Rising Health Care Costs, Prevention & Primary Care, and Personal Responsibility

Barb Langner, Ph.D.
Policy Director
At-Large Advisory Council Meeting – 9/14
Objectives

- To explore evidence regarding rising costs of health care, chronic disease, and health behavior.
- To explore the evidence regarding coordination of care, primary care, a medical home.
- To discuss personal responsibility related to health behaviors, cost effective use of health care services and health literacy, and contribution to the cost of health insurance.
Rising health care costs and the burden of chronic disease
Institute of Medicine’s Top 10 Concerns re: the US Health System

- The number of uninsured
- The rising costs of care and increases in health care expenses
- Deficient quality and safety
- Inadequate evidence about value performance, cost of intervention and insufficient reliance on available evidence
- Dysfunctional competition, perverse incentives, inefficiency and waste

Dr Fineberg, President of IOM, National Governor’s Association Meeting, July 2007
Institute of Medicine’s Top 10 Concerns re: the US Health System

- Insufficient use of Health Information Technology
- Underinvestment in prevention
- Workforce shortages, low morale, and mismatches to current and future needs
- Disparities in access and outcomes
- Low health literacy and poor accommodations to patients
Building a better health system

“30 to 40% of every dollar spent in the US on health care is spent on overuse, underuse, misuse, duplication, etc”

Dr Fineberg, President of IOM, National Governor’s Association Meeting, July 2007
Health care tab ready to explode

Costs could be 19% of economy by 2014

By Julie Appleby
USA TODAY

The nation's tab for health care -- already the highest per person in the industrialized world -- could hit $3.6 trillion by 2014, or nearly 19% of the entire U.S. economy, up from 15.4% now, a sobering government projection says.

Growth in health care spending will outpace economic growth through the next decade, and the government will pick up an increasing share of the tab.

By 2014, the nation's spending for health care will equal $1.1 trillion for every man, woman and child, up from $6.423 trillion in 2002, the government's key economic forecasters say.

While the growth of health insurance premiums will continue to slow, the annual increases will still exceed growth in workers' disposable income. More could become uninsured as a result.

And as spending rises, public health programs such as Medicare and Medicaid will pay an increasing proportion of the national health tab. This could have important implications for the budget as a whole, says the government.

American manufacturers are losing their ability to compete in the global marketplace in large measure because costs, Gen. Electric executive chairman Per Due, said at an annual meeting with a group of executives on Monday, "are well above the world average."

The auto executive, who is responsible for providing health insurance for more people than any other company, said that his company's annual health care costs were $800 per employee.

"It is becoming unaffordable," he said. "It's become a dominant cost driver."

See HEALTH, E2, Col. 1

Continued on Page 12
What accounts for growth in health care spending?

Source: Health Aff © 2005 Project HOPE

Secretary Bremby, KHPA Board Retreat, 2007
Health Care Costs Concentrated in Sick Few—
Sickest 10 Percent Account for 64 Percent of Expenses

Distribution of health expenditures for the U.S. population,
by magnitude of expenditure, 2003

Source: The Commonwealth Fund. Data from S. H. Zuvekas and J. W. Cohen, “Prescription Drugs and the
Health Expenditure Growth 2000–2005
for Selected Categories of Expenditures

Average annual percent growth in health expenditures, 2000–2005

- Total: 8.6
- Hospital care: 8.0
- Physician & clinical services: 7.9
- Nursing home & home health: 6.1
- Prescription drugs: 10.7
- Prog. admin. & net cost of private health insurance: 12.0

<table>
<thead>
<tr>
<th>Country</th>
<th>Private Spending</th>
<th>Out-of-Pocket Spending</th>
<th>Public Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>$2,572</td>
<td>$803</td>
<td>$2,727</td>
</tr>
<tr>
<td>Canada</td>
<td>$2,210</td>
<td>$483</td>
<td>$2,472</td>
</tr>
<tr>
<td>France</td>
<td>$2,475</td>
<td>$444</td>
<td>$2,239</td>
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<tr>
<td>Netherlands</td>
<td>$1,894</td>
<td>$906</td>
<td>$2,350</td>
</tr>
<tr>
<td>Germany</td>
<td>$2,350</td>
<td>$342</td>
<td>$1,940</td>
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<tr>
<td>Australia</td>
<td>$1,940</td>
<td>$354</td>
<td>$2,176</td>
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<tr>
<td>United Kingdom</td>
<td>$2,176</td>
<td>$370</td>
<td>$1,917</td>
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<td>OECD Median</td>
<td>$1,894</td>
<td>$396</td>
<td>$1,832</td>
</tr>
<tr>
<td>Japan</td>
<td>$1,832</td>
<td>$148</td>
<td>$1,940</td>
</tr>
<tr>
<td>New Zealand</td>
<td>$1,611</td>
<td>$113</td>
<td>$1,832</td>
</tr>
</tbody>
</table>

Source: The Commonwealth Fund, calculated from OECD Health Data 2006.
Prevention, Health Behavior, Personal Responsibility
Health Factors

- Genetic Make-Up: 17%
- Medical Care: 10%
- Environment: 22%
- How We Live - Behavior: 51%

Causes of Death United States, 2000

Leading Causes of Death*

- Heart Disease
- Cancer
- Stroke
- Chronic lower respiratory disease
- Unintentional Injuries
- Diabetes
- Pneumonia/influenza
- Alzheimer’s disease
- Kidney Disease

Actual Causes of Death†

- Tobacco
- Poor diet/lack of exercise
- Alcohol
- Infectious agents
- Pollutants/toxins
- Firearms
- Sexual behavior
- Motor vehicles
- Illicit drug use

† Adapted from McGinnis Foege, updated by Mokdad et. al.
Obesity Trends* Among U.S. Adults
(*BMI \geq 30, or about 30 lbs overweight for 5’4” person)
Prevalence of Diabetes in Adults
United States, BRFSS: 2000

- <4%
- 4–6%
- >6%
Percentage of U.S. High School Students Who Did Not Attend Physical Education Classes Daily

Centers for Disease Control & Prevention
Lack of Recommended Preventive Care by Income and Insurance

Percent of adults age 50+ who did not receive recommended preventive care

By income
- More than 200% of poverty
- 200% of poverty or less

By insurance
- Insured
- Uninsured

Note: Top 5 states refer to states with smallest gap between national average and low income/uninsured.
Bottom 5 states refer to states with largest gap between national average and low income/uninsured.
DATA: 2002/2004 BRFSS
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007
Where are the Opportunities for Population Health Management?

- Serious disease
- Minor Disease
- No Disease

Health Promotion Opportunity

Medical & Care Management Opportunity

Disease Management Opportunity

Medical and Drug Costs only
Coordination of care and a primary care medical home
Chronic Care Model

Environment
- Family
- School
- Worksite
- Community

Medical System
- Information Systems
- Decision Support
- Delivery System Design
- Self Management Support

Patient Self-Management
Adults with a Medical Home Are More Likely to Report Checking Their Blood Pressure Regularly and Keeping It in Control

Percent of adults 18–64 with high blood pressure

- Does not check BP
- Checks BP, not controlled
- Checks BP, controlled

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Medical home</th>
<th>Regular source of care, not a medical home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not check BP</td>
<td>56</td>
<td>48</td>
<td>58</td>
</tr>
<tr>
<td>Checks BP, not controlled</td>
<td>15</td>
<td>10</td>
<td>17</td>
</tr>
<tr>
<td>Checks BP, controlled</td>
<td>29</td>
<td>42</td>
<td>25</td>
</tr>
</tbody>
</table>

Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.

Source: The Commonwealth Fund 2006 Quality of Care Survey

Source: Commonwealth Fund 2006 Health Care Quality Survey.
The Majority of Adults with a Medical Home Always Get the Care They Need

Percent of adults 18–64 reporting always getting care they need when they need it

- **Total**: 55%
- **Medical home**: 74%
- **Regular source of care, not a medical home**: 52%
- **No regular source of care/ER**: 38%

Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.

* Compared with medical home, differences remain statistically significant after adjusting for income or insurance.

Source: The Commonwealth Fund 2006 Quality of Care Survey
Source: Commonwealth Fund 2006 Health Care Quality Survey.
Adults with a Medical Home Have Higher Rates of Counseling on Diet and Exercise Even When Uninsured

Percent of obese or overweight adults 18–64 who were counseled on diet and exercise by doctor

- Medical home
- Regular source of care, not a medical home
- No regular source of care/ER

<table>
<thead>
<tr>
<th></th>
<th>Insured all year</th>
<th>Any time uninsured</th>
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</thead>
<tbody>
<tr>
<td>Medical home</td>
<td>80</td>
<td>65</td>
</tr>
<tr>
<td>Regular source</td>
<td>73</td>
<td>69</td>
</tr>
<tr>
<td>No regular source</td>
<td></td>
<td>34*</td>
</tr>
</tbody>
</table>

Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
* Compared with medical home, differences are statistically significant.
Source: The Commonwealth Fund 2006 Quality of Care Survey
Source: Commonwealth Fund 2006 Health Care Quality Survey.
Following Treatment Regimens for Chronic Diseases

Percent of privately insured adults 21–64 with chronic conditions who strongly/somewhat agree that they follow their treatment regimens very carefully

<table>
<thead>
<tr>
<th>Condition</th>
<th>Comprehensive (n=90)</th>
<th>HDHP (n=74)</th>
<th>CDHP (n=70)</th>
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<tbody>
<tr>
<td>Allergies</td>
<td>59</td>
<td>51</td>
<td>51</td>
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<tr>
<td>Arthritis</td>
<td>62</td>
<td>49</td>
<td>70</td>
</tr>
<tr>
<td>Depression</td>
<td>64</td>
<td>63</td>
<td>73</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>67</td>
<td>75</td>
<td>65</td>
</tr>
<tr>
<td>Hypertension or Stroke</td>
<td>88</td>
<td>84</td>
<td>89</td>
</tr>
</tbody>
</table>

Comprehensive = health plan with no deductible or <$1,000 (individual), <$2,000 (family).
HDHP = high-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
CDHP = consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
*Difference between HDHP/CDHP and Comprehensive is statistically significant at p ≤ 0.05 or better.

Went to ER for Condition That Could Have Been Treated by Regular Doctor, Among Sicker Adults, 2005

Percent of adults who went to ER in past two years for condition that could have been treated by regular doctor if available

International comparison

<table>
<thead>
<tr>
<th>Country</th>
<th>2005</th>
<th>23</th>
<th>15</th>
<th>21</th>
<th>26</th>
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<td>GER</td>
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<td>NZ</td>
<td>9</td>
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<tr>
<td>UK</td>
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<tr>
<td>AUS</td>
<td>15</td>
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<tr>
<td>CAN</td>
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<tr>
<td>US</td>
<td>26</td>
<td></td>
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</table>

United States, by race/ethnicity, income, and insurance status

<table>
<thead>
<tr>
<th>Category</th>
<th>2005</th>
<th>23</th>
<th>24</th>
<th>20</th>
<th>29</th>
<th>23</th>
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<td>White</td>
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<tr>
<td>Black</td>
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<tr>
<td>Hispanic</td>
<td>24</td>
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<tr>
<td>Above average</td>
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<tr>
<td>income</td>
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<td></td>
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</tr>
<tr>
<td>Below average</td>
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<td></td>
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<tr>
<td>Insured</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Uninsured</td>
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<td></td>
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</tr>
</tbody>
</table>

GER=Germany; NZ=New Zealand; UK=United Kingdom; AUS=Australia; CAN=Canada; US=United States.
Data: Analysis of 2005 Commonwealth Fund International Health Policy Survey of Sicker Adults; Schoen et al. 2005a.
Adults Without Insurance Are Less Likely to Be Able to Manage Chronic Conditions

Percent of adults ages 19–64 with at least one chronic condition*

- Insured all year
- Insured now, time uninsured in past year
- Uninsured now

Skipped doses or did not fill prescription for chronic condition because of cost
- Insured all year: 18%
- Insured now, time uninsured in past year: 58%
- Uninsured now: 59%

Visited ER, hospital, or both for chronic condition
- Insured all year: 16%
- Insured now, time uninsured in past year: 27%
- Uninsured now: 35%

*Hypertension, high blood pressure, or stroke; heart attack or heart disease; diabetes; asthma, emphysema, or lung disease.

Kansas specific data on
health behavior and
chronic disease
Risk Factors for Coronary Artery Disease & Stroke in Kansas

- **Tobacco Smoking - 2003**
  - 20.4% of adult Kansans currently smoked cigarettes.
  - 1 in 5 high school students and 6.0% of middle school students reported smoking cigarettes.

Risk Factors for Coronary Artery Disease & Stroke in Kansas

- **Physical Inactivity - 2003**
  - 25.9% of adult Kansans reported that they did not participate in any leisure time physical activity.

- **Low Fruit and Vegetable Consumption - 2003**
  - Only 1 in 5 adult Kansans attained the goal of eating at least 5 fruits and vegetables per day.

Overweight & Obesity - 2003

- 60.5% of adult Kansans were overweight or obese.
- 22.6% of adult Kansans were obese in 2003 compared to 13.0% in 1992.
- The highest prevalence of obesity was seen among non-Hispanic blacks (32.8%).

Overweight or obese $\Rightarrow$ body mass index $\geq 25.0$ kg/m$^2$  Obese $\Rightarrow$ body mass index $\geq 30.0$ kg/m$^2$

Source: 2003 Kansas Behavioral Risk Factor Surveillance System. Office of Health Promotion, KHDE
Childhood Overweight and Obesity Statistics in Kansas

- In 1999-2000, 15% of 6-19 year old children & teens were overweight.
  - Over 10% of pre-school-aged children (ages 2 - 5) are overweight (up from 7% in 1994).
  - Another 15% of children and teens are considered at risk for becoming overweight.
  - Childhood obesity has increased 36% in the past 20 years.

Source: Kansas Department of Health & Environment
Office of Health Promotion
Risk Factors for Coronary Artery Disease & Stroke in Kansas

- **High Blood Cholesterol - 2003**
  - Almost one-third (29.4%) of adult Kansans who had ever been tested for serum cholesterol levels were told by their health care provider that they have high serum cholesterol levels.
  - Prevalence was higher for whites as compared to blacks (30.5% and 25.1%, respectively).
Risk Factors for Coronary Artery Disease & Stroke in Kansas

- **High Blood Pressure - 2003**
  - Almost 1/4th (23.3%) of adult Kansans had high blood pressure.
  - Prevalence of high blood pressure increases with increasing age. 50% of adults aged 65 and older had hypertension.
  - Non-Hispanic blacks had the highest prevalence (29.2%) of hypertension.

Risk Factors for Coronary Artery Disease & Stroke in Kansas

- **Diabetes - 2003**
  - 6.0% of adult Kansans had been diagnosed with diabetes.
  - Prevalence of diabetes increases with increasing age. 14.5% of adults aged 65 and older had diabetes.
  - The highest prevalence of diabetes was seen in non-Hispanic blacks (10.1%).
BRFSS Trends Data: Kansas
Adult Percent Overweight By BMI
BMI 25-29.9

Source: Kansas Department of Health & Environment
Behavioral Risk Factor Surveillance System
BRFSS Trends Data: Kansas
Adult Percent Obese: By BMI
BMI \geq 30

Kansas Department of Health & Environment
Behavioral Risk Factor Surveillance System
Adults in Kansas Reporting No Leisure Time Physical Activity

Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. Behavioral Risk Factor Surveillance System Trends Data: Kansas
Prevalence of cigarette use among adults in Kansas has remained relatively unchanged. This trend is similar to the trend in the United States.

Prevalence of cigarette use in Kansas is highest among individuals of low education (36.4% for less than high school) and low income (28.6% for < $15,000 annual household income)

Tobacco Use in Kansas – Key Indicators

- Youth rates have declined in the recent past, leveling out at approximately the adult prevalence rate. Youth rates are used to measure youth access and initiation.

- Adult quit attempts in the past 12 months by adult Kansas smokers have remained consistently in the 40-50% range since 2000. Cessation attempts are used to gauge community norm changes as well as short/intermediate term outcome objectives.

2000 and 2002 Kansas Youth Tobacco Survey, Office of Health Promotion, Kansas Department of Health of Environment
Recommendations
Getting Value for Money: Health System Transformation

- Transparency; public information on clinical quality, patient-centered care, and efficiency by provider; insurance premiums, medical outlays, and provider payment rates

- Payment systems that reward quality and efficiency; transition to population and care episode payment system

- Patient-centered medical home; Integrated delivery systems and accountable physician group practices

- Adoption of health information technology; creation of state-based health insurance exchange

- National Institute of Clinical Excellence; invest in comparative cost-effectiveness research; evidence-based decision-making

- Investment in high performance primary care workforce

- Health services research and technical assistance to spread best practices

- Public-private collaboration; national aims; uniform policies; simplification; purchasing power

Source: The Commonwealth Fund
Transformation Is Possible

"What you would see as both an achievable and a desirable goal or target for policy action within the next 10 years?"


Note: Goal percentages represent median responses.
* Or 5% of household income for low-income households; OOP = “out-of-pocket”.

Current Goal

- Proportion of under-65 population that has no health insurance: Current 18%, Goal 5%
- Total cost of health care as a percentage of GDP: Current 16%, Goal 16%
- Proportion of households spending >10% of income on OOP costs and premiums*: Current 17%, Goal 10%
- Proportion of recommended preventive care adults receive: Current 49%, Goal 75%
- Proportion of recommended preventive care children receive: Current 43%, Goal 85%
State Ranking on Overall Health System Performance

SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007
Health Care Opinion Leaders: Views on Controlling Rising Health Care Costs

“How effective do you think each of these approaches would be to control rising costs and improve the quality of care?”

Percent saying “extremely/very effective”

<table>
<thead>
<tr>
<th>Approach</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce inappropriate medical care</td>
<td>75%</td>
</tr>
<tr>
<td>Use evidence-based guidelines to determine if a test, procedure should be done</td>
<td>70%</td>
</tr>
<tr>
<td>Increased and more effective use of IT</td>
<td>66%</td>
</tr>
<tr>
<td>Increase the use of disease and care management strategies for the chronically ill</td>
<td>65%</td>
</tr>
<tr>
<td>Reward providers who are more efficient and provide higher quality care</td>
<td>61%</td>
</tr>
<tr>
<td>Allow Medicare to negotiate drug prices</td>
<td>57%</td>
</tr>
<tr>
<td>Reduce administrative costs of insurers, providers</td>
<td>54%</td>
</tr>
<tr>
<td>Establish a public/private mechanism to produce, disseminate information of effectiveness, best practices</td>
<td>54%</td>
</tr>
<tr>
<td>Have all payers, including private insurers, Medicare, and Medicaid, adopt common payment methods or rates</td>
<td>51%</td>
</tr>
<tr>
<td>Consolidate purchasing power by public, private insurers working together to moderate rising costs of</td>
<td>50%</td>
</tr>
</tbody>
</table>

Note: Based on a list of 19 options.
Elements of State Based Reforms

- Extract as much from the federal government as you can
- Build on existing private and public schemes
- Extend participation by employers through incentives and requirements
- Facilitate insurance markets
- Apply income related fees, deductibles, and copays

Dr Fineberg, President of IOM, National Governor’s Association Meeting, July 2007
Elements of State Based Reforms

- Define basic coverage
- Encourage disease prevention and health promotion
- Correct for adverse insurance selection
- Promote quality improvements, efficient disease management, and use of evidence