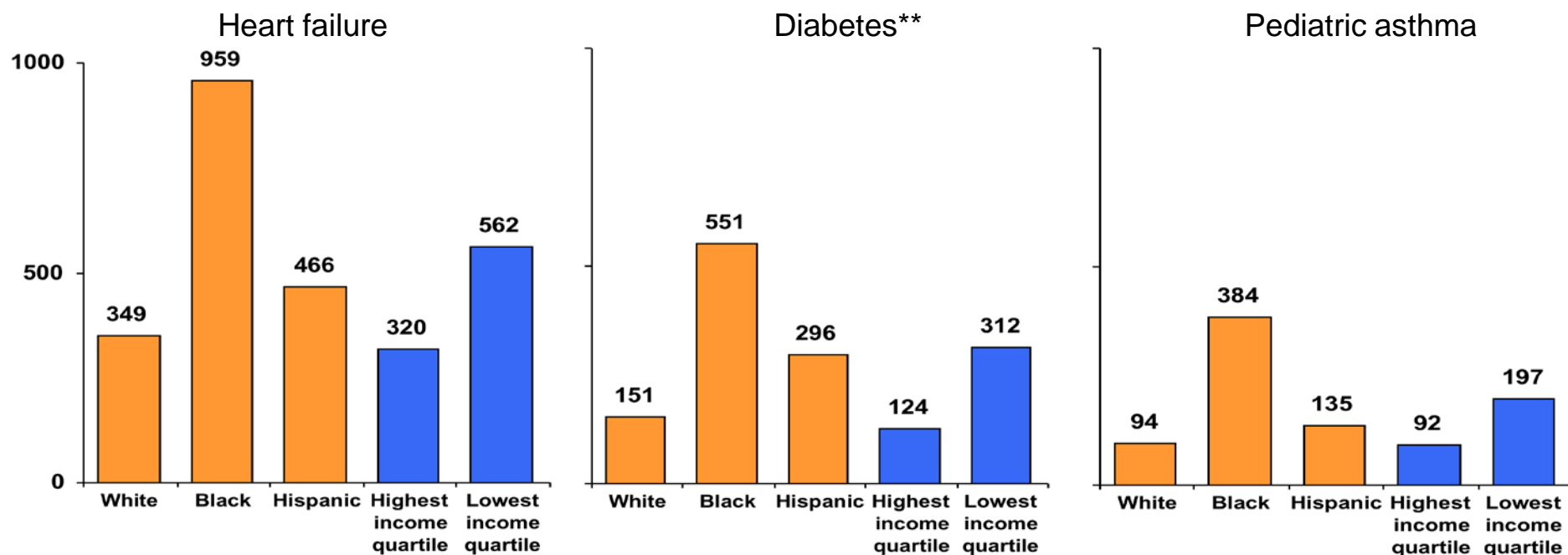
Percent of diabetics age 40 and older who received hemoglobin A1c test, retinal exam, and foot exam in past year



Source: Adapted from The Commonwealth Fund National Scorecard on U.S. Health System Performance, 2011.

Hospital Admissions for Select Ambulatory Care–Sensitive Conditions, by Race/Ethnicity and Patient Income Area, 2007

Adjusted rate per 100,000 population*



* Rates are adjusted by age and gender using the total U.S. population for 2000 as the standard population.

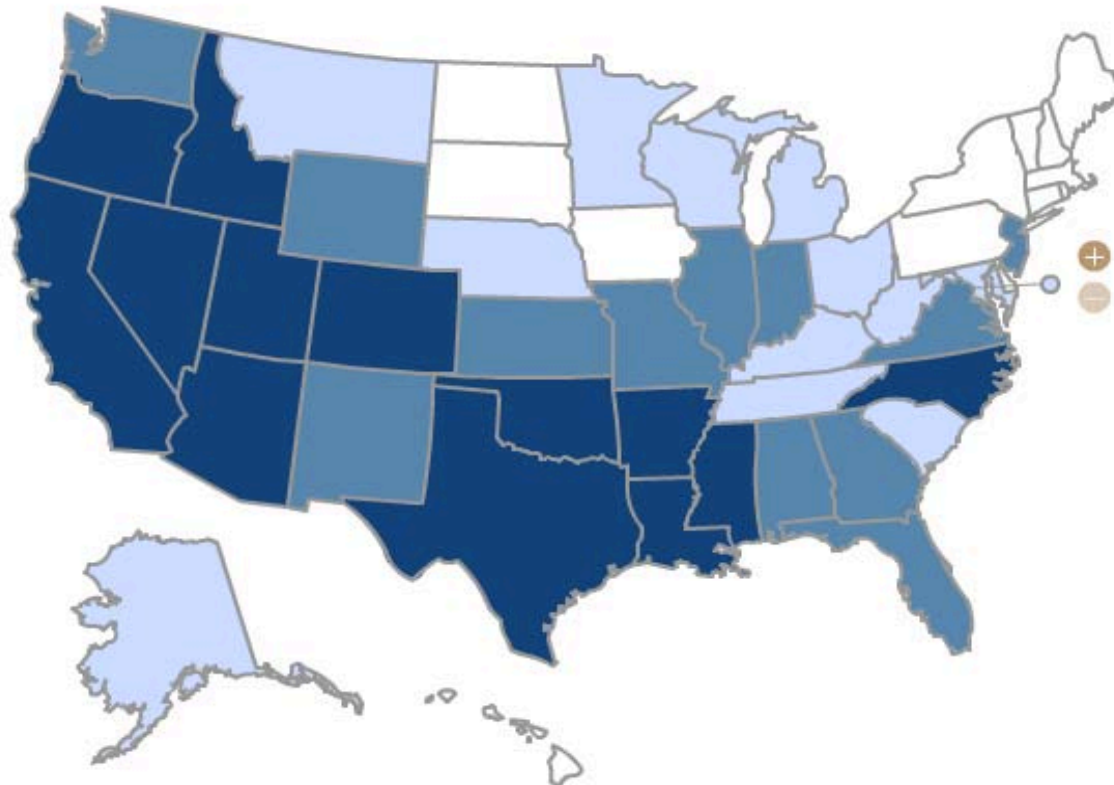
** Combines three diabetes admission measures: uncontrolled diabetes without complications, diabetes with short-term complications, and diabetes with long-term complications.

Patient Income Area=median income of patient zip code.

State Scorecard on Equity

Equity Rank: 2009

Top Quartile Second Quartile Third Quartile Bottom Quartile

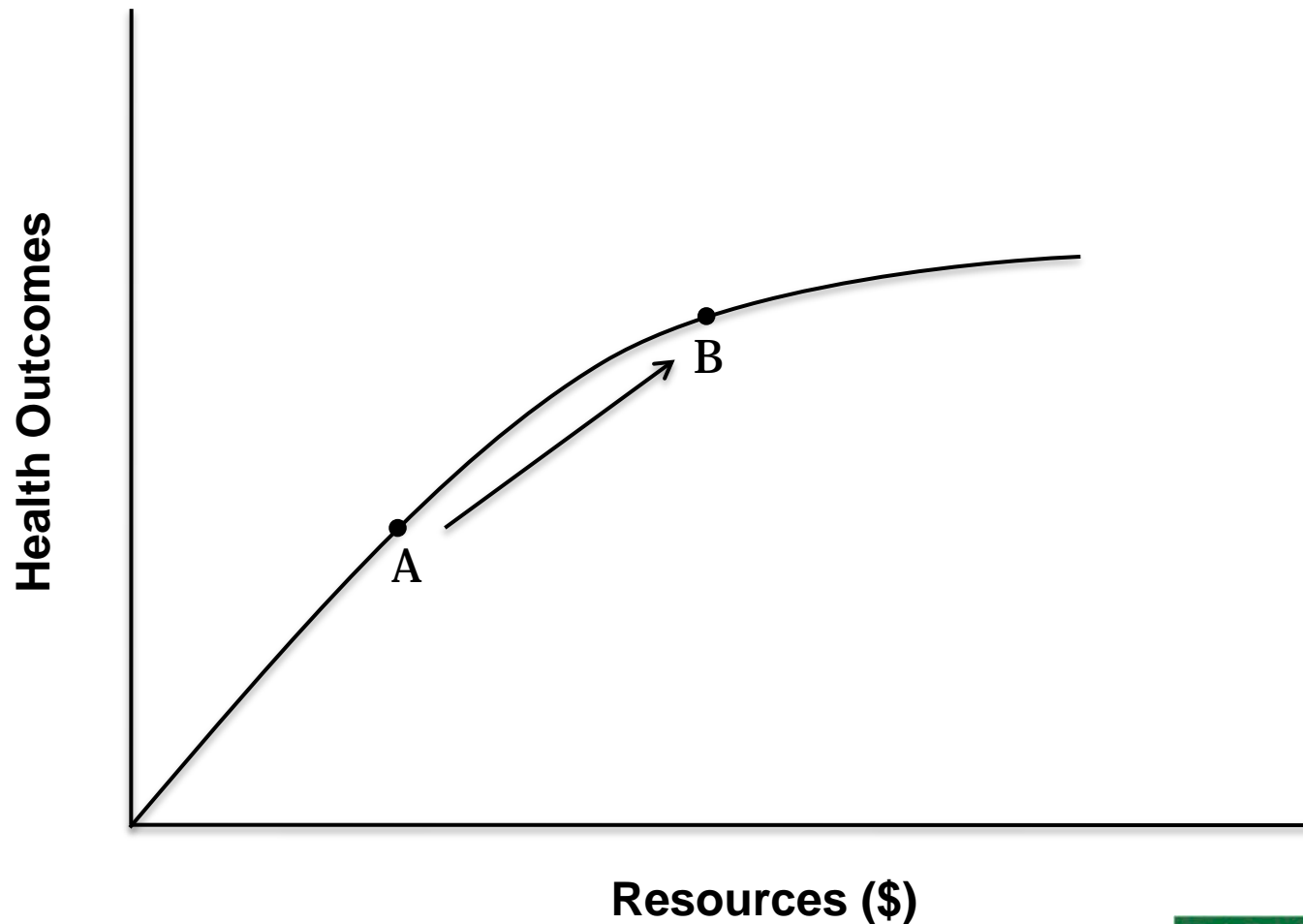


Framework for Addressing Health Disparities

- Layer 1 – Micro system level
- Layer 2 – Health system level
- Layer 3 – Societal level

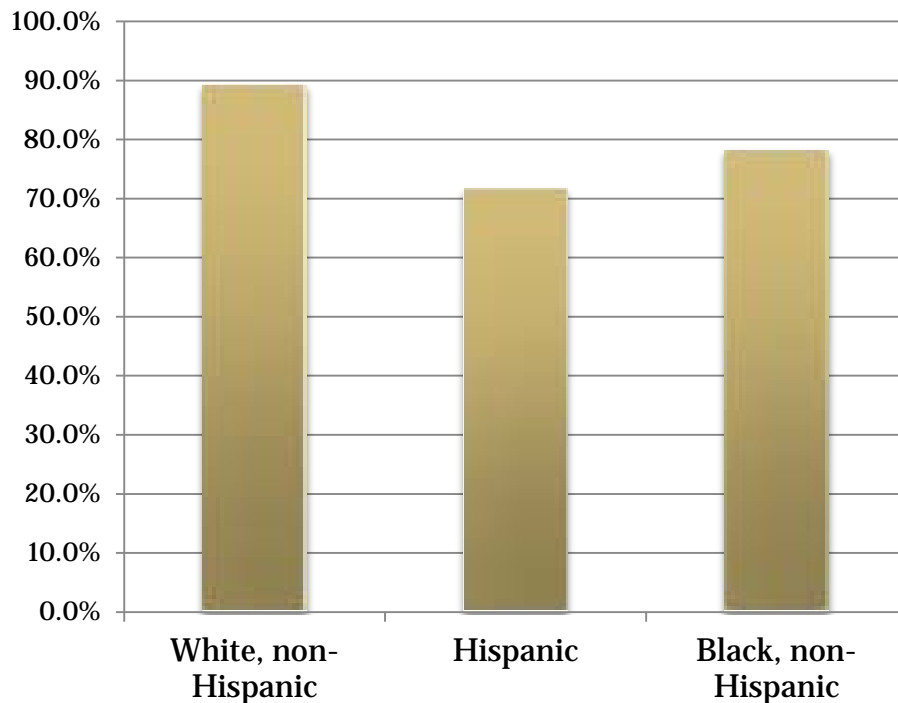


Eliminate Disparities (ver. 1)

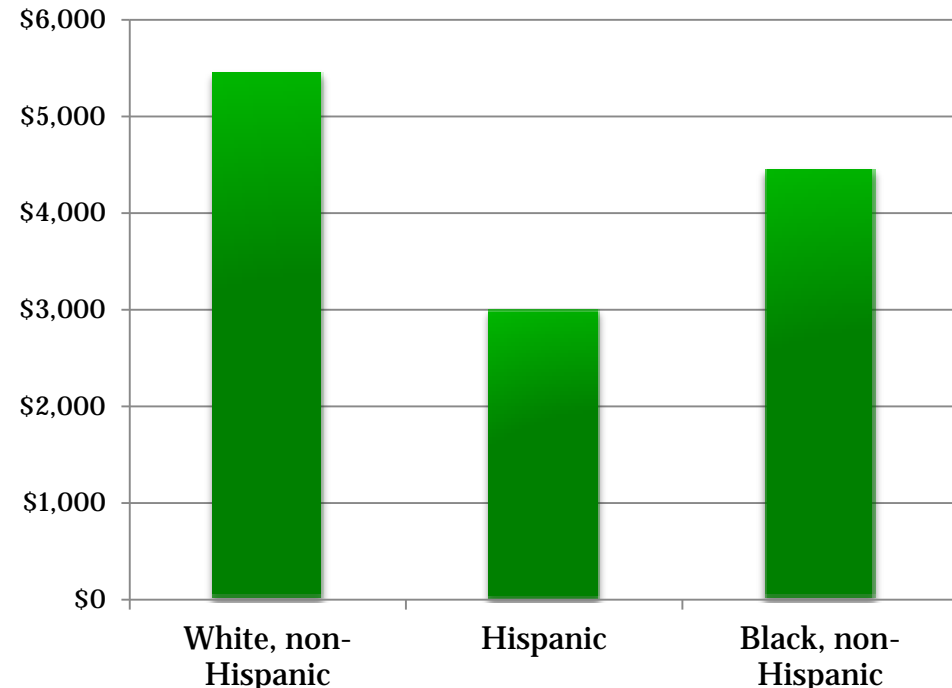


Health Care Spending, 2009

Percent with expense by race/ethnicity for all payers

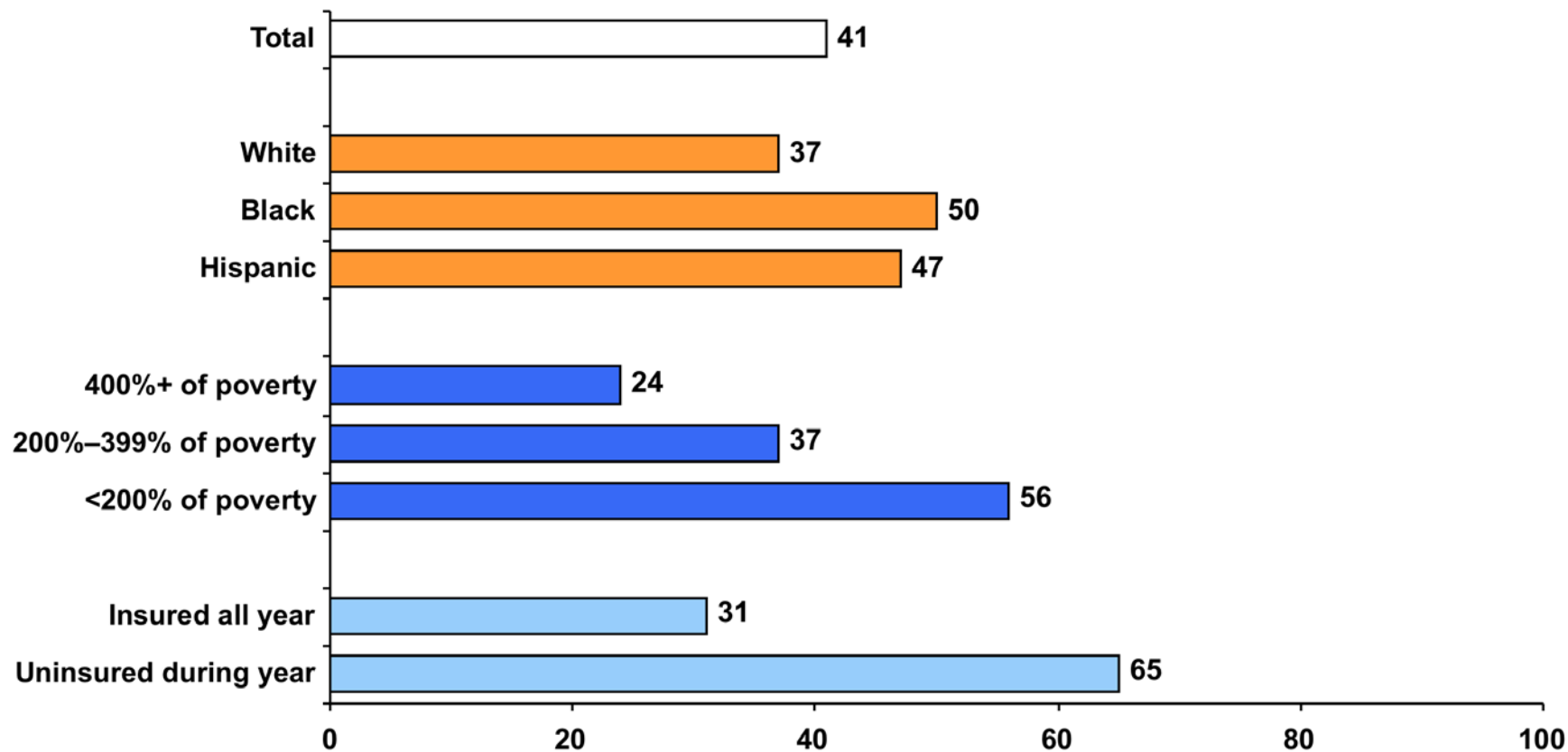


Average expense by race/ethnicity for all payers



Cost-Related Access Problems, by Race/Ethnicity, Income, and Insurance Status, 2010

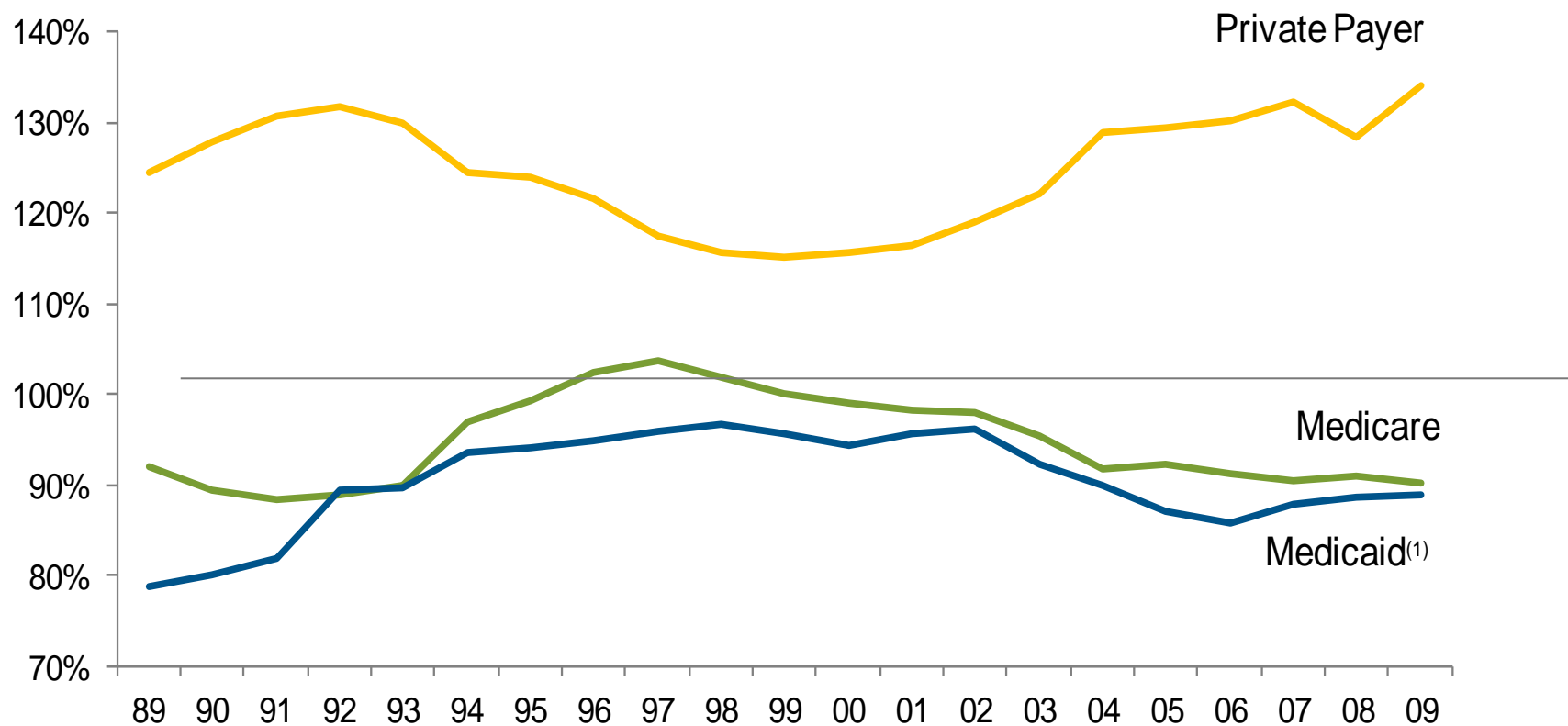
Percent of adults ages 19–64 who had any of four access problems* in past year because of cost



* Did not fill a prescription; skipped recommended medical test, treatment, or follow-up; had a medical problem but did not visit doctor or clinic; or did not see a specialist when needed.

Source: The Commonwealth Fund National Scorecard on U.S. Health System Performance, 2011.

Aggregate Hospital Payment-to-cost Ratios for Private Payers, Medicare, and Medicaid, 1989 – 2009



Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2009, for community hospitals.

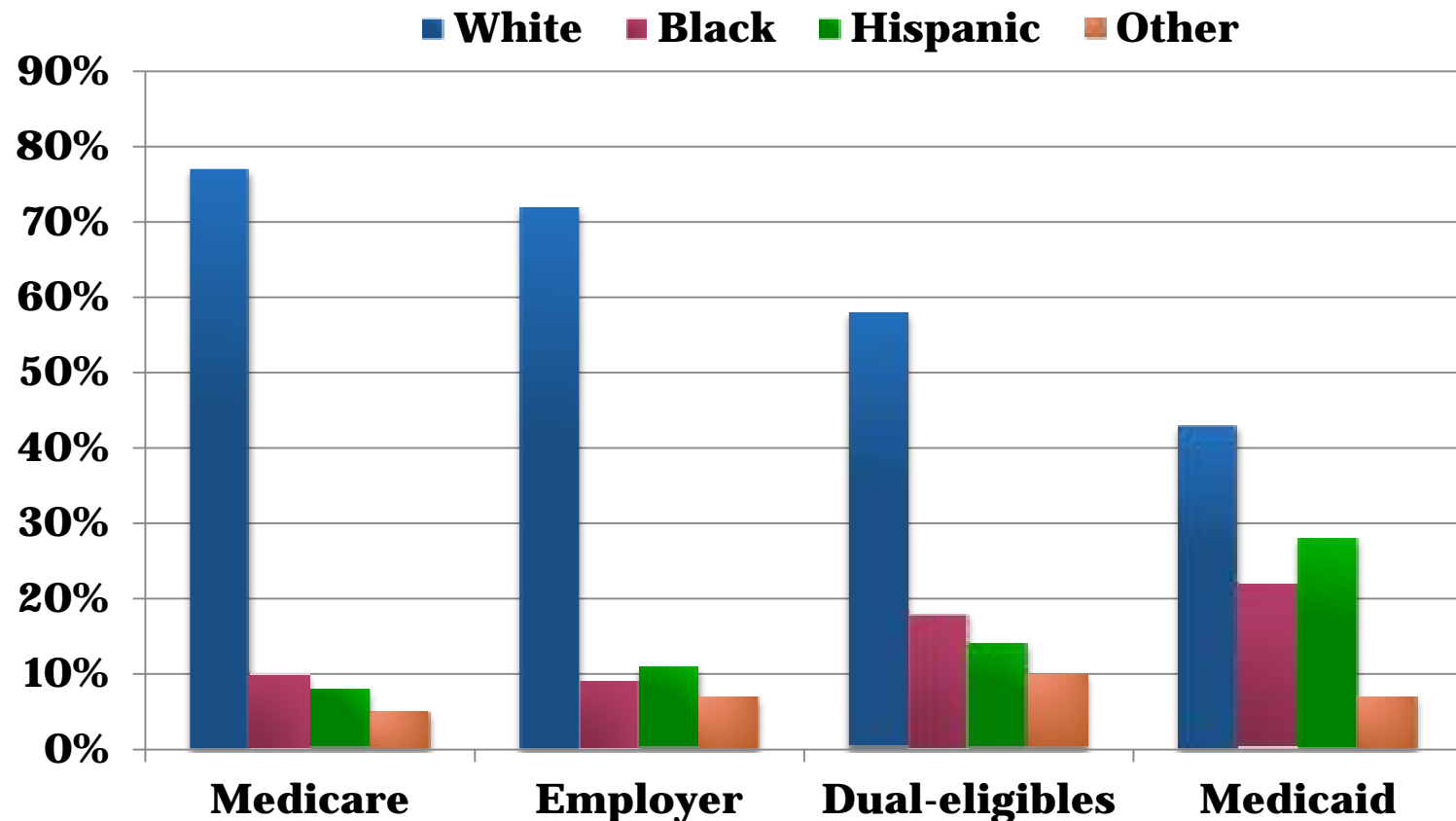
⁽¹⁾ Includes Medicaid Disproportionate Share payments.

Medicaid-To-Medicare Fee Index, By Type Of Service, 2008

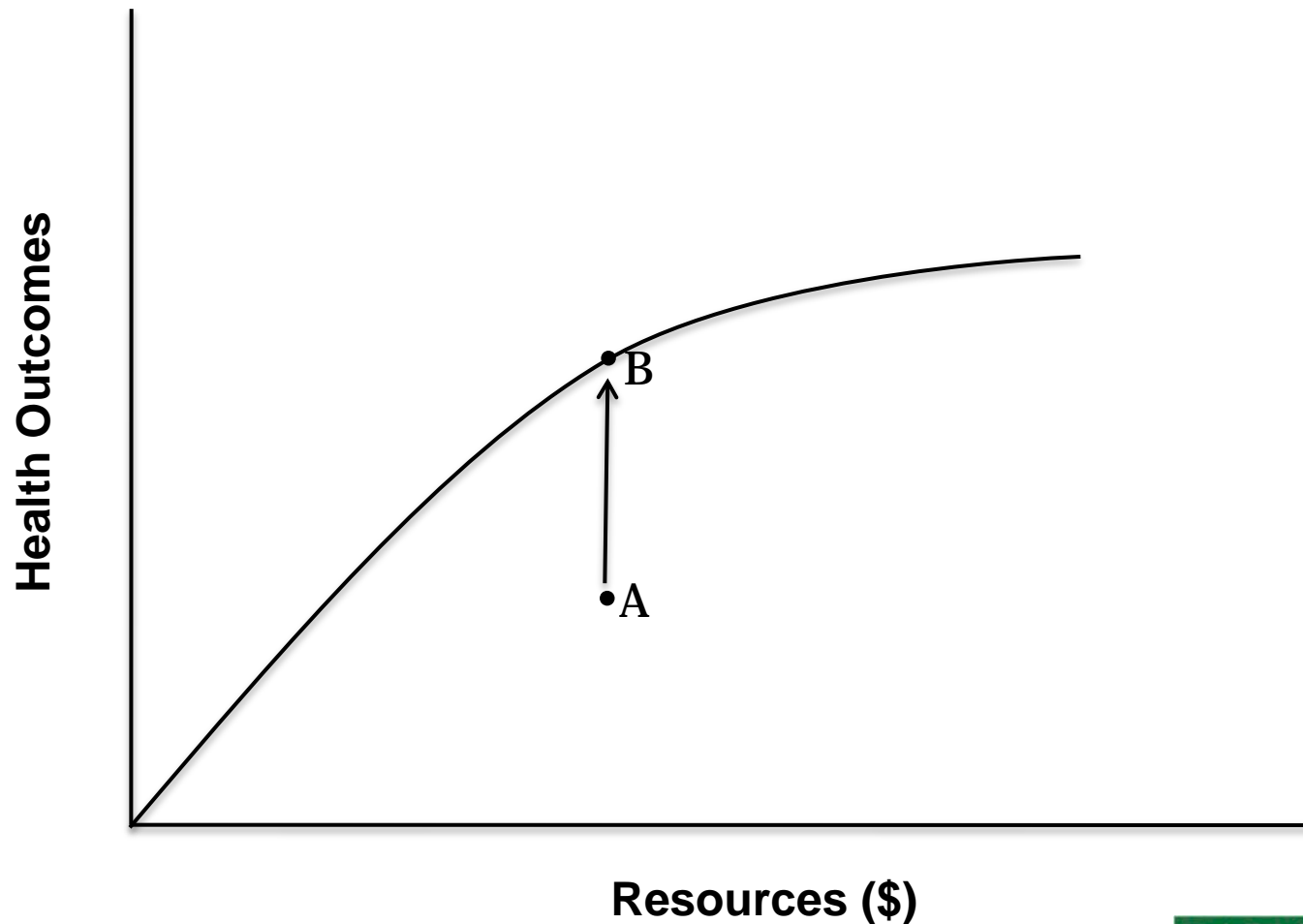
State	All services	Primary care	Obstetric care	Other services
US	0.72	0.66	0.93	0.72
CA	0.56	0.47	0.64	0.69
FL	0.63	0.55	0.99	0.59
IL	0.63	0.57	0.82	0.64
NY	0.43	0.36	0.67	0.31
TX	0.74	0.68	0.87	0.83

Source: Stephen Zuckerman, Aimee F. Williams and Karen E. Stockley, "Trends In Medicaid Physician Fees, 2003–2008," *Health Affairs*, 28, no.3 (2009):w510-w519

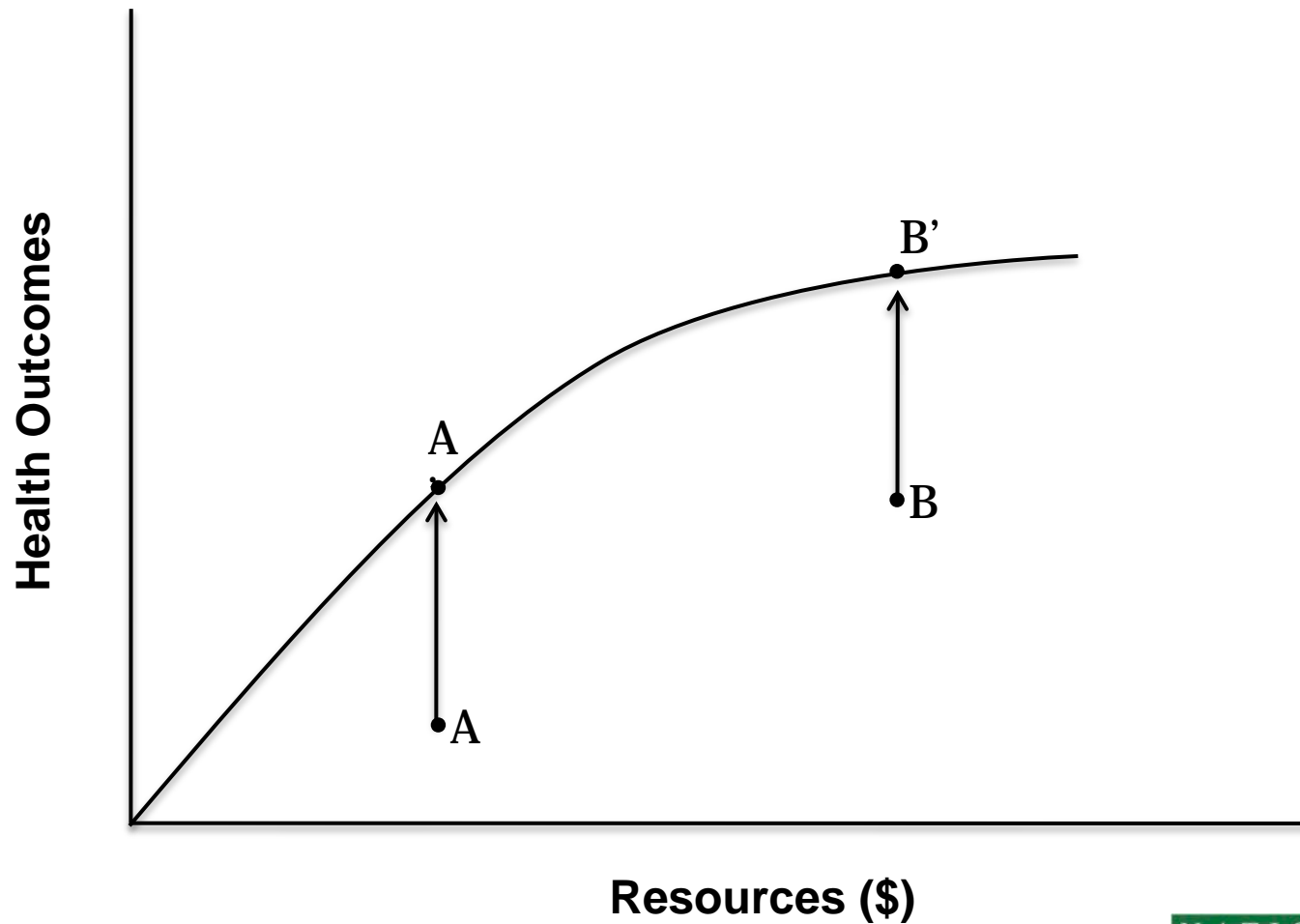
Racial Composition of Various Programs



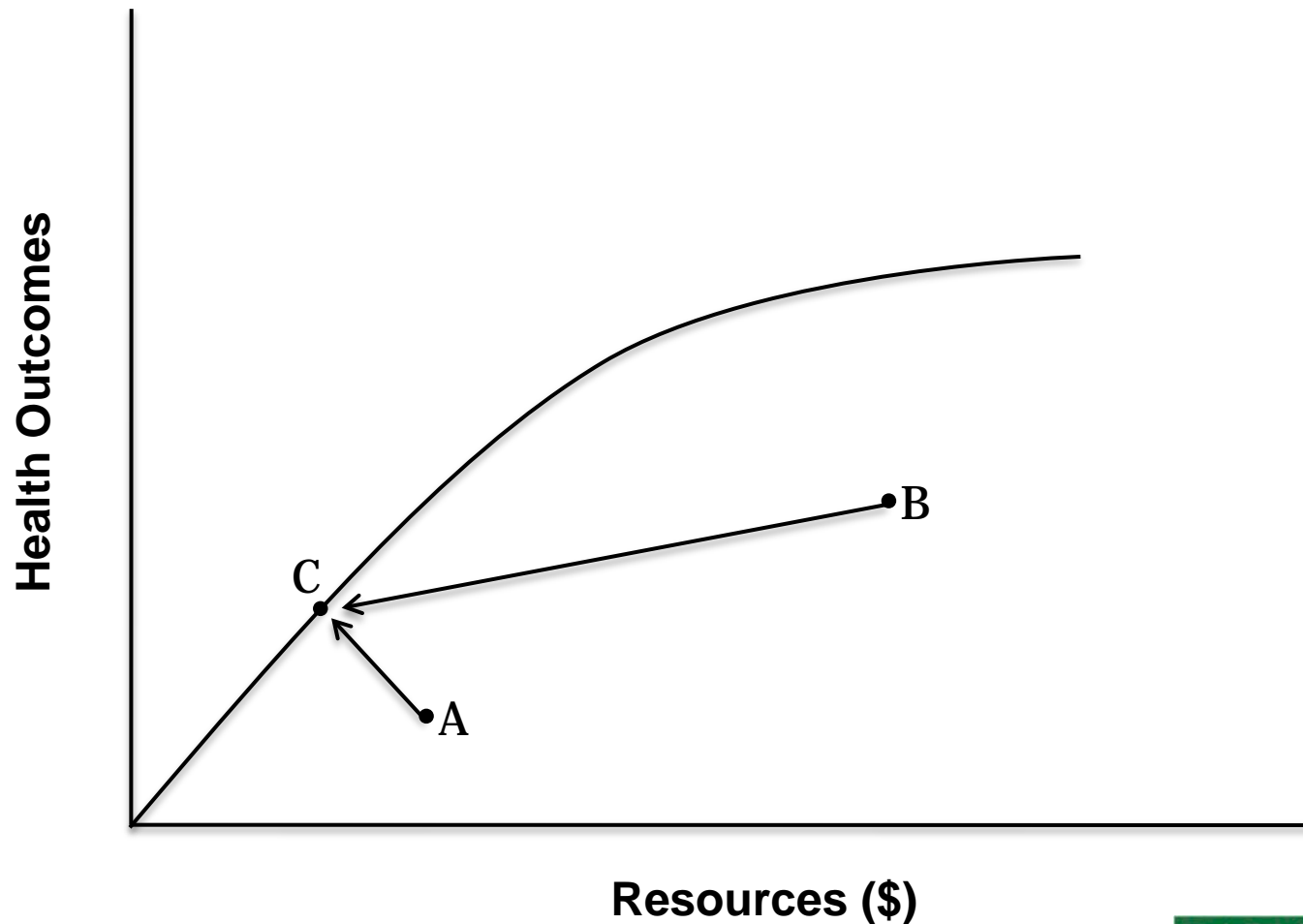
Eliminate Disparities (ver. 2)



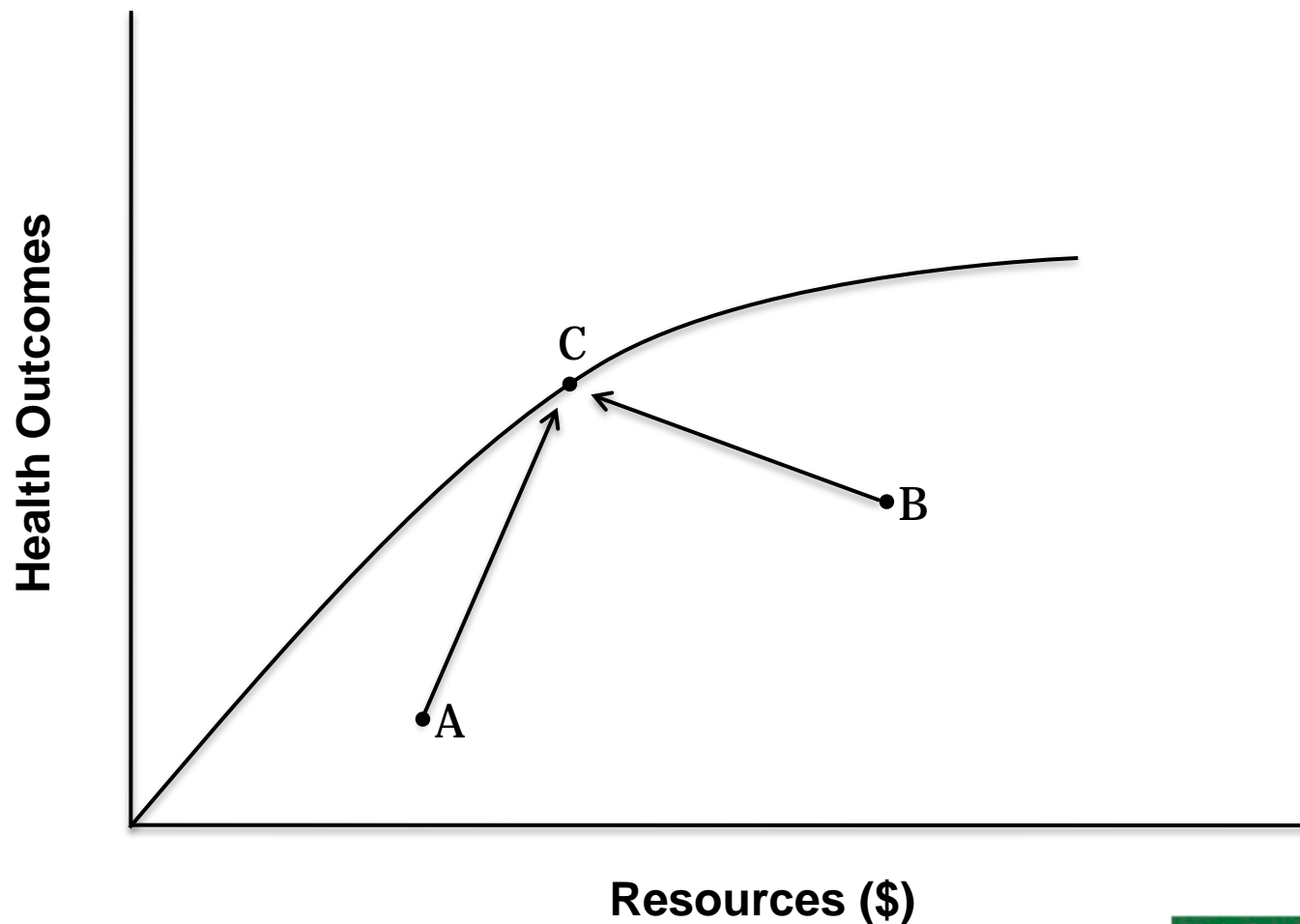
Where We Are



Eliminate Disparities (ver. 3)

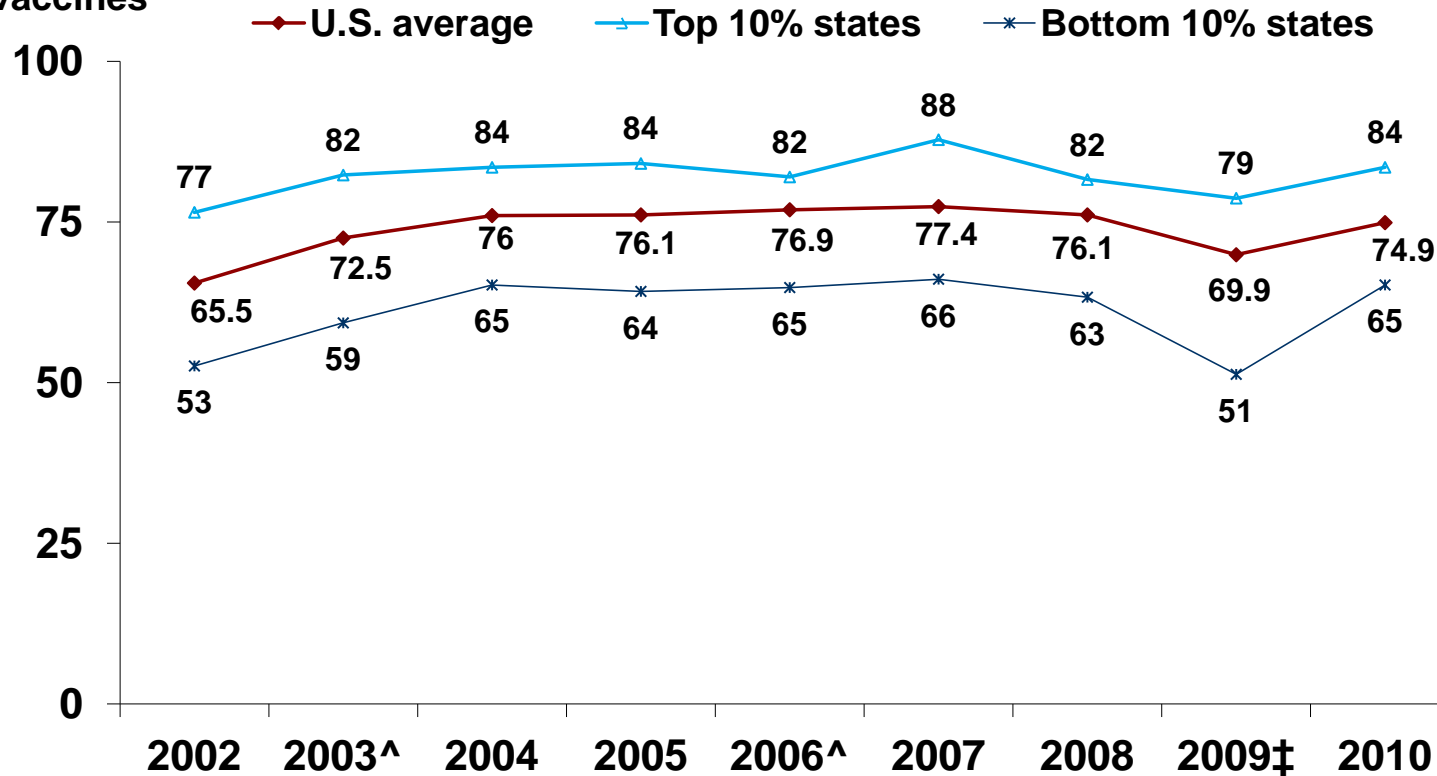


Eliminate Disparities (ver. 4)



Immunizations for Young Children

Percent of children ages 19–35 months who received all recommended doses of six key vaccines*

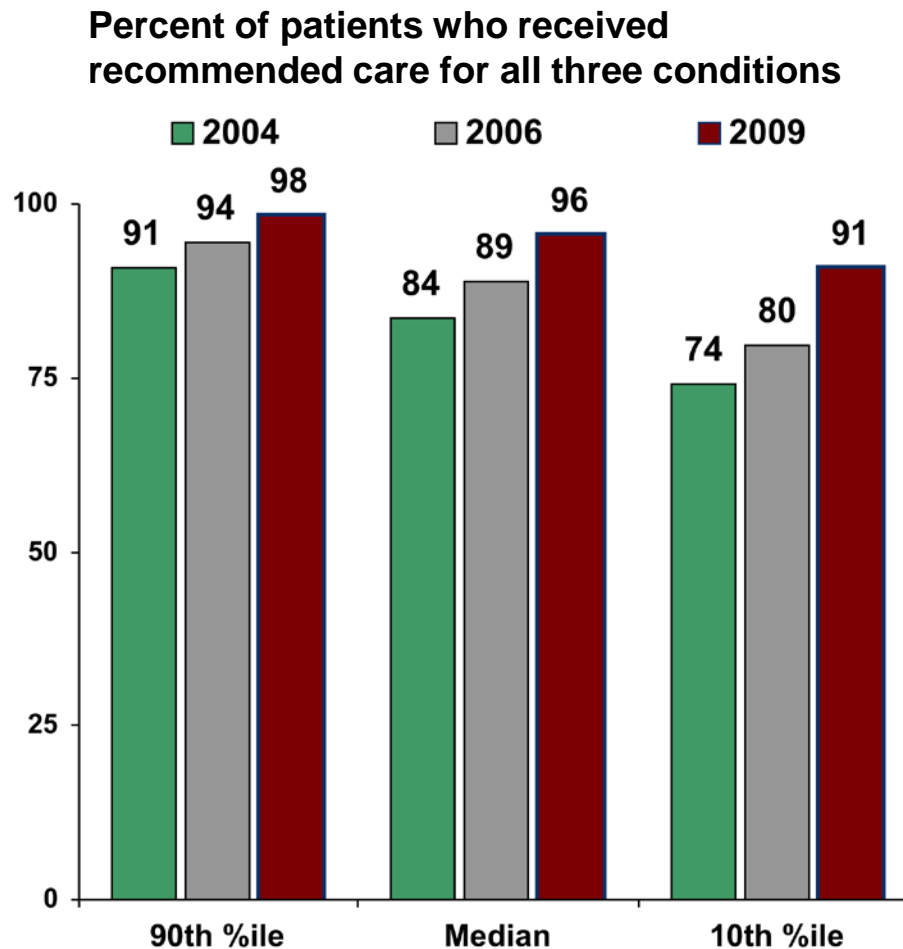


* Recommended vaccines include: 4+ doses of diphtheria-tetanus-pertussis (DTP), 3+ doses of polio, 1+ doses of measles-mumps-rubella, 3+ doses of *Haemophilus influenzae* type B, 3+ doses of hepatitis B, and 1+ doses of varicella. [^] Denotes years in 2006 and 2008 National Scorecards. [‡] 2009 data are affected by a shortage of Hib vaccine in Dec. 2007–Sept. 2009.

Data: National Immunization Survey

Source: Adapted from The Commonwealth Fund National Scorecard on U.S. Health System Performance, 2011.

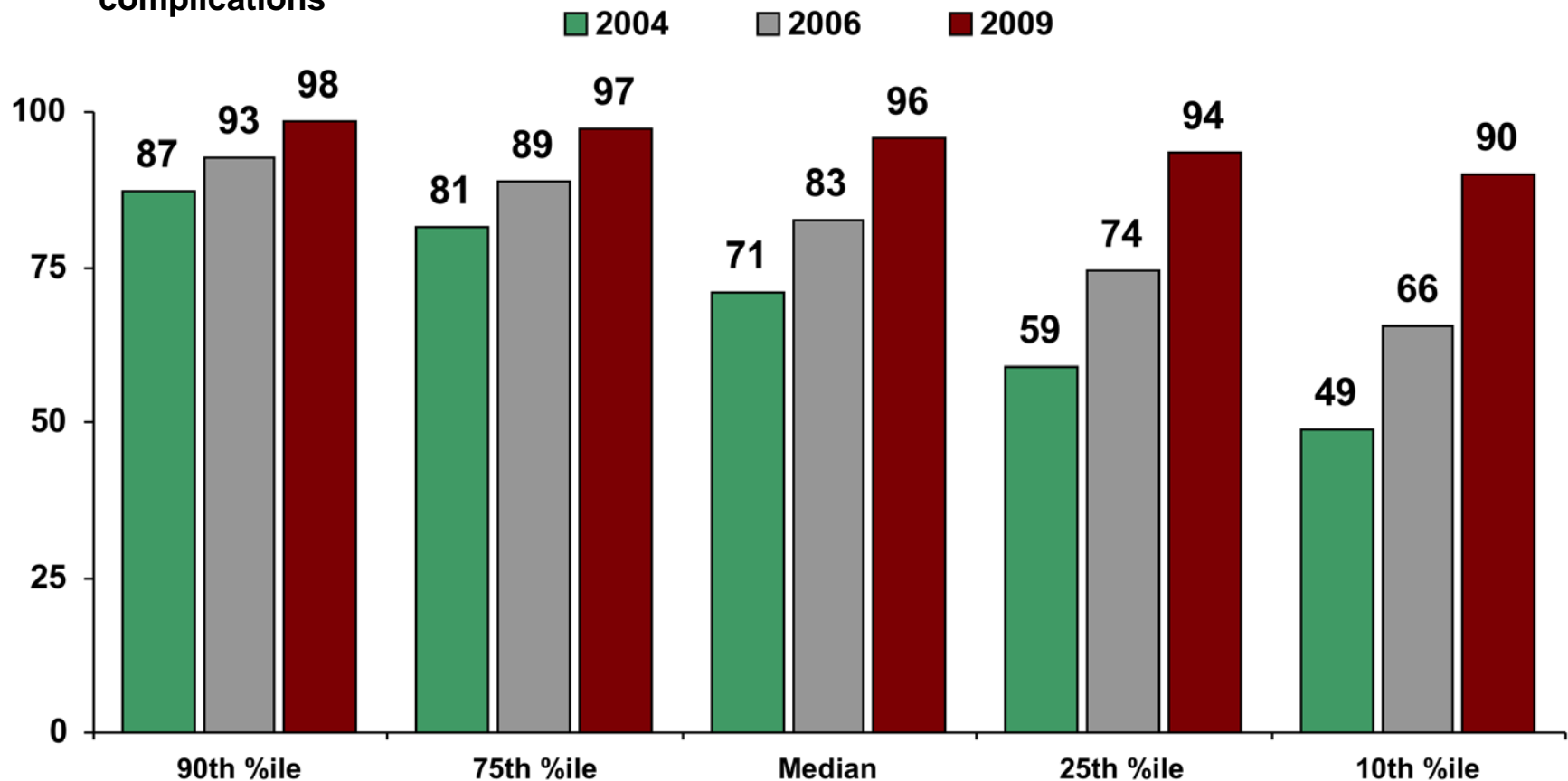
Hospitals: Quality of Care for Heart Attack, Heart Failure, and Pneumonia



Source: Adapted from The Commonwealth Fund National Scorecard on U.S. Health System Performance, 2011.

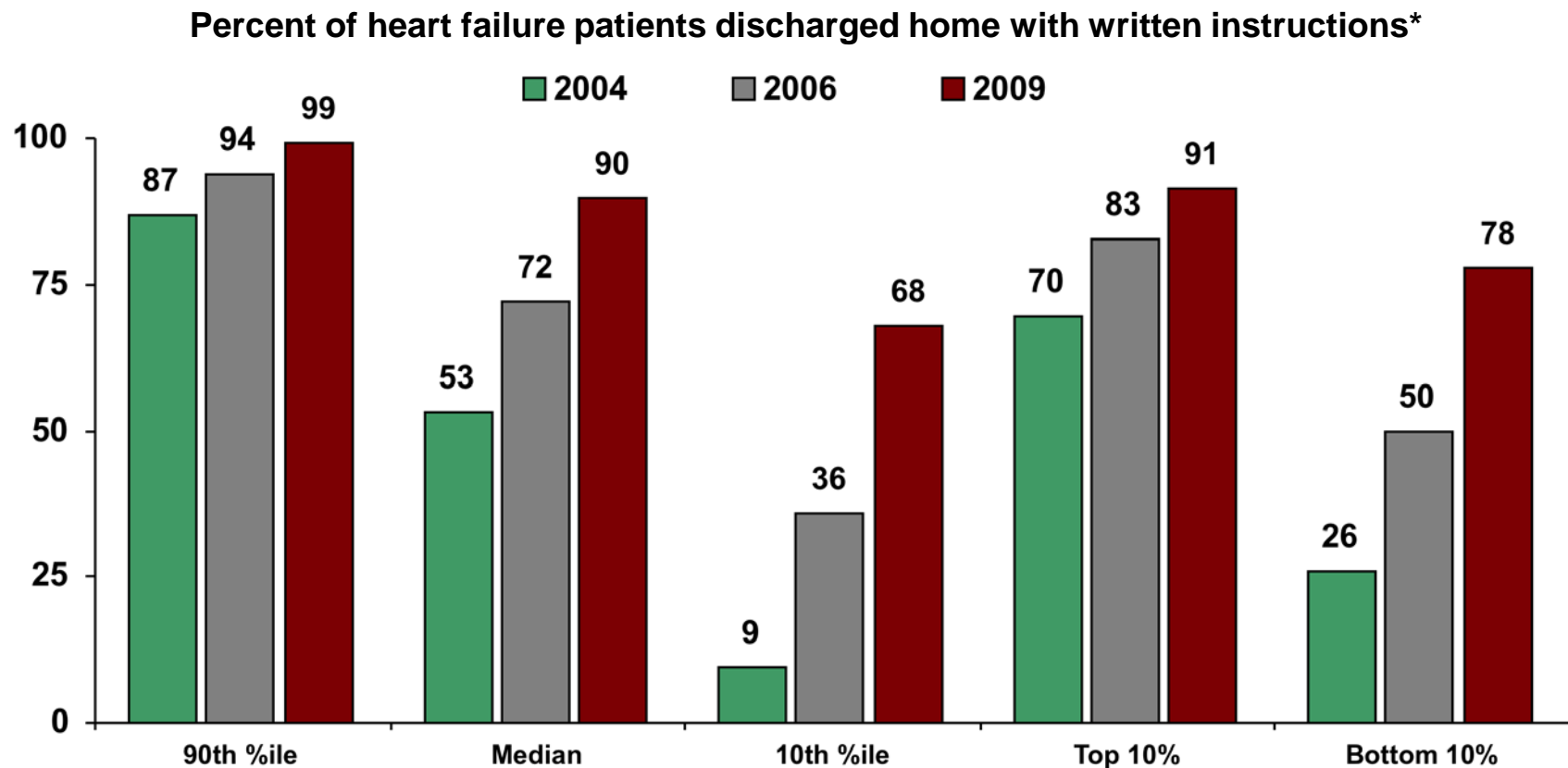
Hospitals: Prevention of Surgical Complications

Percent of adult surgical patients who received appropriate care to prevent complications



Source: Adapted from The Commonwealth Fund National Scorecard on U.S. Health System Performance, 2011.

Heart Failure Patients Given Complete Written Instructions When Discharged, by Hospitals and States



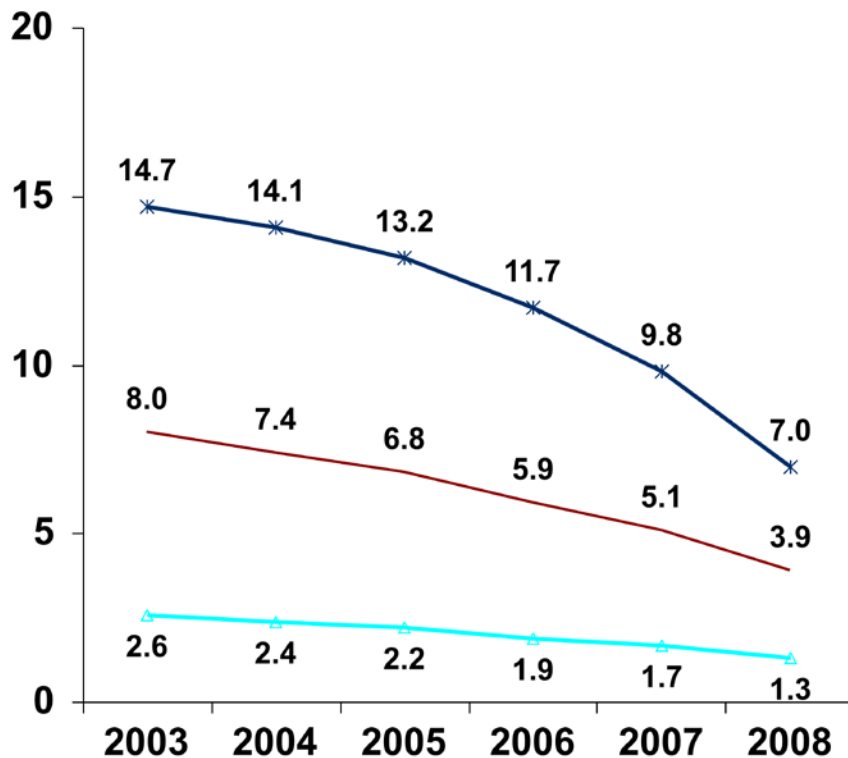
* Discharge instructions must address all of the following: activity level, diet, discharge medications, follow-up appointment, weight monitoring, and what to do if symptoms worsen.

Source: Adapted from The Commonwealth Fund National Scorecard on U.S. Health System Performance, 2011.

Physical Restraints in Nursing Facilities

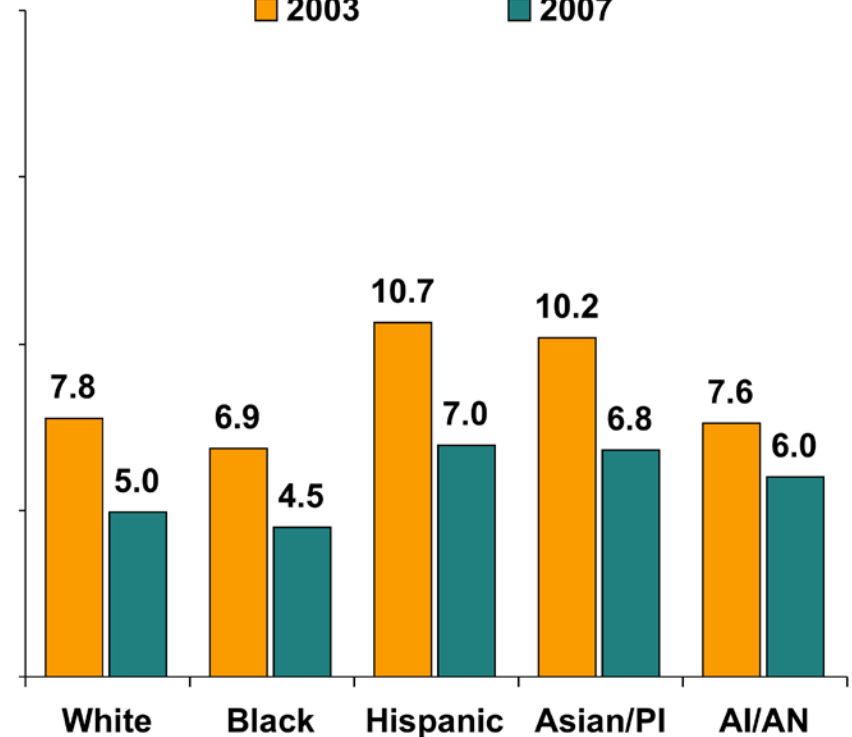
U.S. average and state distribution

— U.S. average * Bottom 10% states ▲ Top 10% states

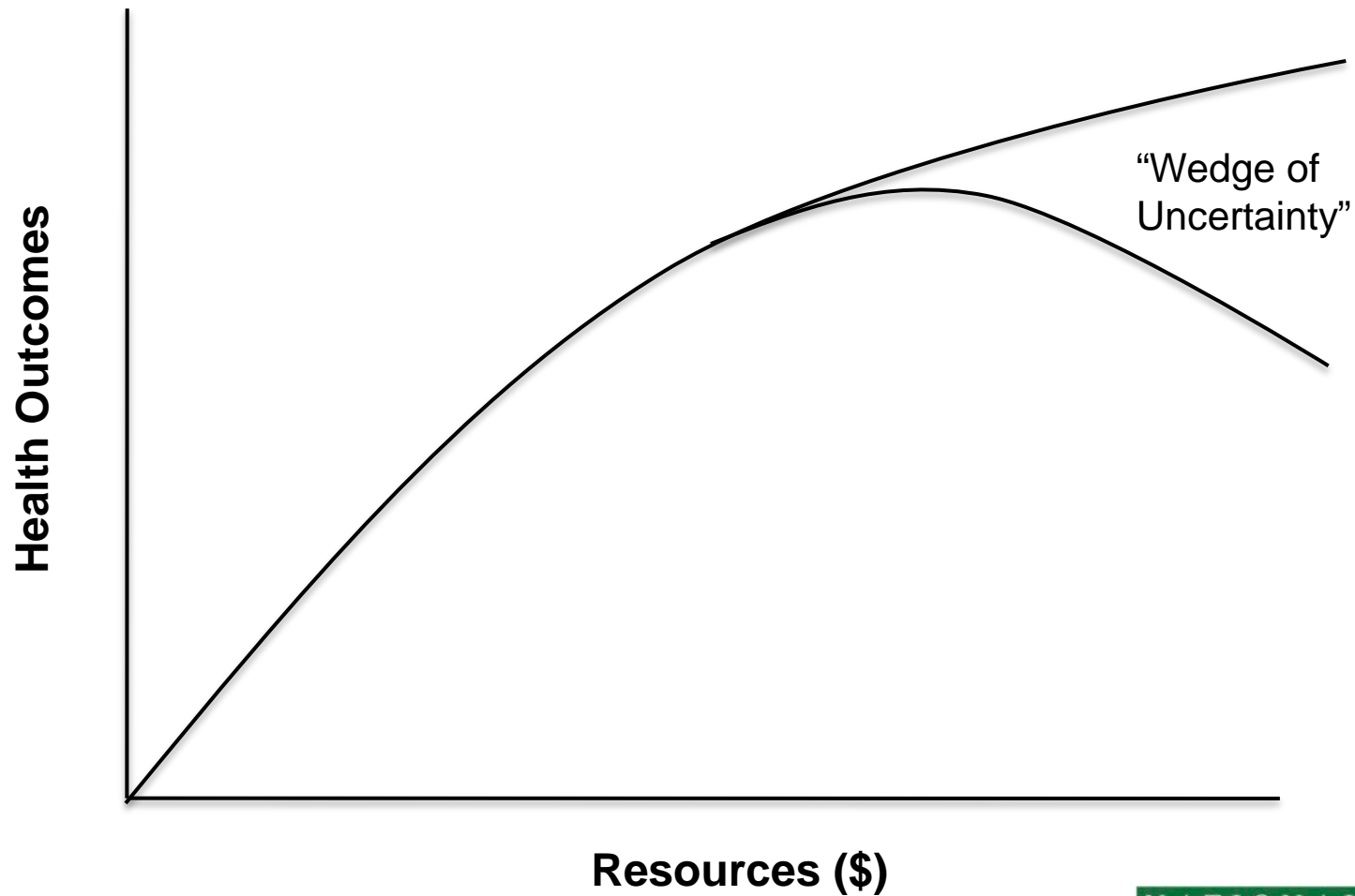


By race/ethnicity

■ 2003 ■ 2007



Confounding Problem



Framework for Addressing Health Disparities

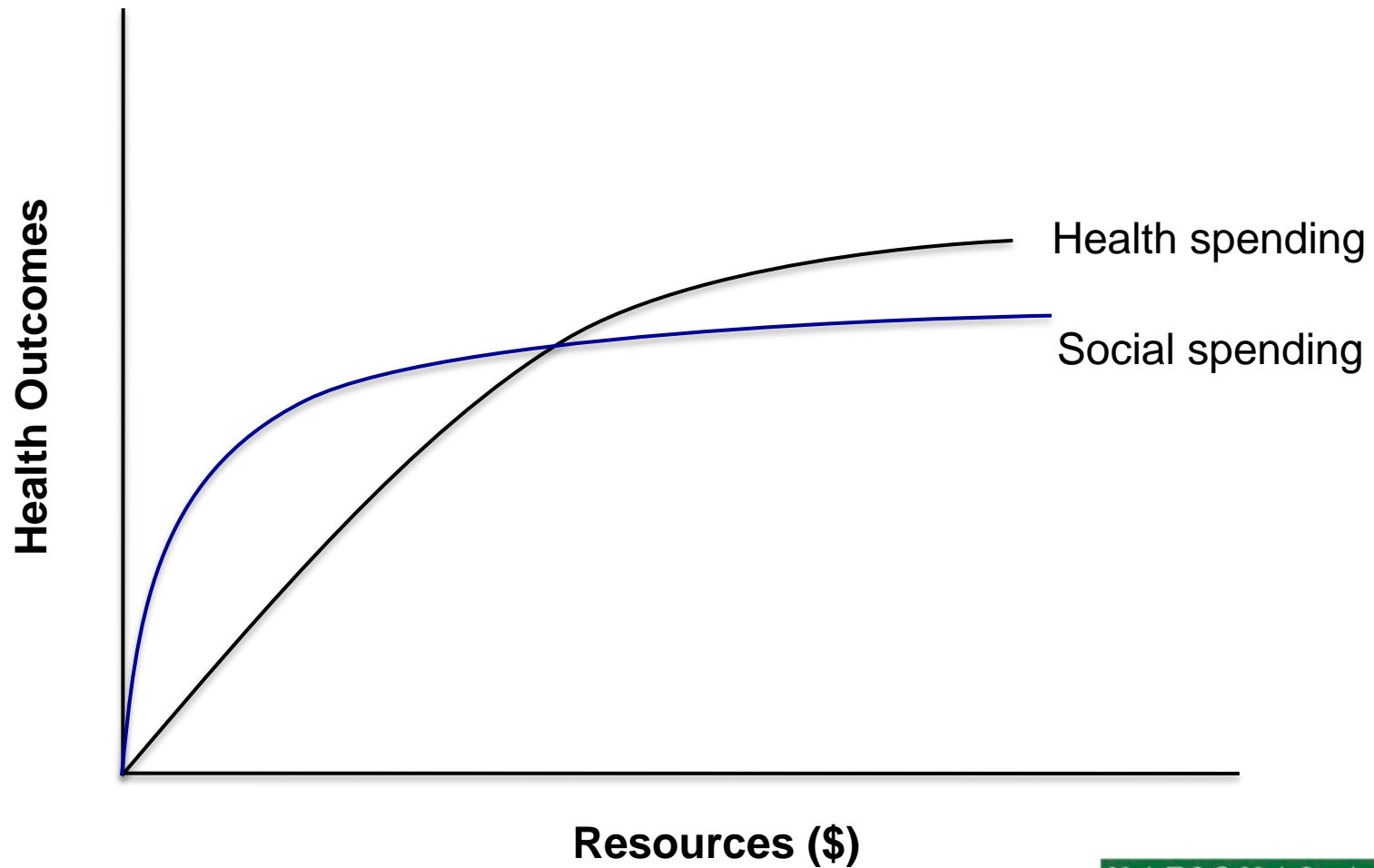
- Layer 1 – Micro system level
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“...improving the clinical care delivery system’s efficiency and effectiveness will probably have only modest effects on the health of the population overall in the absence of an ecologic, population-based approach to health improvement.”

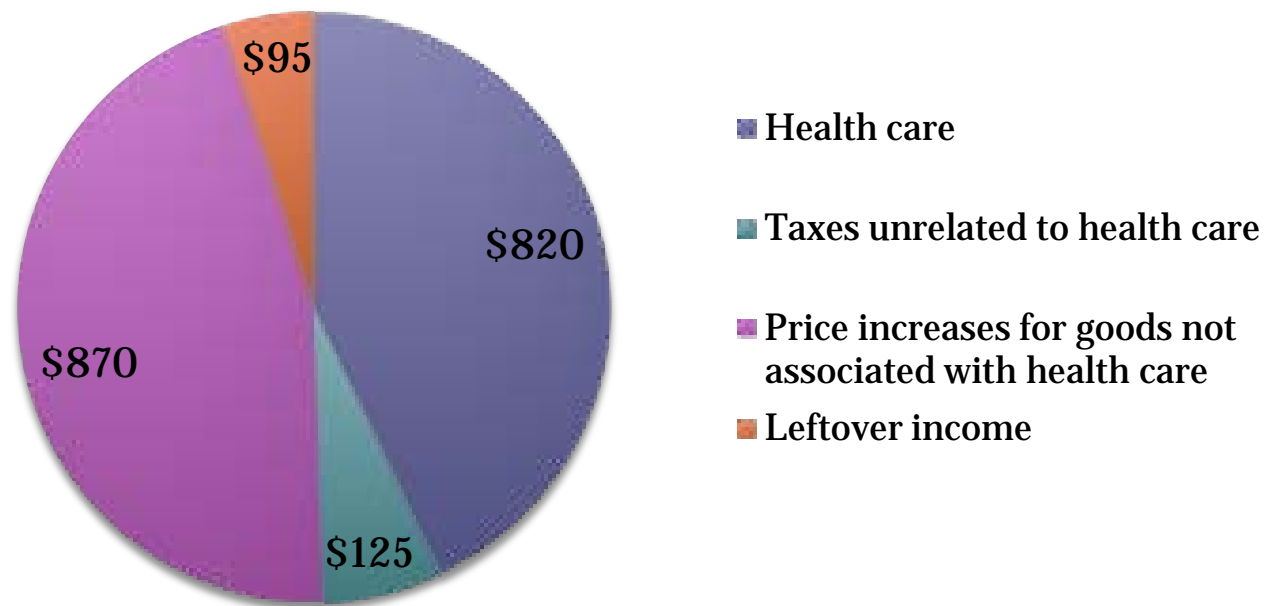
- Institute of Medicine

We All Know This



Where Did Family Income Go in the Last Decade?

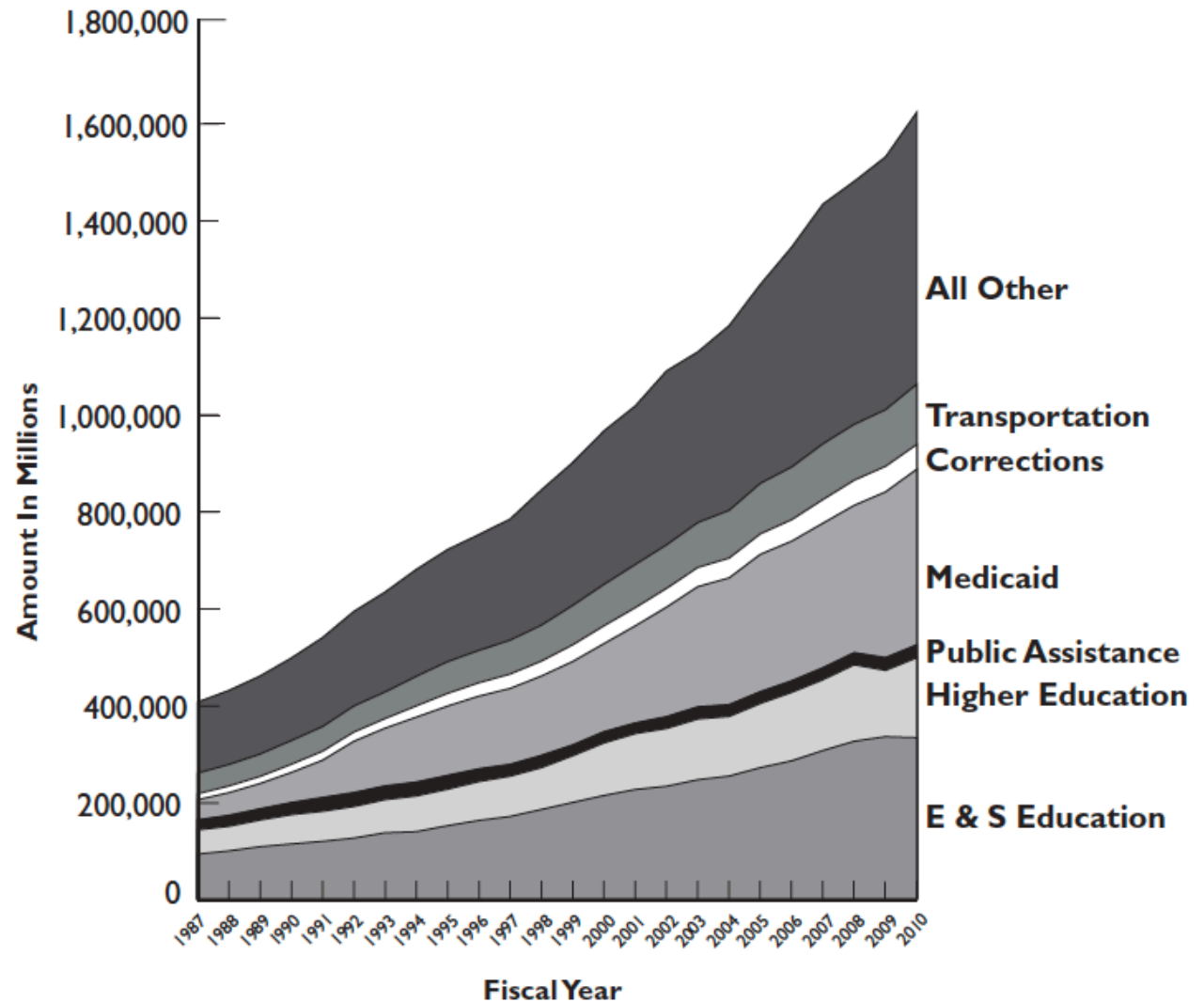
Family spending of increased income
Monthly income increase from 1999-2009: \$1,910



Source: David I. Auerbach and Arthur L. Kellermann, "A Decade Of Health Care Cost Growth Has Wiped Out Real Income Gains For An Average US Family," *Health Affairs*, 30, no.9 (2011):1630-1636

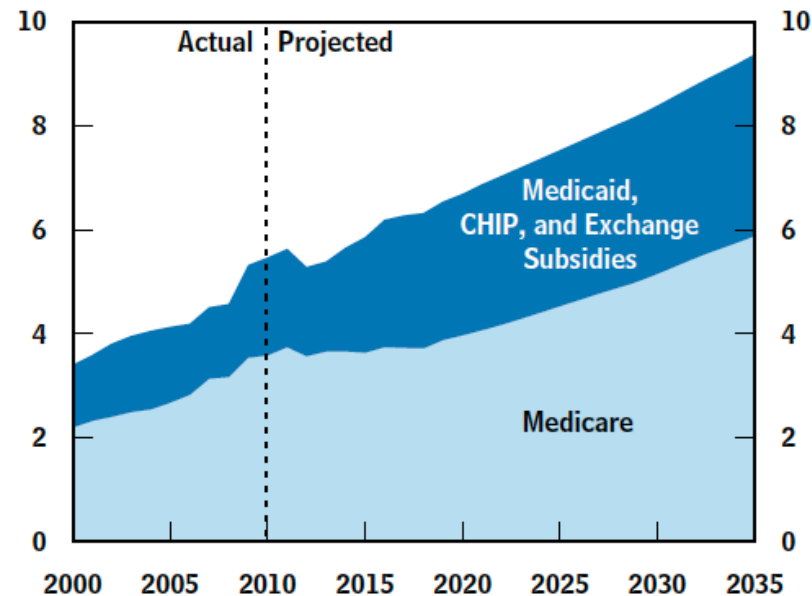
COMPOSITION OF TOTAL STATE EXPENDITURES BY FUNCTION, FISCAL 1987 TO 2010

- (“All other” is a broad category that includes state functions not tracked individually in this report, such as hospitals, economic development, housing, environmental programs, health programs and the Children’s Health Insurance Program (CHIP), parks and recreation, natural resources, air transportation, and water transport



Mandatory Federal Spending on Health Care, by Category, Under CBO's Extended-Baseline Scenario

(Percentage of gross domestic product)

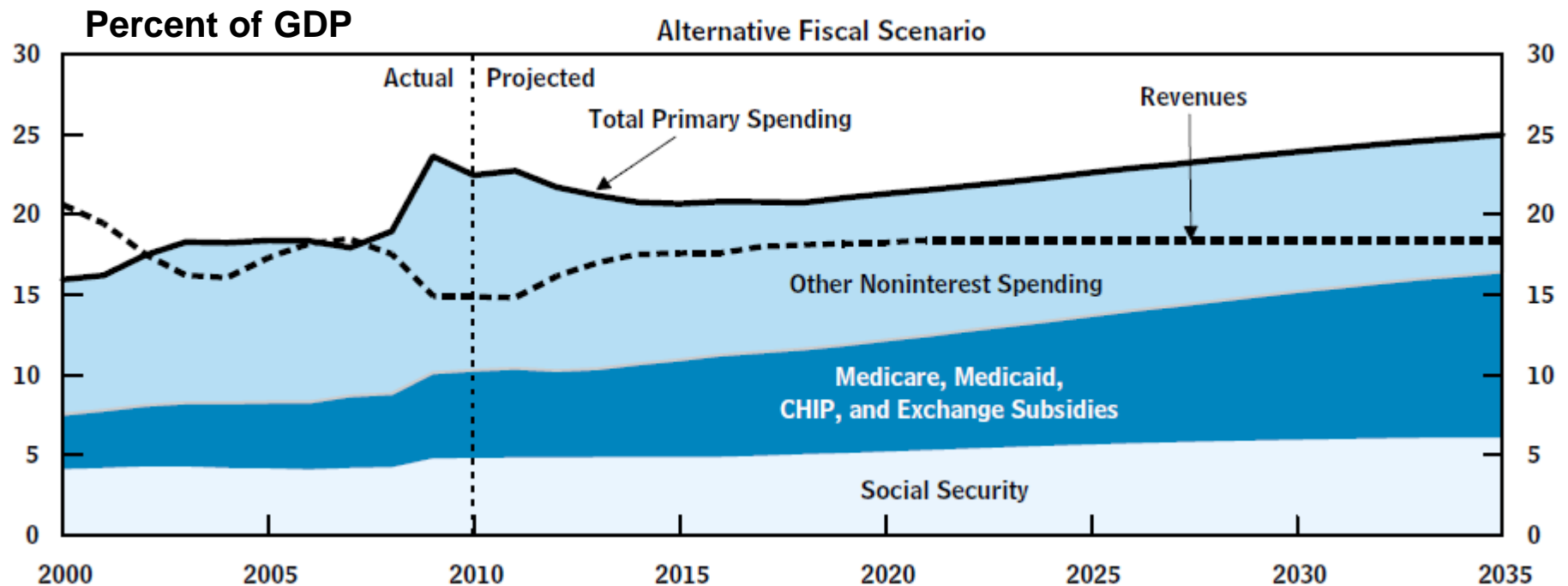


Source: Congressional Budget Office.

Notes: The extended-baseline scenario adheres closely to current law, following CBO's 10-year baseline budget projections through 2021 and then extending the baseline concept for the rest of the long-term projection period. (For details, see Table 1-1 on page 4.)

CHIP = Children's Health Insurance Program.

Federal Revenues and Primary Spending, by Category, Under CBO's Alternative Fiscal Scenario



Note: The alternative fiscal scenario incorporates several changes to current law that are widely expected to occur or that would modify some provisions that might be difficult to sustain for a long period, including: Medicare payment rates for physicians are maintained at the 2011 levels through 2021 (rather than at the lower rates of the sustainable growth rate mechanism) and that, after 2021, several policies that would restrain spending growth are assumed not to be in effect; and, all individual income tax provisions scheduled to expire in the next 10 years are extended through 2021, including the income tax reductions and AMT relief temporarily extended in the 2010 tax act.

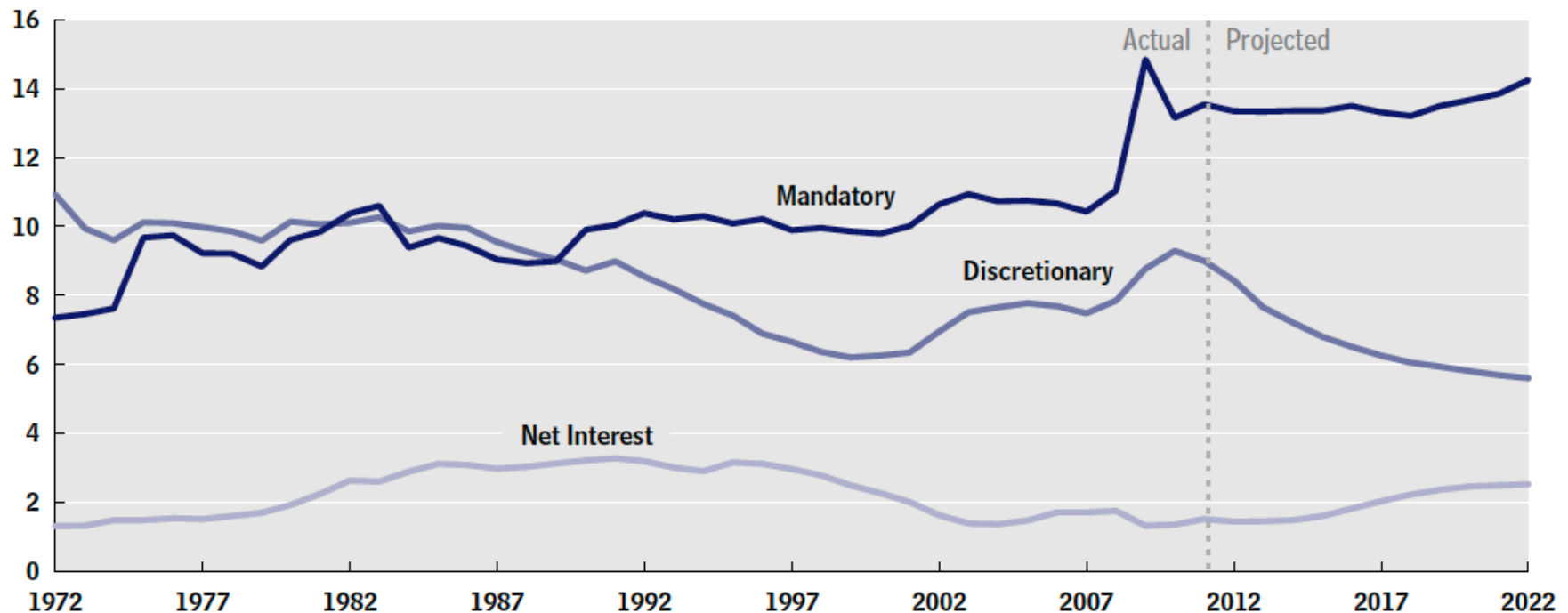
Source: Congressional Budget Office, The Long-Term Budget Outlook, June 2011.

Long-term Budget Outlook

Baseline scenario

Outlays, by Category

(Percentage of gross domestic product)



Source: Congressional Budget Office.

Source: CBO, "The Budget and Economic Outlook: Fiscal Years 2012 to 2022," January 2012, page 50

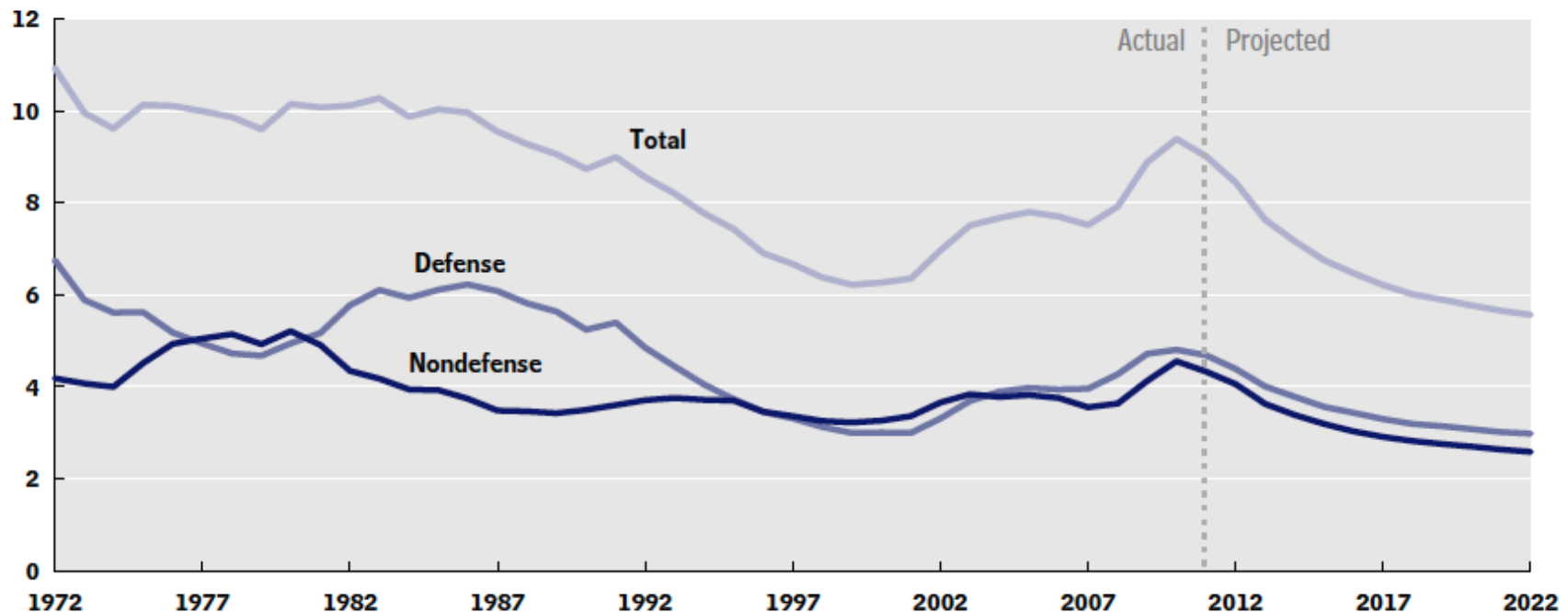
Long-term Budget Outlook – Discretionary Outlays

Baseline scenario

Figure 3-5.

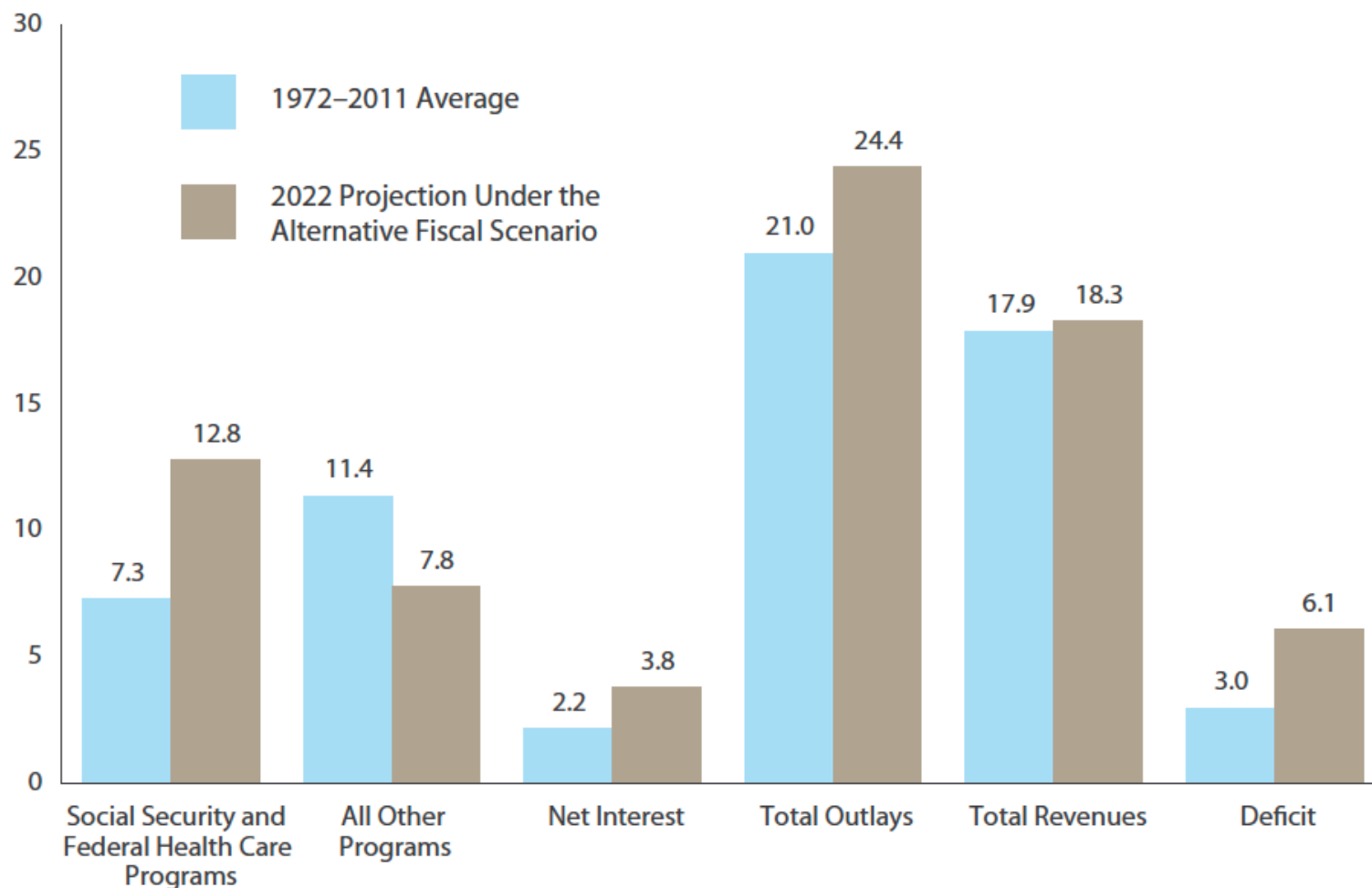
Discretionary Outlays, by Category

(Percentage of gross domestic product)



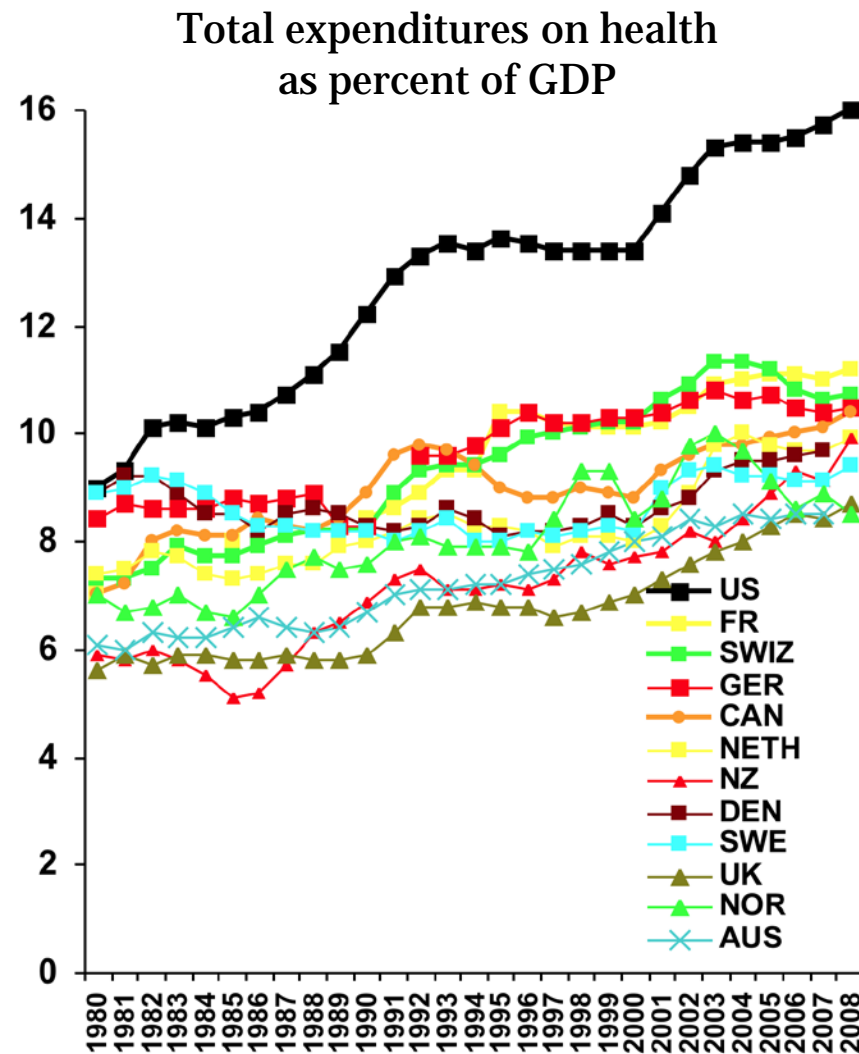
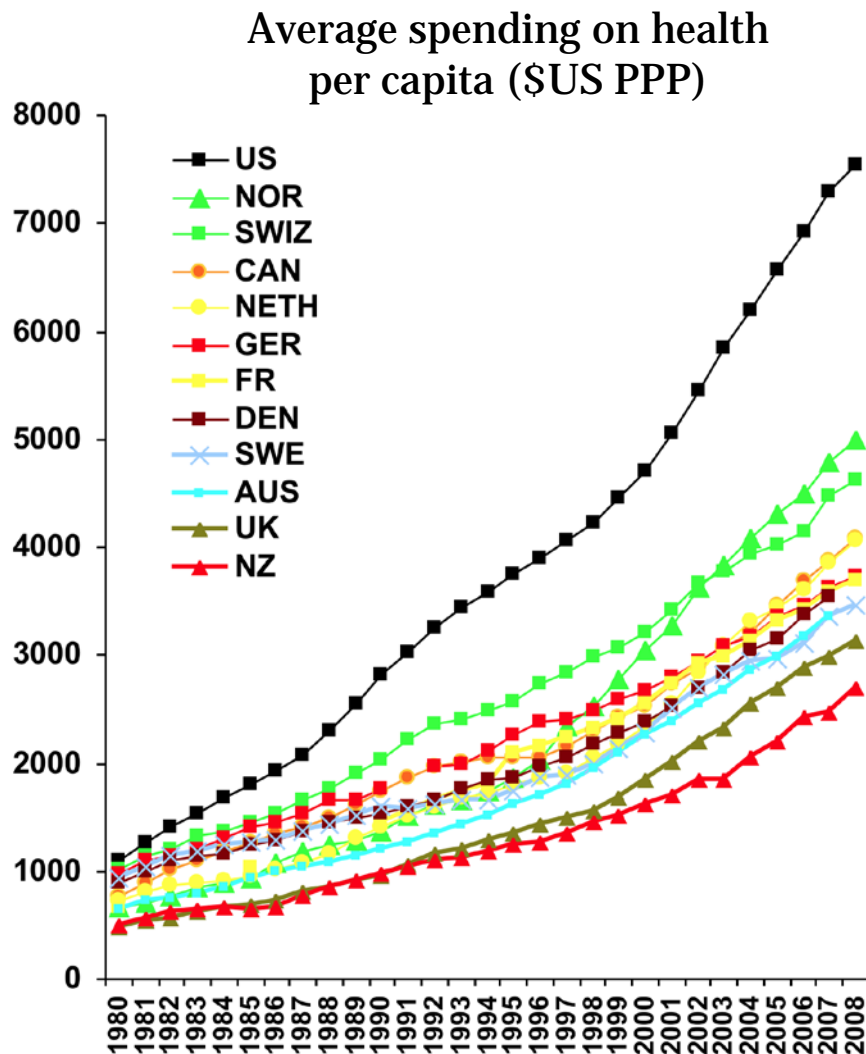
Source: CBO, "The Budget and Economic Outlook: Fiscal Years 2012 to 2022," January 2012, page

Components of the Federal Budget as Shares of GDP:1972-2011 Average and 2022 Projection Under the Alternative Fiscal Scenario



Source: Douglas W. Elmendorf, "The Budget and Economic Outlook: Fiscal Years 2012 to 2022,"
Testimony before the Senate Budget Committee, February 2012

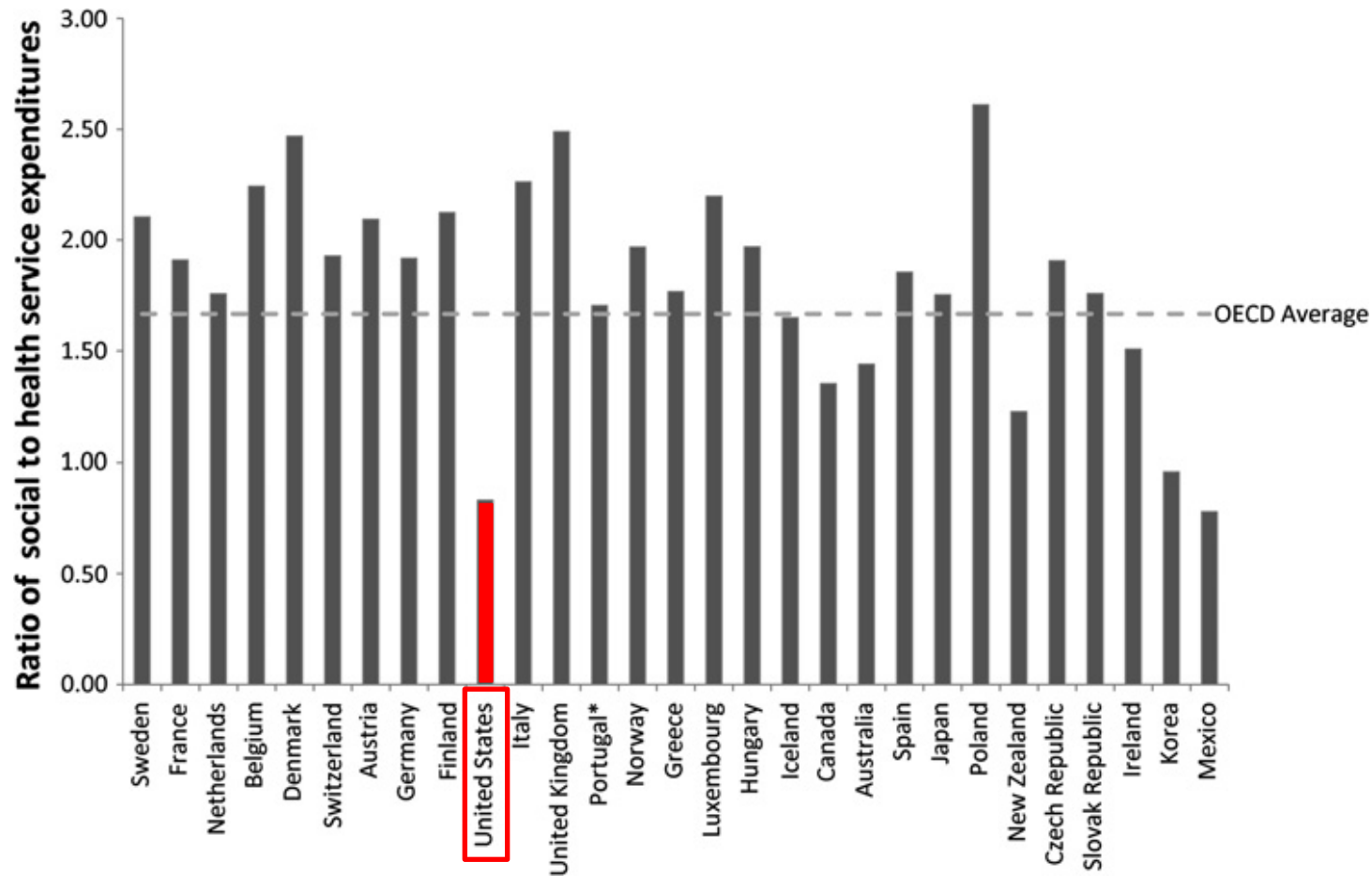
International Comparison of Spending on Health, 1980–2008



Total Hospital and Physician Costs for Select Surgeries—International Comparisons

	Appendectomy	Hip Replacement	Bypass Surgery
Canada	\$3,810	\$10,753	\$22,212
France	\$2,795	\$12,629	\$16,325
Germany	\$3,285	\$15,329	\$27,237
Netherlands	\$4,624	\$12,737	\$19,180
Spain	\$2,537	\$9,327	\$15,802
Switzerland	\$2,750	\$6,683	\$11,618
UK	\$3,476	\$9,637	\$13,998
US (avg)	\$13,123	\$34,454	\$59,770
US (95 th percentile)	\$25,344	\$75,369	\$126,182

International Comparison of Health and Social Services Expenditures



Source: Elizabeth H Bradley et al., "Health and social services expenditures: associations with health outcomes," BMJ Quality and Safety (2011)

Reasons for Optimism

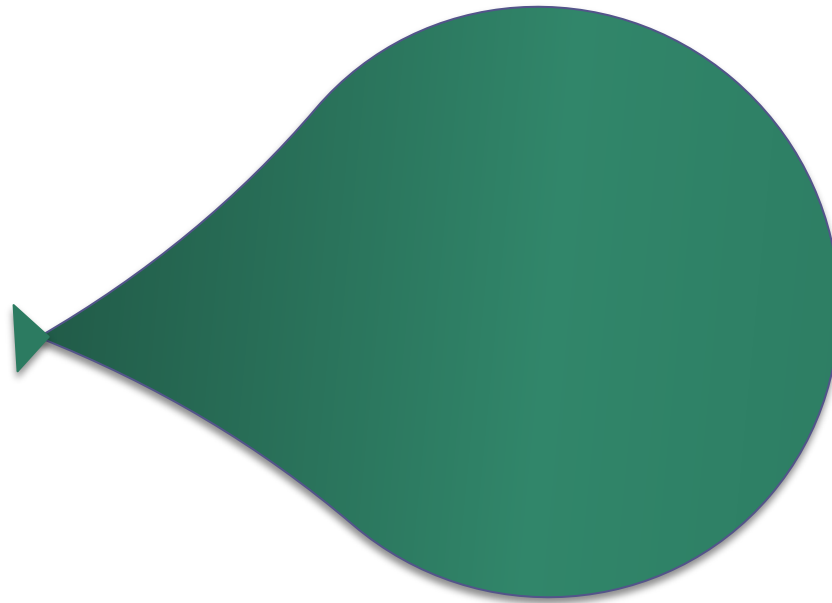
- Significant layer 1 activity
- ACA provisions affect layers 1 and 2
- Delivery system primed for reform

Unfinished Business

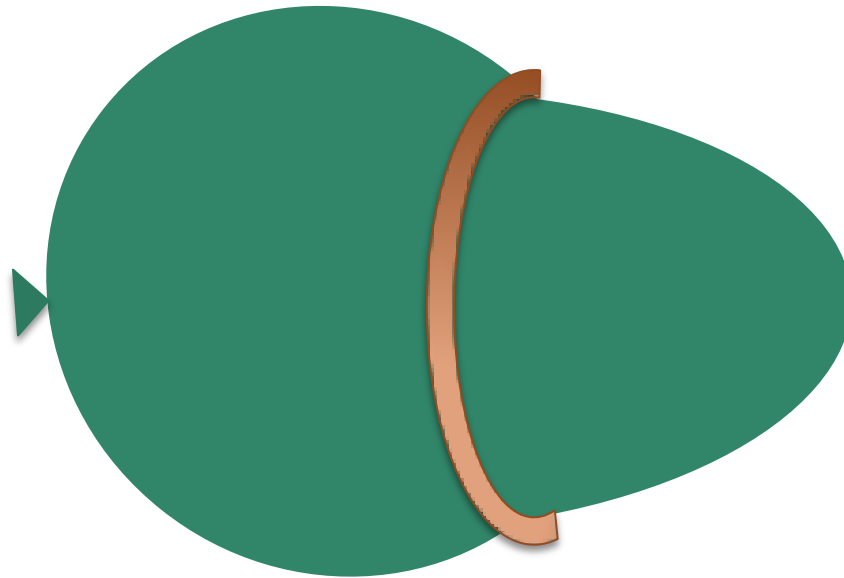
The Allocation Problem

Prevention, Health Promotion, Public Health, Social Investments	Core Health Care Services	Leading Edge of Health Care
<ul style="list-style-type: none"> •Underinvestment •Isolation •Unreasonably high burden of proof 	<ul style="list-style-type: none"> •Overuse •Administrative waste •Quality defects •Underuse •Misallocation 	<ul style="list-style-type: none"> •Excessively rapid adoption •Excessively slow rejection •Pricing errors •Irrational exuberance

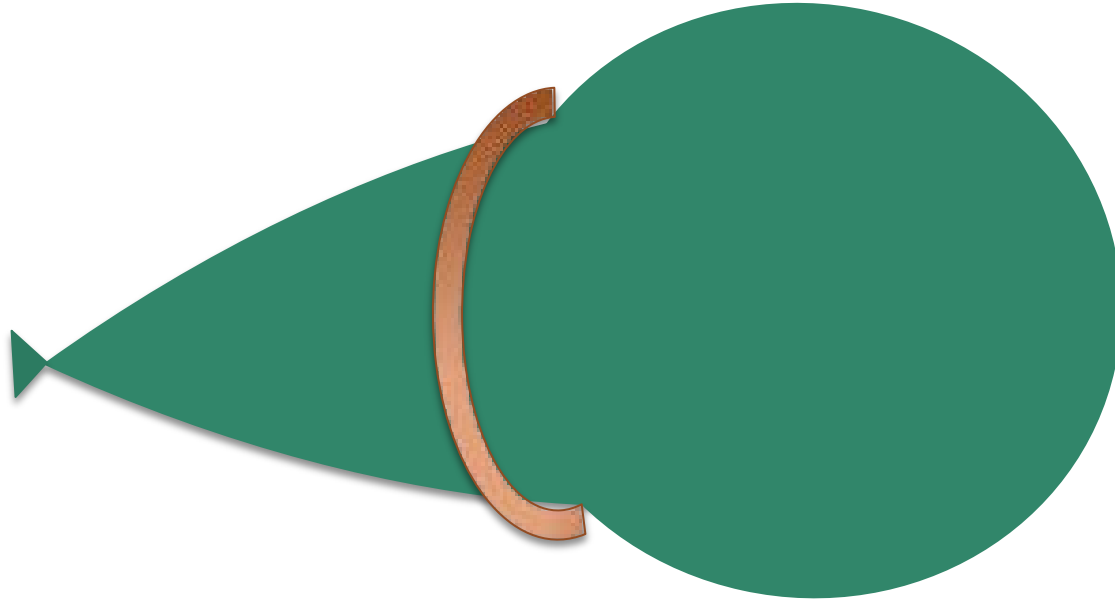
Where We Are



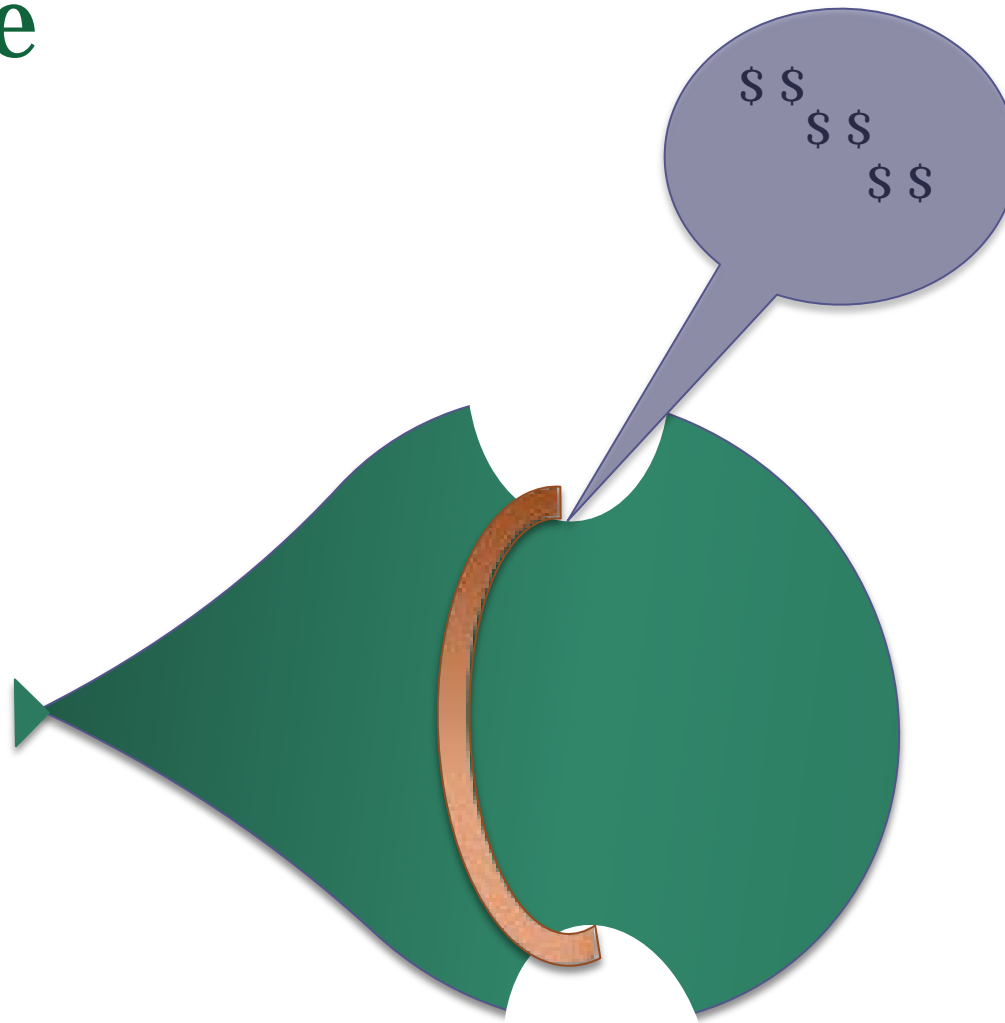
Where We Need to Be



But We Could End Up Here



Or Here



Deficit Reduction
Tax Cuts

Five Opening Observations on Squeezing the Balloon

1. Allocation problem is structural
2. From “accountable care” to “population health” is a big leap
3. American federalism is a strength (and weakness)
4. Lack of infrastructure is a huge problem
5. Cost containment must have a purpose

Role of Philanthropy

Can We Challenge Our Assumptions?

- Medicare and Medicaid defense
- Essential Health Benefits and benefit design
- Malpractice reform
- Can we hear a cry for help?
- Can we engage two lost souls: patients and physicians?

Our Health Sector “Ask”

- Adopt a coherent vision (triple aim)
- Shift from individual to system performance metrics
- Redefine quality from technical to contextual performance
- Reengineer to drive out waste
- Take risk/bear risk
- Lead and bring your board along with you
- Work across organizations of differing sizes and missions
- Break down professional barriers; work in teams
- Don't compete over the wrong things
- Be nimble
- Share your data
- Share the credit
- Get paid less if you don't succeed at making all of these changes

My Philanthropic ~~Our~~ Health Sector “Ask”

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Grantmakers In Health (GIH) is a nonprofit, educational organization dedicated to helping foundations and other grantmakers improve the health of all people. Its mission is to foster collaboration among grantmakers and other stakeholders, strengthen the community's knowledge, skills, and effectiveness.

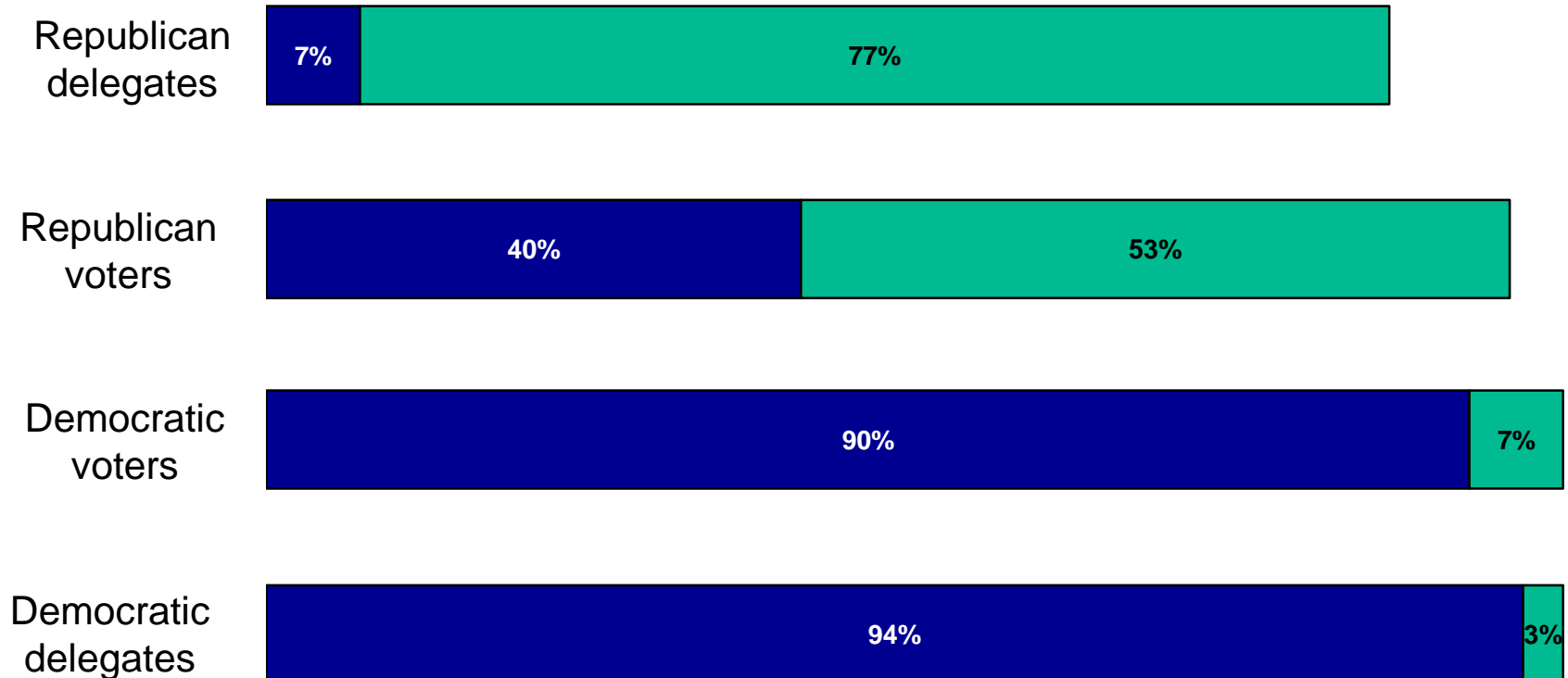
Grantmakers In Health (GIH): Working tirelessly to reduce the burden of the health care system on the health of the American people.

Fundamental Disagreement About Priorities

Is it more important to provide health care coverage for all Americans or hold down taxes?

■ Provide health care for all

■ Hold down taxes



Note: "Don't know" responses not shown

Source: Mollyann Brodie, Kaiser Family Foundation. New York Times/CBS News Poll (Jul 23 – Aug 26, 2008)

Two Ways to Sweeten an Onion



NATIONAL ACADEMY
for STATE HEALTH POLICY
CELEBRATING 25 YEARS OF EXCELLENCE

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