



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

Marcia Nielsen, Ph.D., MPH

Executive Director

July Advisory Council Meetings

# 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



# Business Day

The New York Times

## U.S. Trade Deficit Soars Past \$617 Billion



A14

YT

THE NEW YORK TIMES NATIONAL TUESDAY

## Nation's Health Spending Slows, but It Still Hits a Record

By ROBERT PEAR

WASHINGTON, Jan. 10 — The torrid pace of growth in national health spending cooled a bit in 2003, but the spending, at \$1.7 trillion, topped 15 percent of the gross domestic product for the first time, the government said on Monday.

Total health spending rose 7.7 percent in 2003, compared with an increase of 9.3 percent the year before, in part because of state cutbacks in the Medicaid program and a slower increase in drug spending. But it

omist at the Department of Health and Human Services, said that "at least 34 states took measures to control Medicaid costs in 2003," typically by tightening eligibility or restricting benefits.

Factors contributing to the slowdown in the growth of drug spending included a smaller increase in the number of prescriptions; greater use of low-cost generic drugs; higher co-payments, which tend to discourage use of some drugs; and the conversion of Claritin, the popular allergy drug, to over-the-counter status.

an pharmacies, estimated at \$1.1 billion in 2003, were not counted in health spending for the United States. American sales of generic drugs grew at twice the rate of brand-name drug sales in 2003. "When offered a choice, consumers opt for a generic drug almost 90 percent of the time in chain drug stores," the report said.

President Bush, campaigning for limits on malpractice lawsuits, said last week that "we have the best health care system in the world."

But the United States devotes a

output to health care than industrial countries do. Members of the C.E.C. Economic Cooperation and Development, the countries' largest shares, Switzerland, spend less than 8 percent of their G.D.P. on health care.

Health spending is the fastest growing part of the economy, and it is projected to grow rapidly as the population ages and the economy grows.

Paul B. Ginsburg, director of the Center for Studying

American manufacturing base and a concurrent loss of jobs. The annual report showed that the United States lost ground last year, not only in manufacturing but also in ad-

are," said Rod Nichols, chief spokesman at the time.

Continued on Page 12

THE NATION'S NEWSPAPER

# USA TODAY

NO. 1 IN THE USA

## 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 \$11,045 for every man, woman and child, up from \$6,423 each this year, says the report released Wednesday by the Centers for Medicare & Medicaid Services. Those numbers are not adjusted for inflation.

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, hitting 49% of all spending by 2014, up from 45.6% in 2003. "That could have important implications for the budget as a whole," says the government.

The Washington Post

# BUSINESS

FRIDAY, FEBRUARY 11, 2005

## U.S. Firms Losing Health Care Battle, GM Chairman Says

By CEGI CONNOLLY  
Washington Post Staff Writer

American manufacturers are losing their ability to compete in the global marketplace in large measure because of rising health care costs, General Motors executive G. M. said on Monday.

He called on Congress to take "some serious medicine" for the nation's ailing health system.

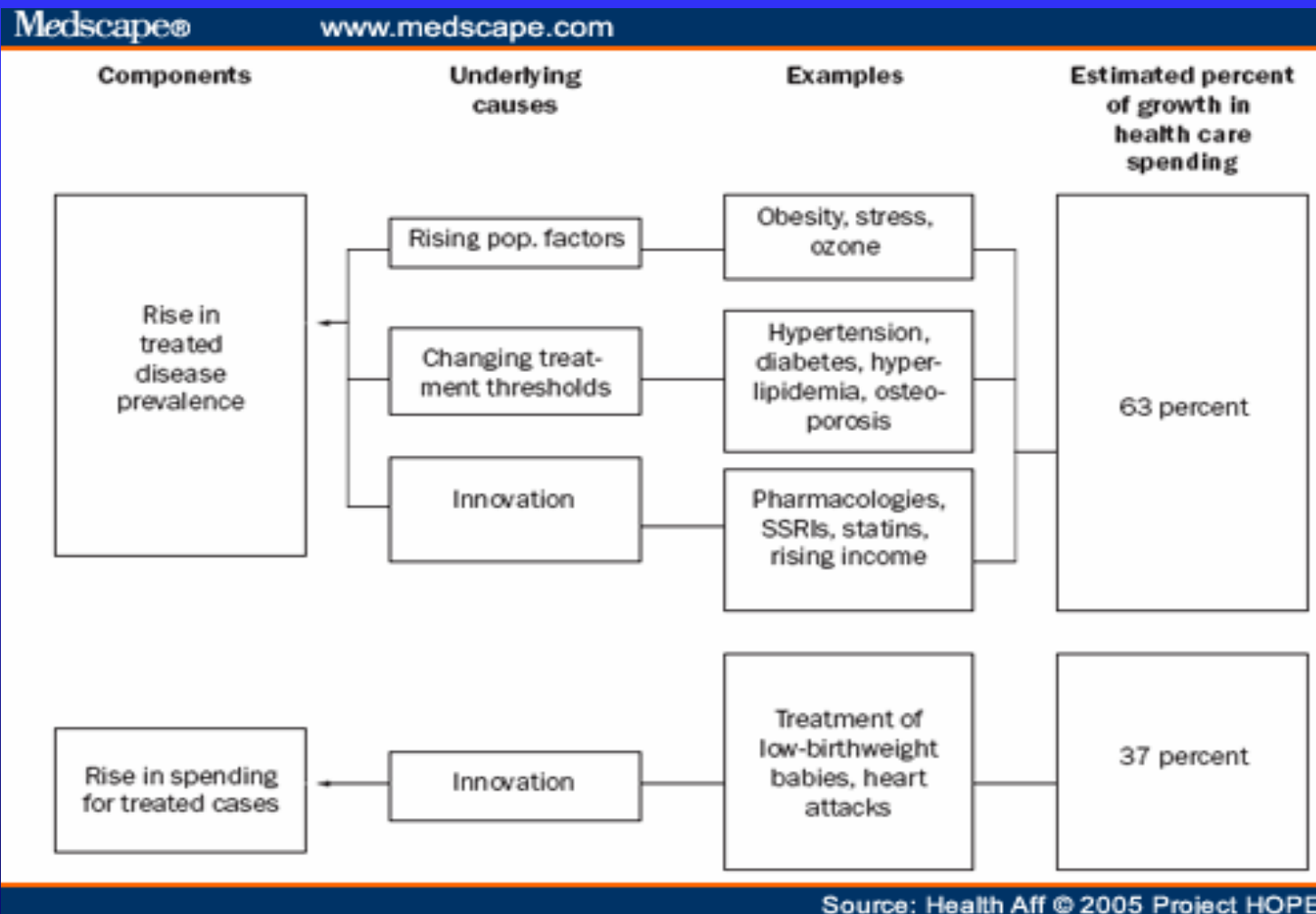
In a speech at the Economic Club of Chicago, the auto executive, who is responsible for providing health insurance for more people than any other private employer in the nation, graphically detailed how rising medical bills are eating into his company's bottom line and cost U.S. firms.

is would be the worst kind of procrastination, Wagoner said, "the kind that places our children and our grandchildren at risk and threatens the health and global competitiveness of our nation's economy."

After spending several years on the health policy sidelines, Wagoner is launching a mini media blitz, hoping the competitiveness argument will be the one that finally

See HEALTH, E2, Col. 1

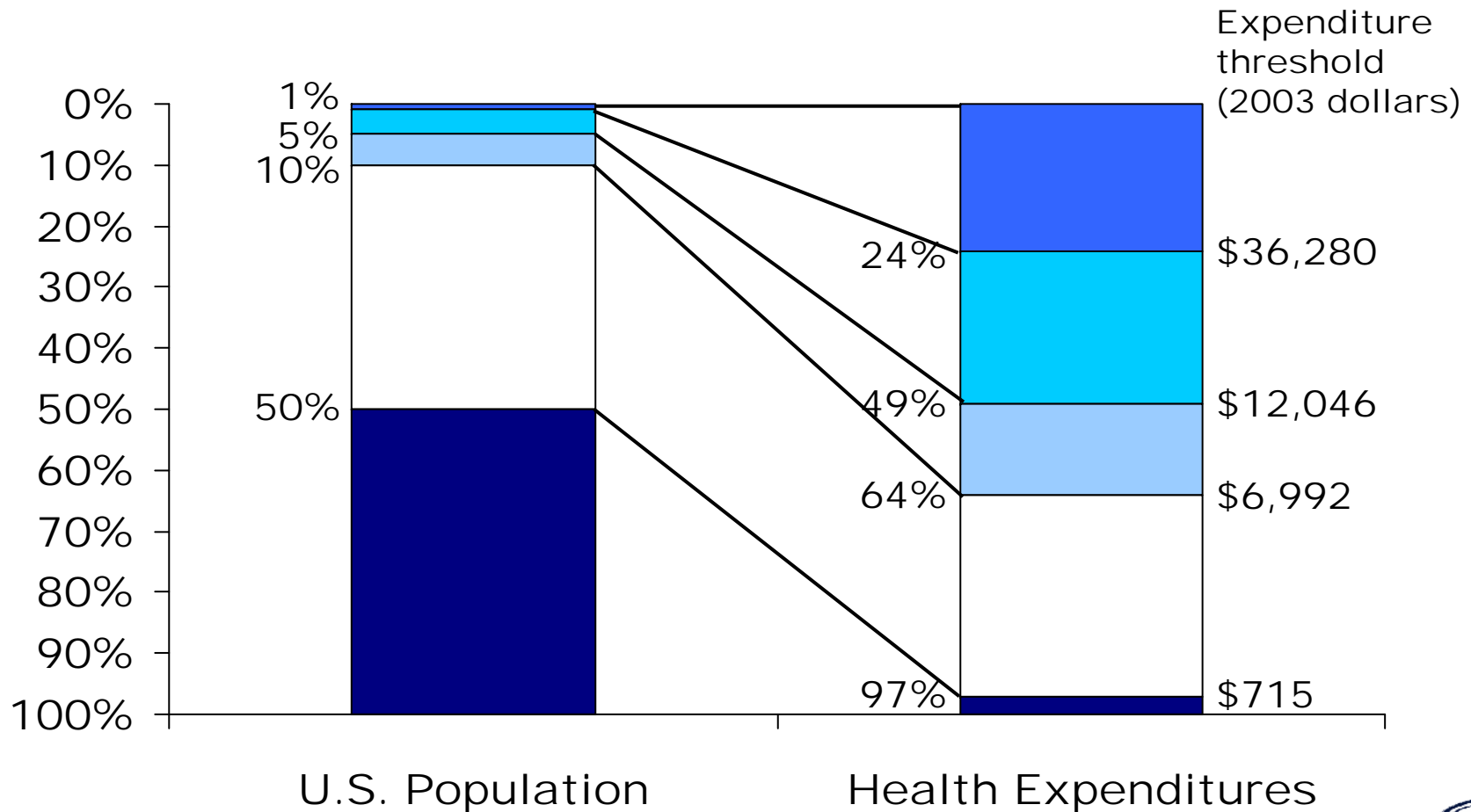
# What accounts for growth in health care spending ?





# 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

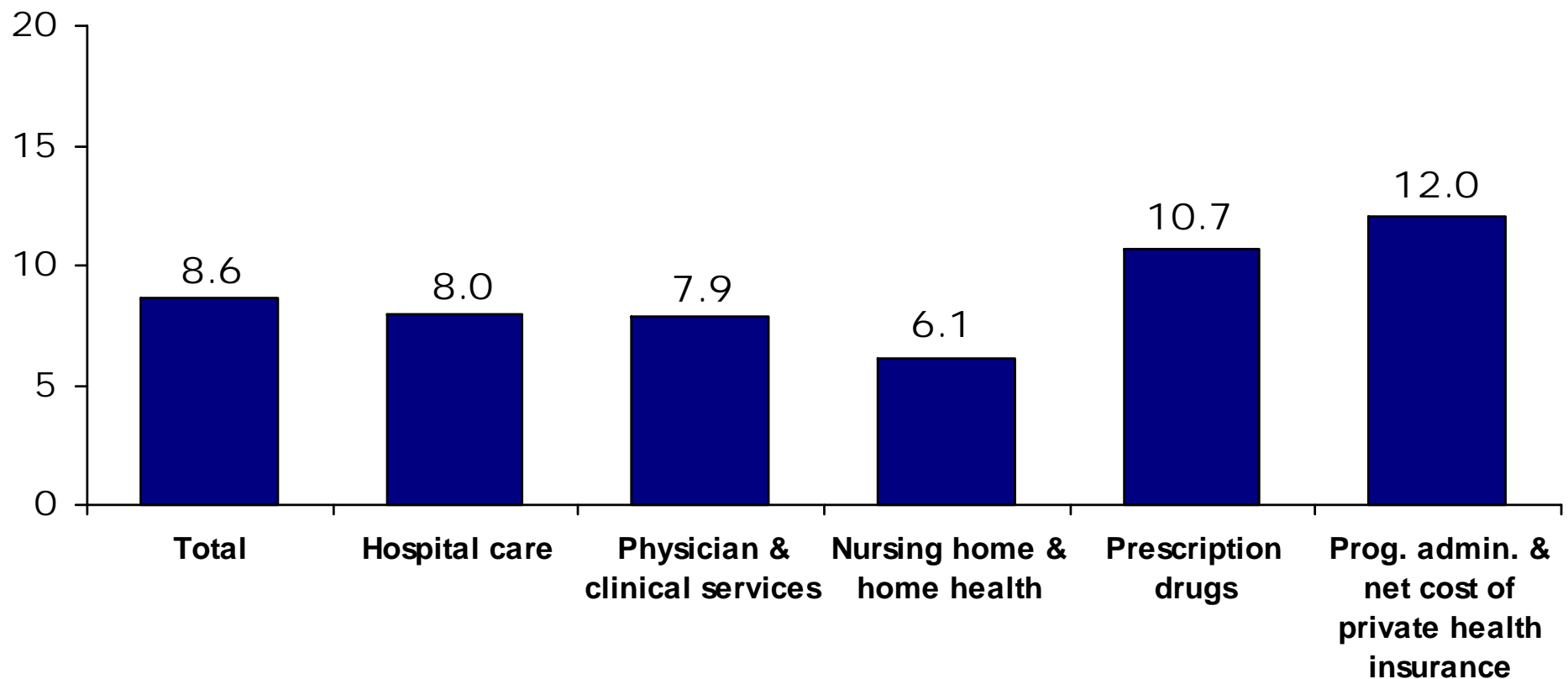


Source: The Commonwealth Fund. Data from S. H. Zuvekas and J. W. Cohen, "Prescription Drugs and the Changing Concentration of Health Care Expenditures," *Health Affairs*, Jan./Feb. 2007 26(1):249-57.



# Health Expenditure Growth 2000–2005 for Selected Categories of Expenditures

Average annual percent growth in health expenditures, 2000–2005

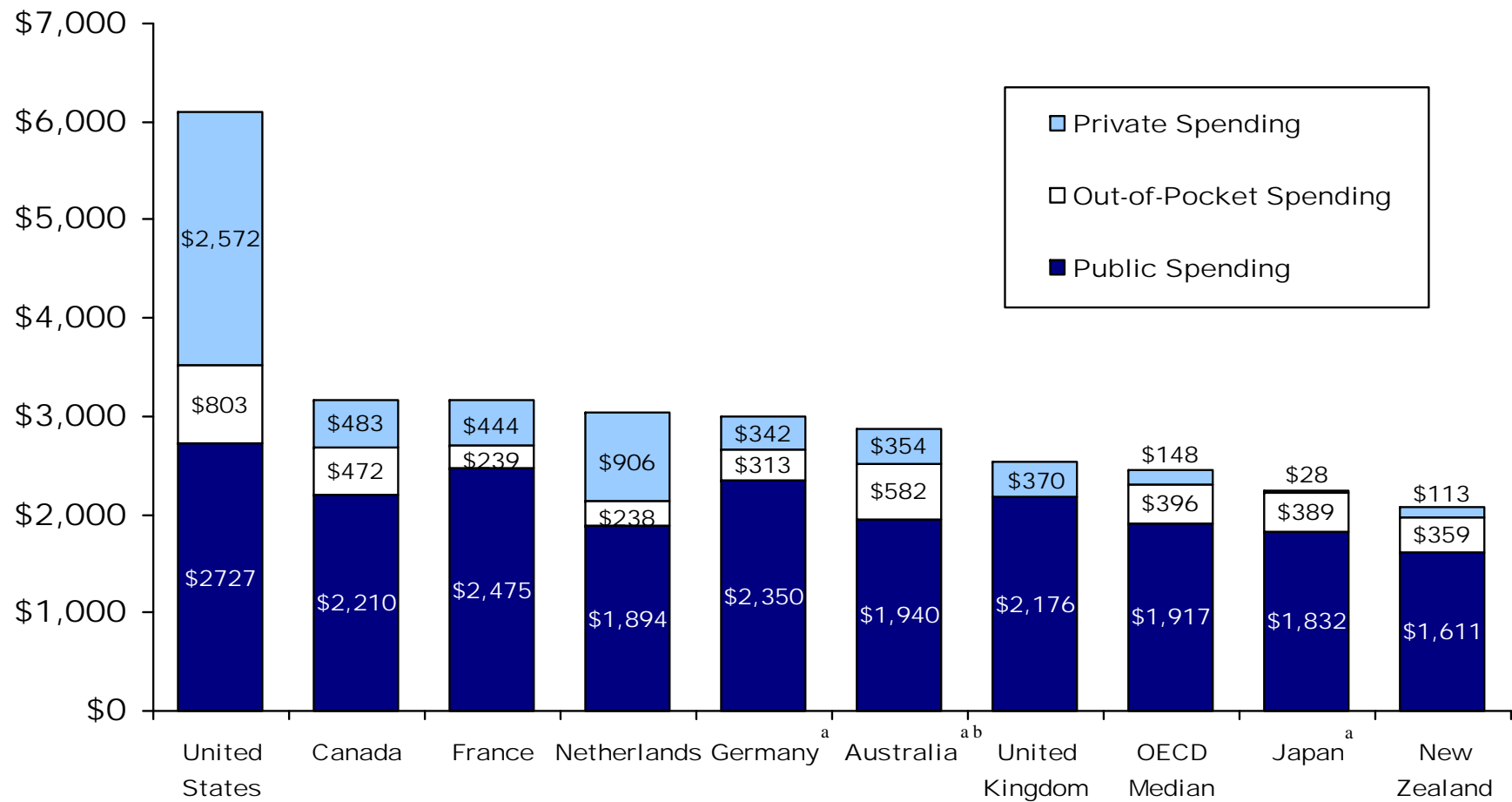


Source: A. Catlin et al., "National Health Spending in 2005: The Slowdown Continues," *Health Affairs*, Jan./Feb. 2007 26(1):142–53.



# Health Care Expenditure per Capita by Source of Funding in 2004

Adjusted for Differences in Cost of Living



<sup>a</sup>2003

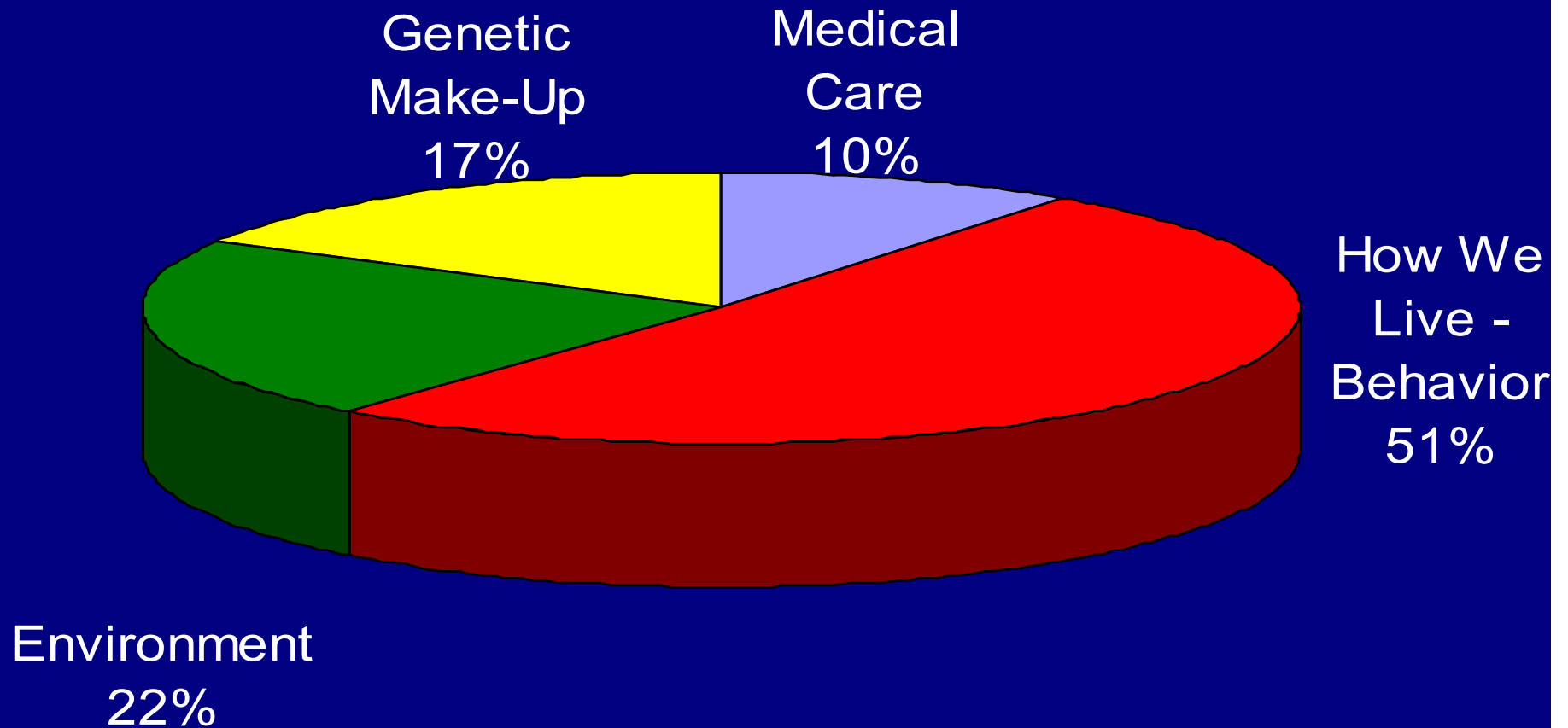
<sup>b</sup>2002 (Out-of-Pocket)



Source: The Commonwealth Fund, calculated from OECD Health Data 2006.

# Prevention, Health Behavior, Personal Responsibility

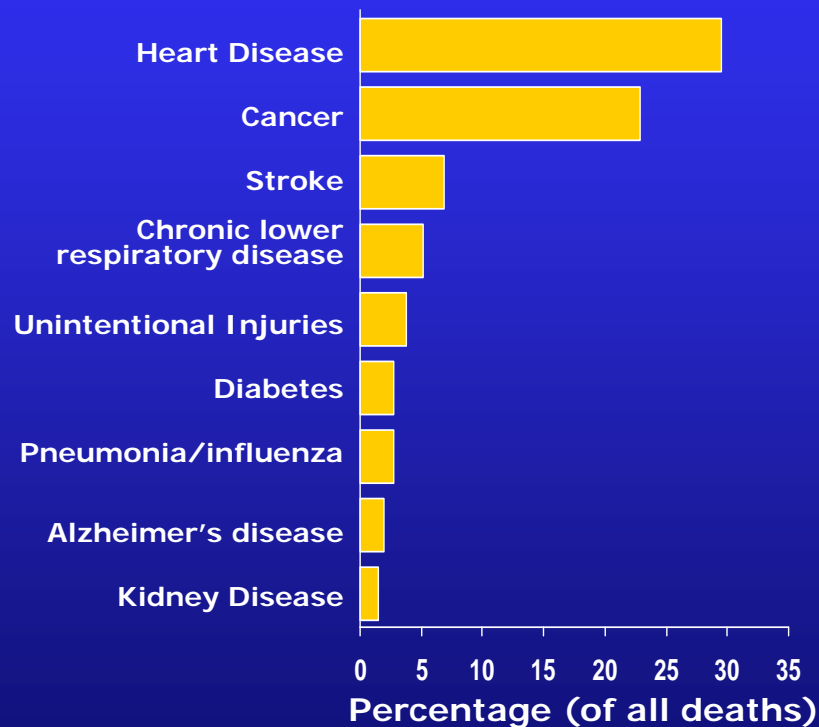
# Health Factors



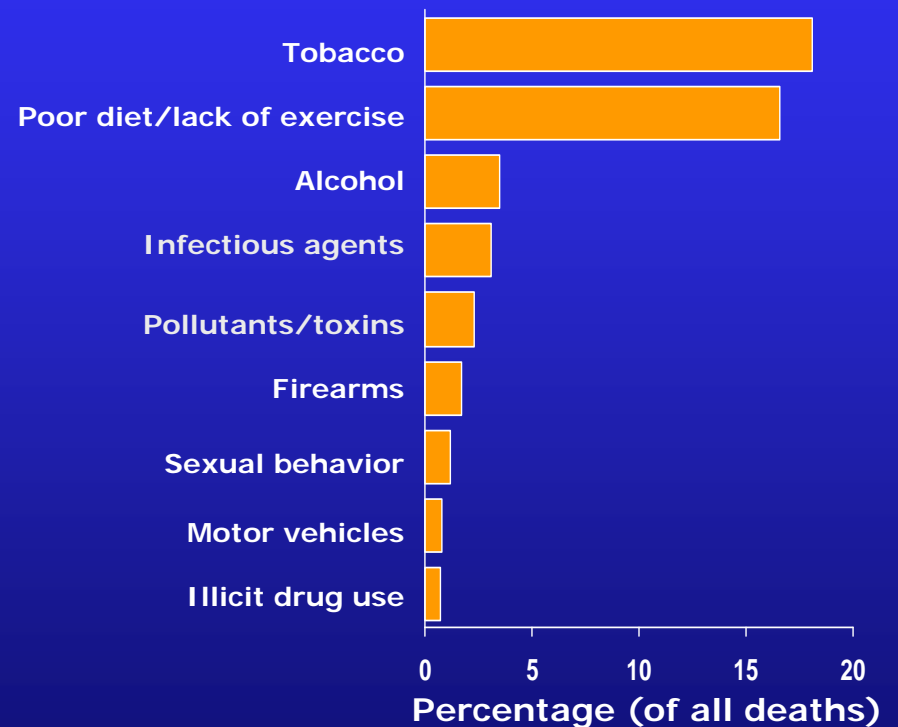
Source: USDHEW, PHS, CDC. "Ten Leading Causes of Death in US 1975."  
Atlanta, GA, Bureau of State Services, Health Analysis & Planning  
for Preventive Services, p 35, 1978

# Causes of Death United States, 2000

## Leading Causes of Death\*



## Actual Causes of Death†



\* National Center for Health Statistics. Mortality Report. Hyattsville, MD: US Department of Health and Human Services; 2002

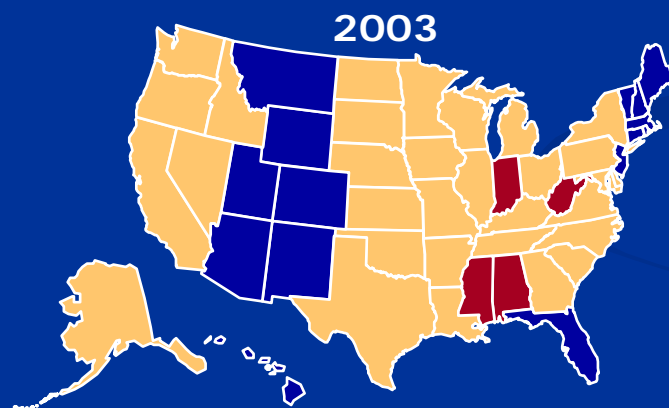
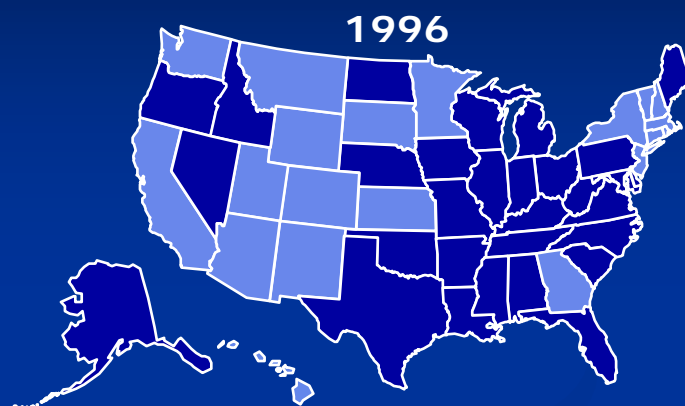
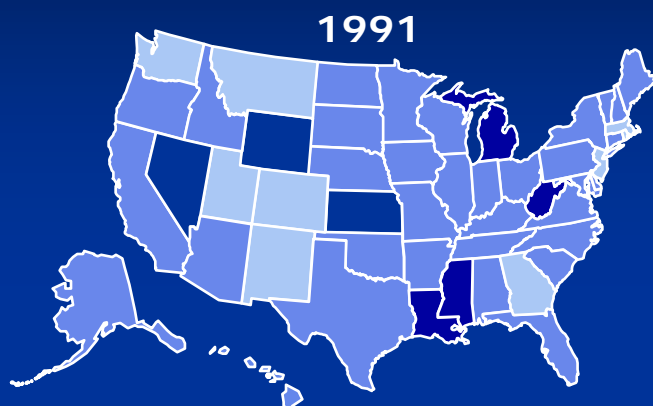
† Adapted from McGinnis Foege, updated by Mokdad et. al.



# Obesity Trends\* Among U.S. Adults

**BRFSS, 1991, 1996, 2003**

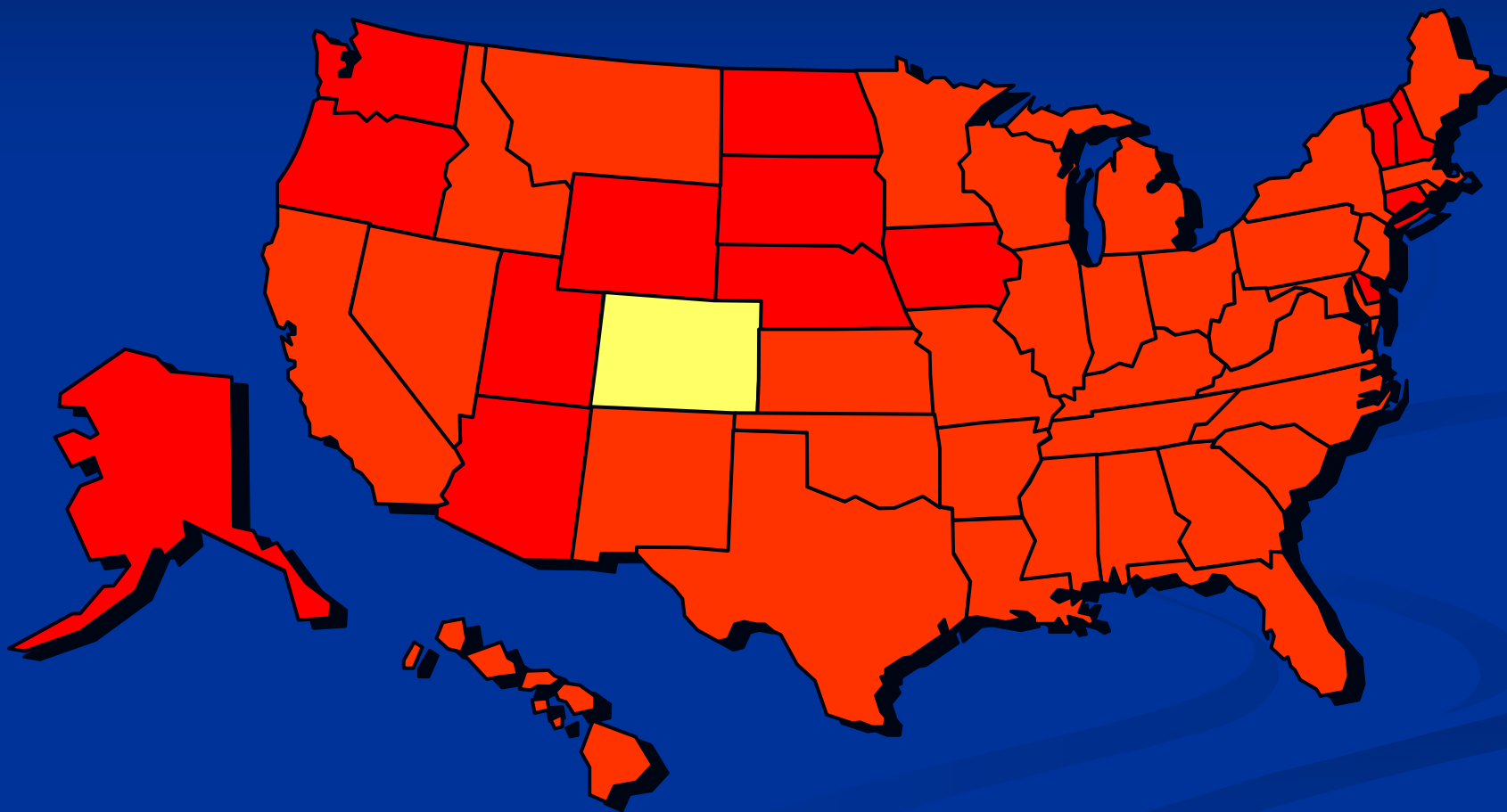
(\*BMI  $\geq 30$ , or about 30 lbs overweight for 5'4" person)



□ No Data    □ <10%    □ 10%-14%    □ 15%-19%    □ 20%-24%    □  $\geq 25\%$

# Prevalence of Diabetes in Adults

## United States, BRFSS: 2000

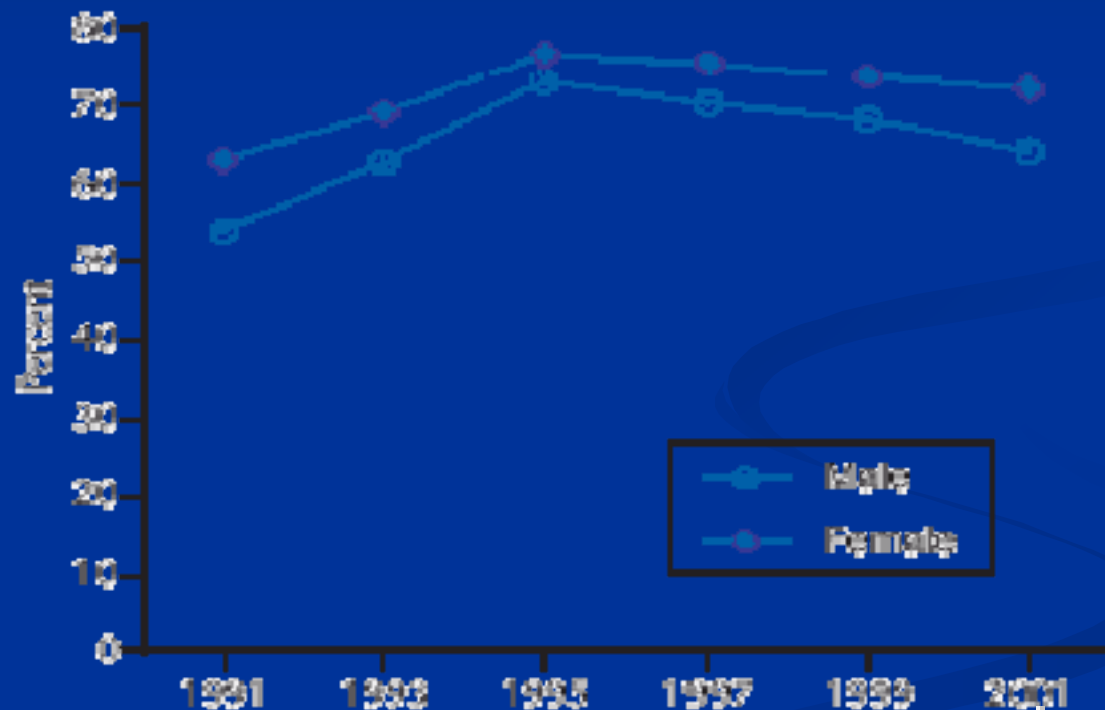


<4%

4–6%

>6%

# Percentage of U.S. High School Students Who Did Not Attend Physical Education Classes Daily



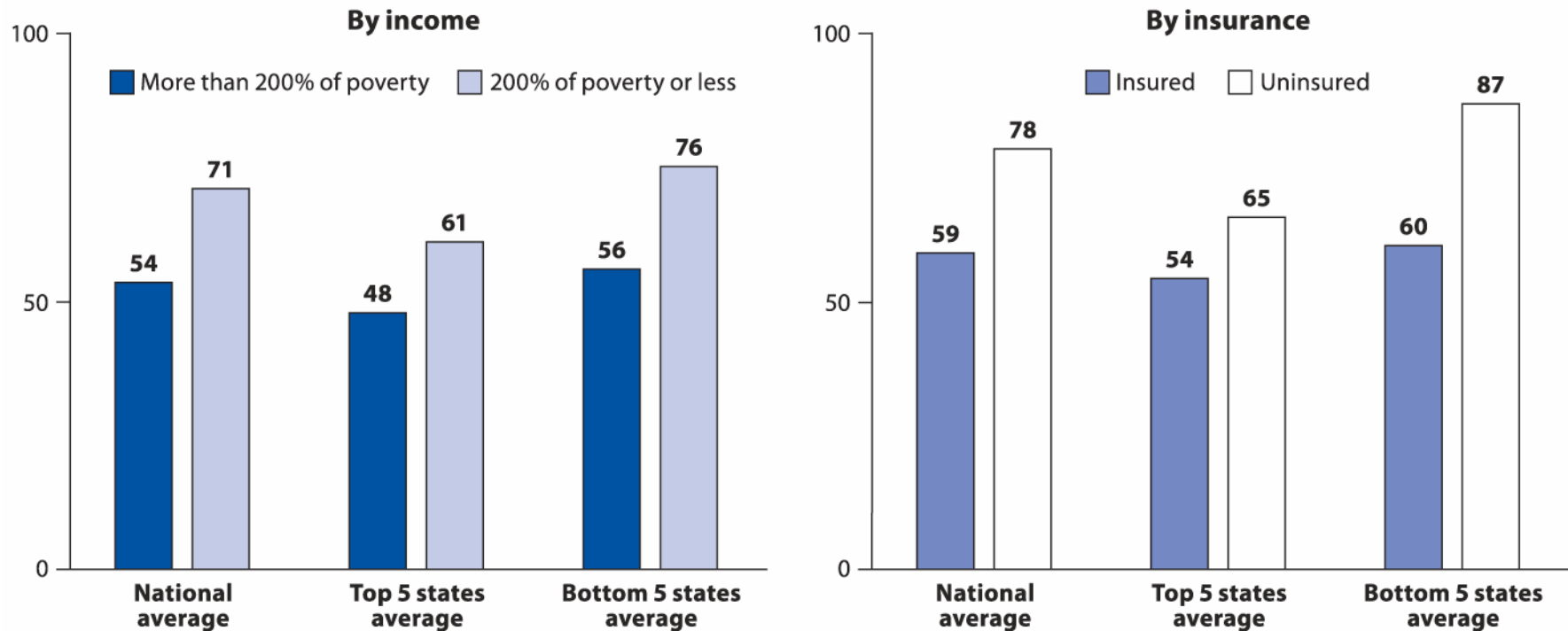
YRBS National Surveys, 1991–2001

Centers for Disease Control & Prevention

## EQUITY

# Lack of Recommended Preventive Care by Income and Insurance

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



Note: Top 5 states refer to states with smallest gap between national average and low income/uninsured.

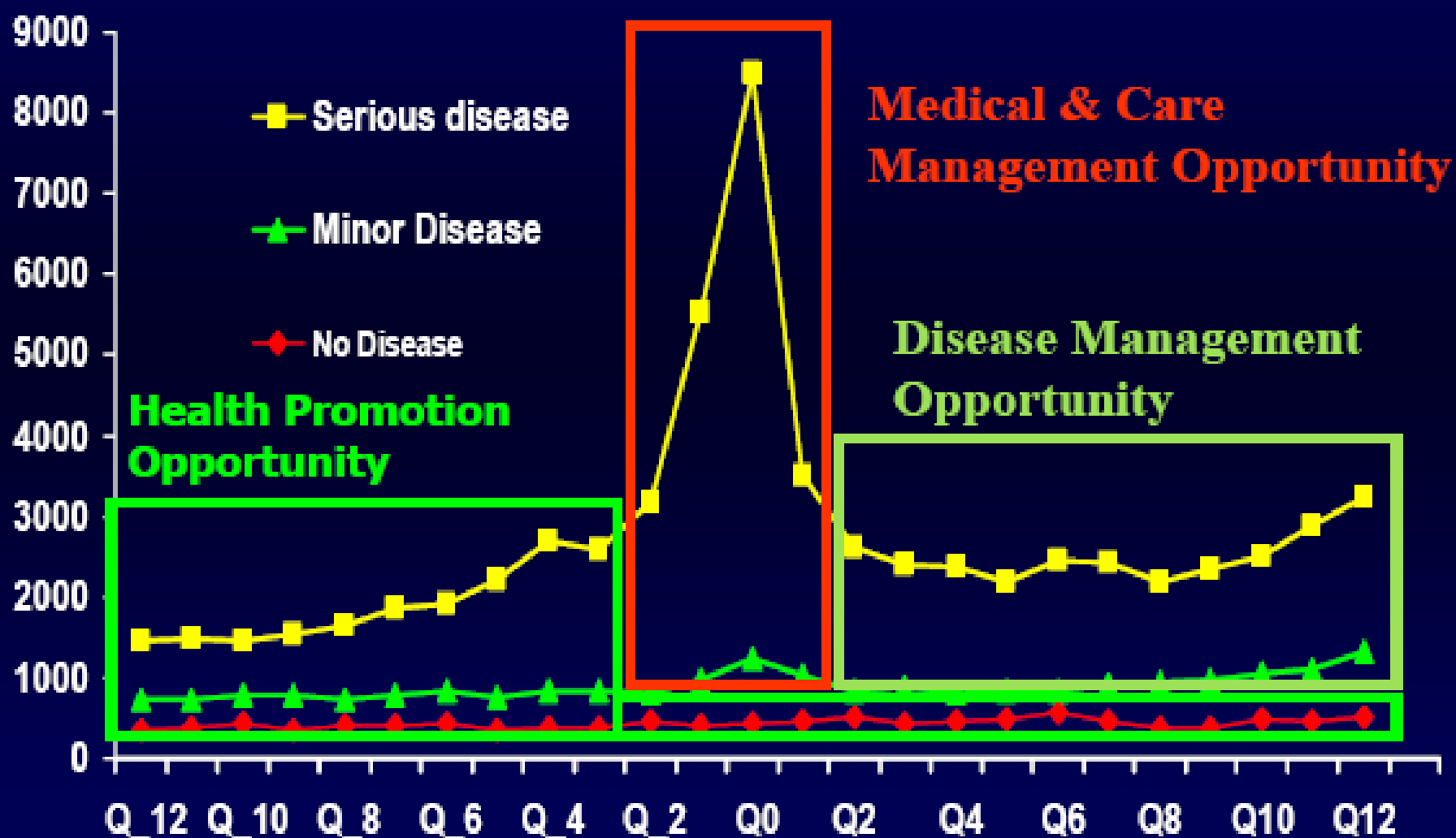
Bottom 5 states refer to states with largest gap between national average and low income/uninsured.

DATA: 2002/2004 BRFSS

SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007



# Where are the Opportunities for Population Health Management?



Medical and Drug Costs only

University of Michigan Health Management Research Center

# Coordination of care and a primary care medical home



# Chronic Care Model

## Environment

Family  
School  
Worksite  
Community



## Medical System

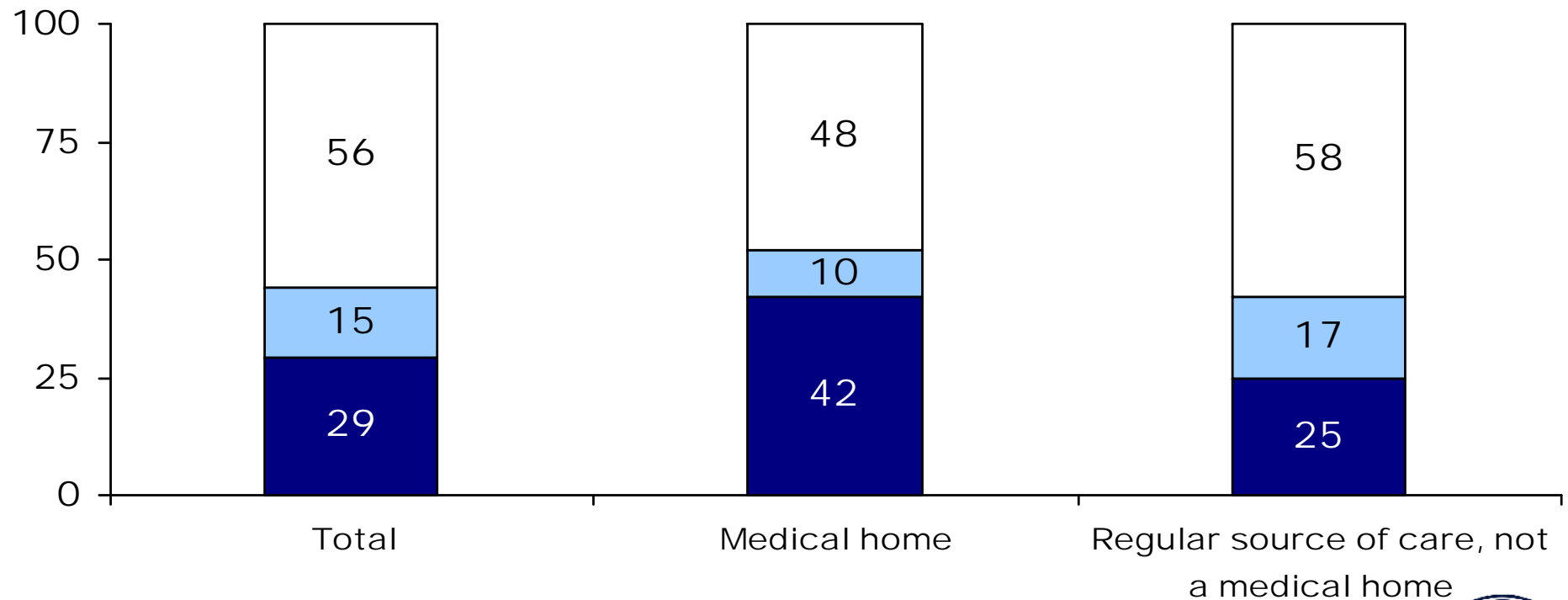
Information Systems  
Decision Support  
Delivery System Design  
Self Management Support



# 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



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.

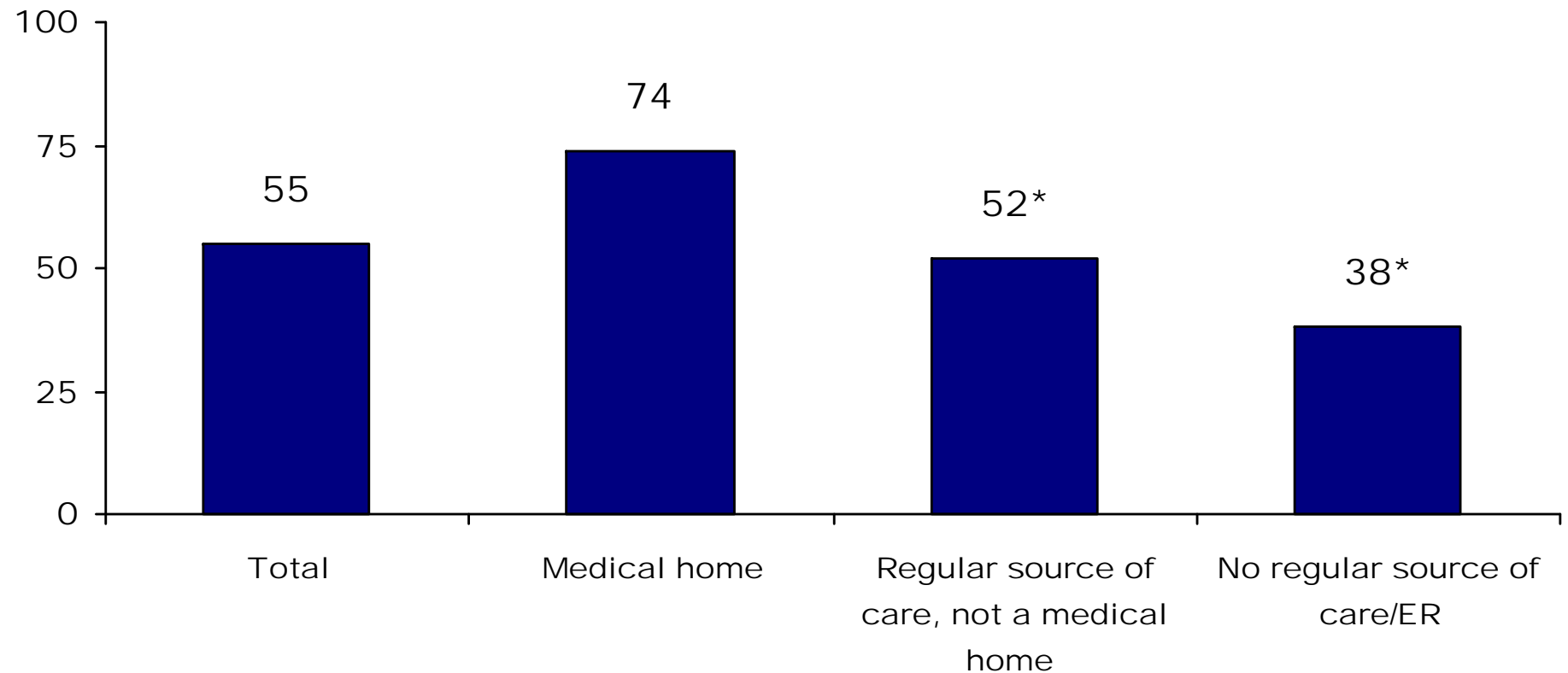
Source: The Commonwealth Fund 2006 Quality of Care Survey

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



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.

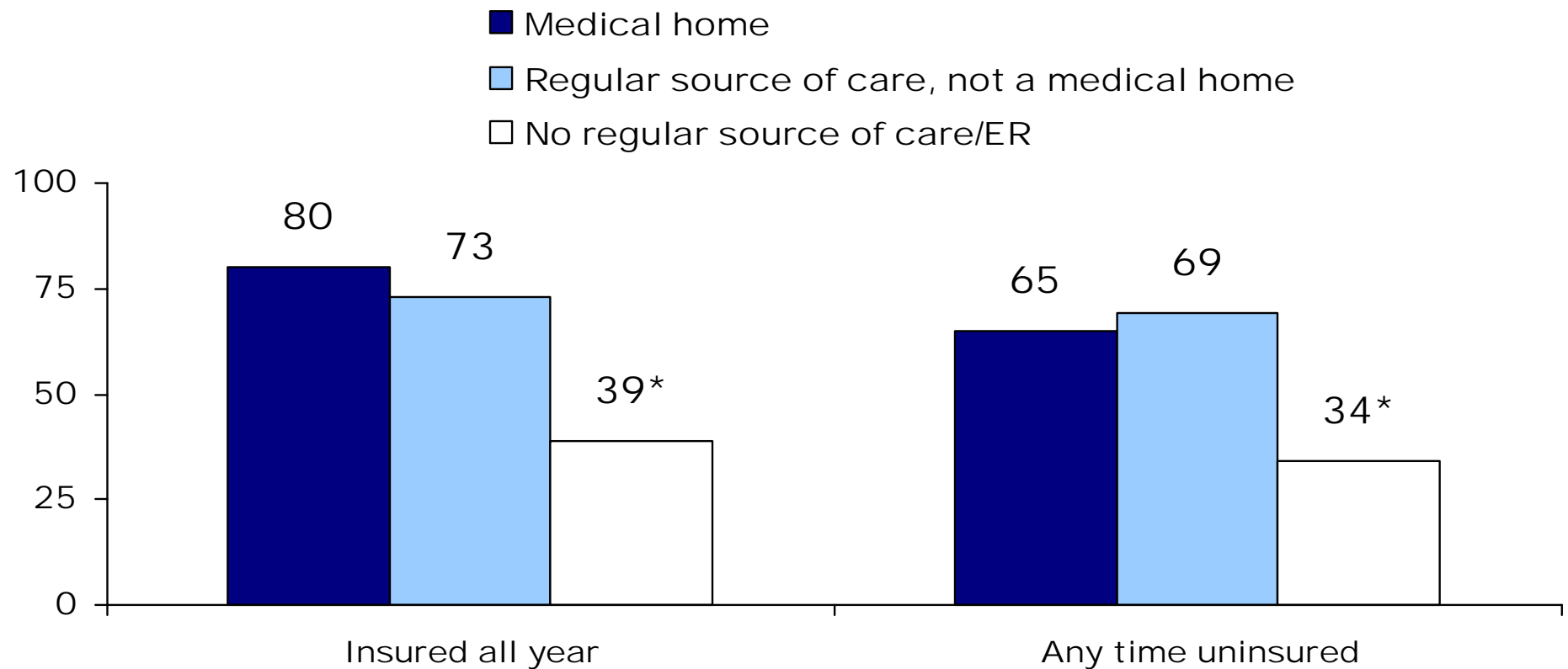
**Source: The Commonwealth Fund 2006 Quality of Care Survey**

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



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.

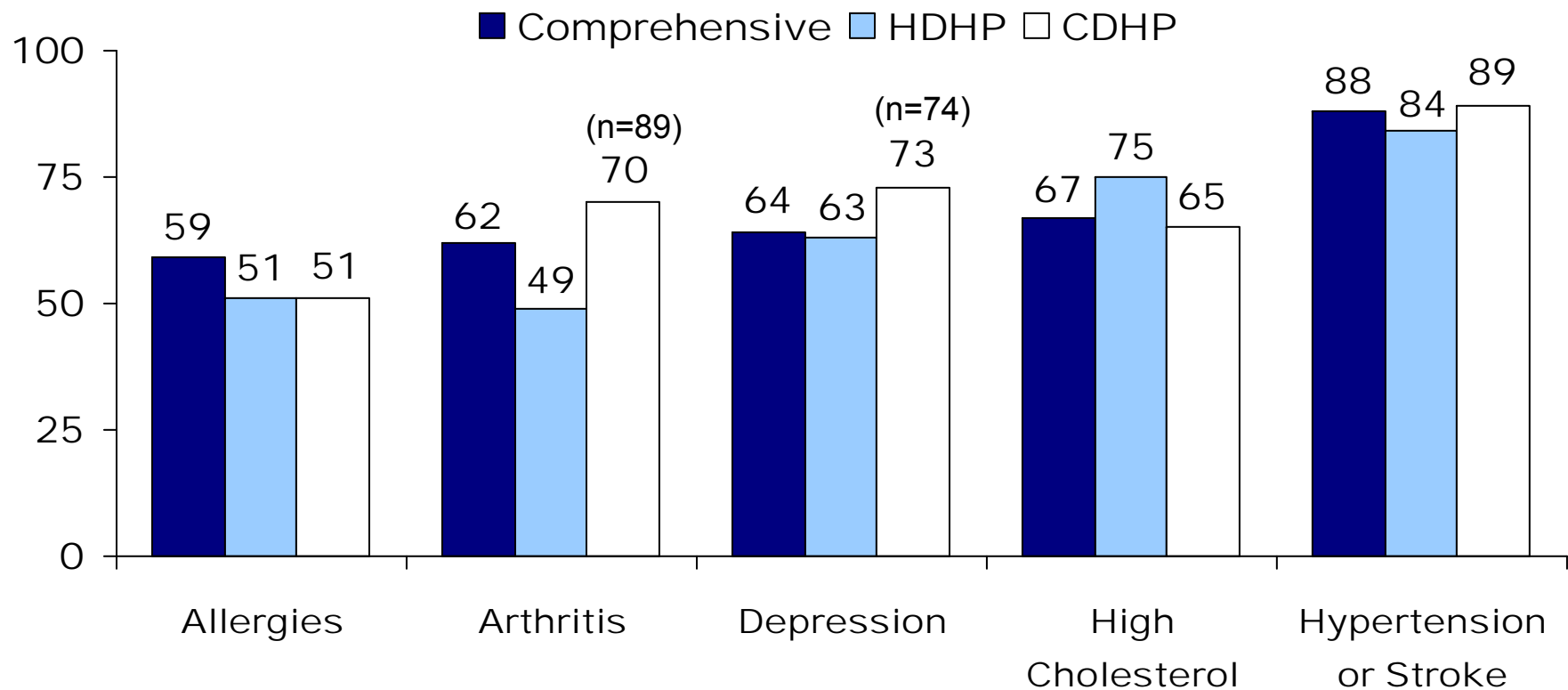
Source: The Commonwealth Fund 2006 Quality of Care Survey

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



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  $p \leq 0.05$  or better.

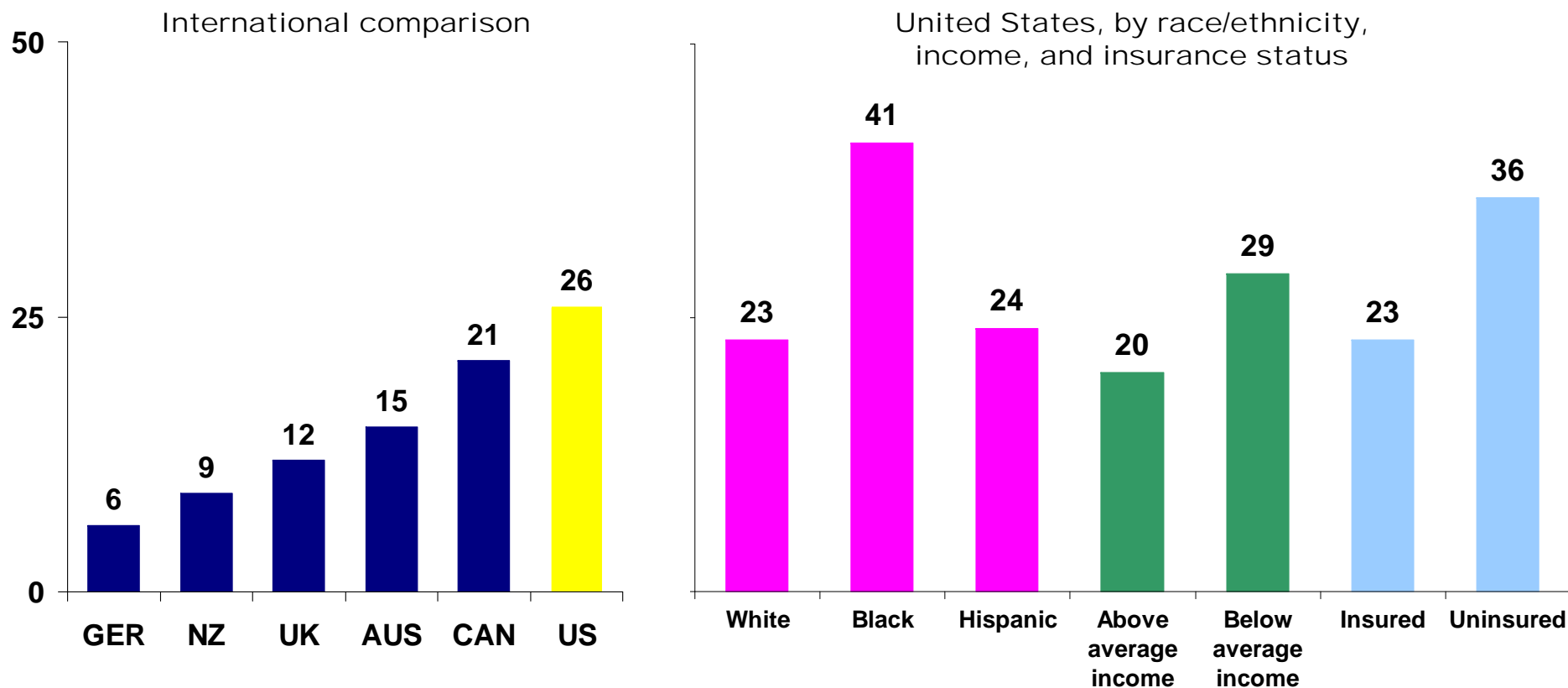
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006.



## EQUITY: COORDINATED AND EFFICIENT CARE

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**

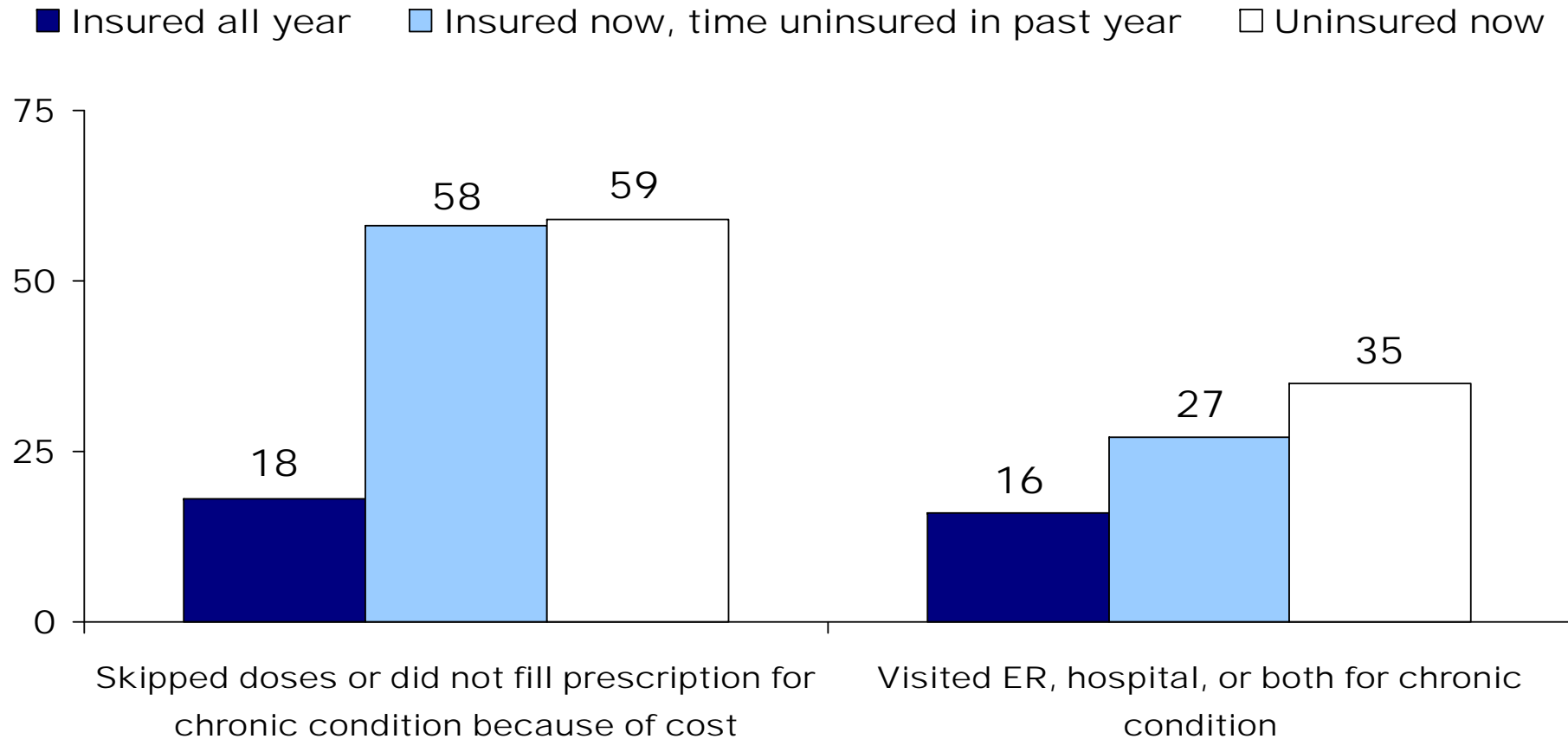


GER=Germany; NZ=New Zealand; UK=United Kingdom; AUS=Australia; CAN=Canada; US=United States.  
Data: Analysis of 2005 Commonwealth Fund International Health Policy Survey of Sicker Adults;  
Schoen et al. 2005a.



## 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\*



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

Source: S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, A. L. Holmgren, *Gaps in Health Insurance: An All-American Problem*, Findings from the Commonwealth Fund Biennial Health Insurance Survey (New York: The Commonwealth Fund, Apr. 2006).



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.

Source: 2003 Kansas Behavioral Risk Factor Surveillance System. 2002 Kansas Youth Tobacco Survey. Office of Health Promotion, KDHE.

# 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.

Source: 2003 Kansas Behavioral Risk Factor Surveillance System.

# Risk Factors for Coronary Artery Disease & Stroke in Kansas

## ■ 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 → body mass index  $\geq 25.0$  kg/m<sup>2</sup> Obese → body mass index  $\geq 30.0$  kg/m<sup>2</sup>

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 1/4<sup>th</sup> (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.

Source: 2003 Kansas Behavioral Risk Factor Surveillance System.

# Risk Factors for Coronary Artery Disease & Stroke in Kansas

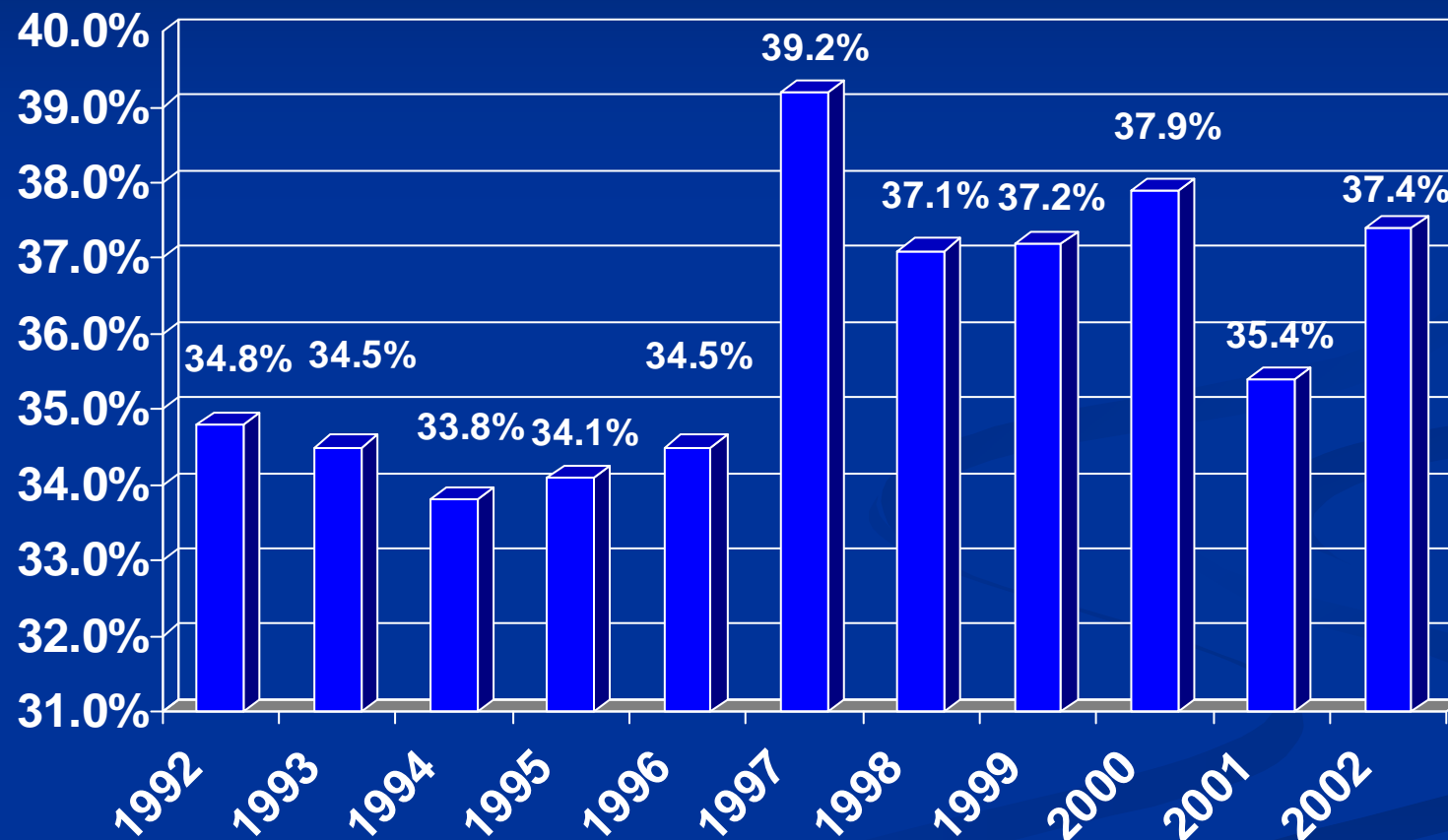
## ■ Diabetes - 2003

- 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

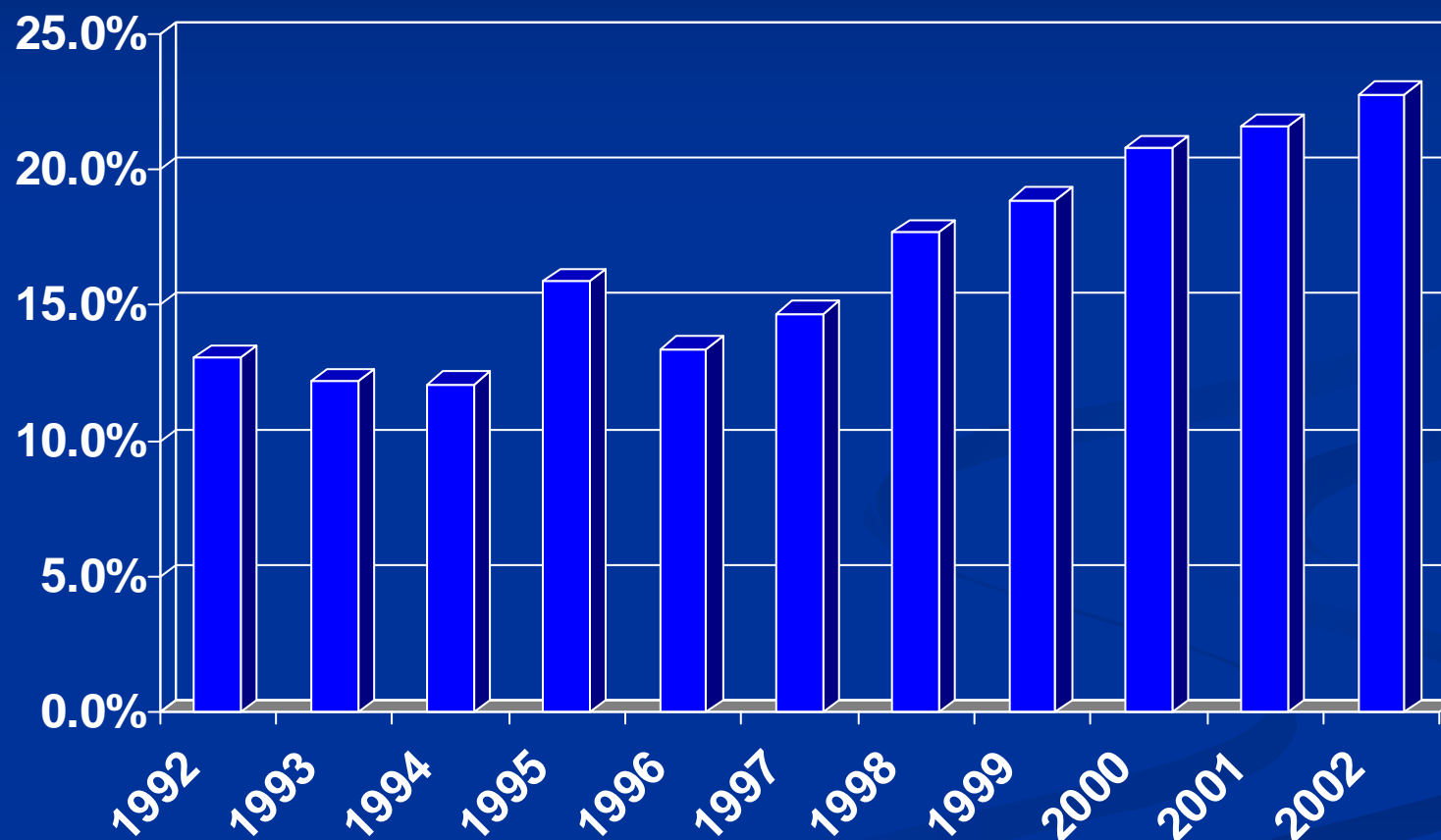


Source: Kansas Department of Health & Environment  
Behavioral Risk Factor Surveillance System

# BRFSS Trends Data: Kansas

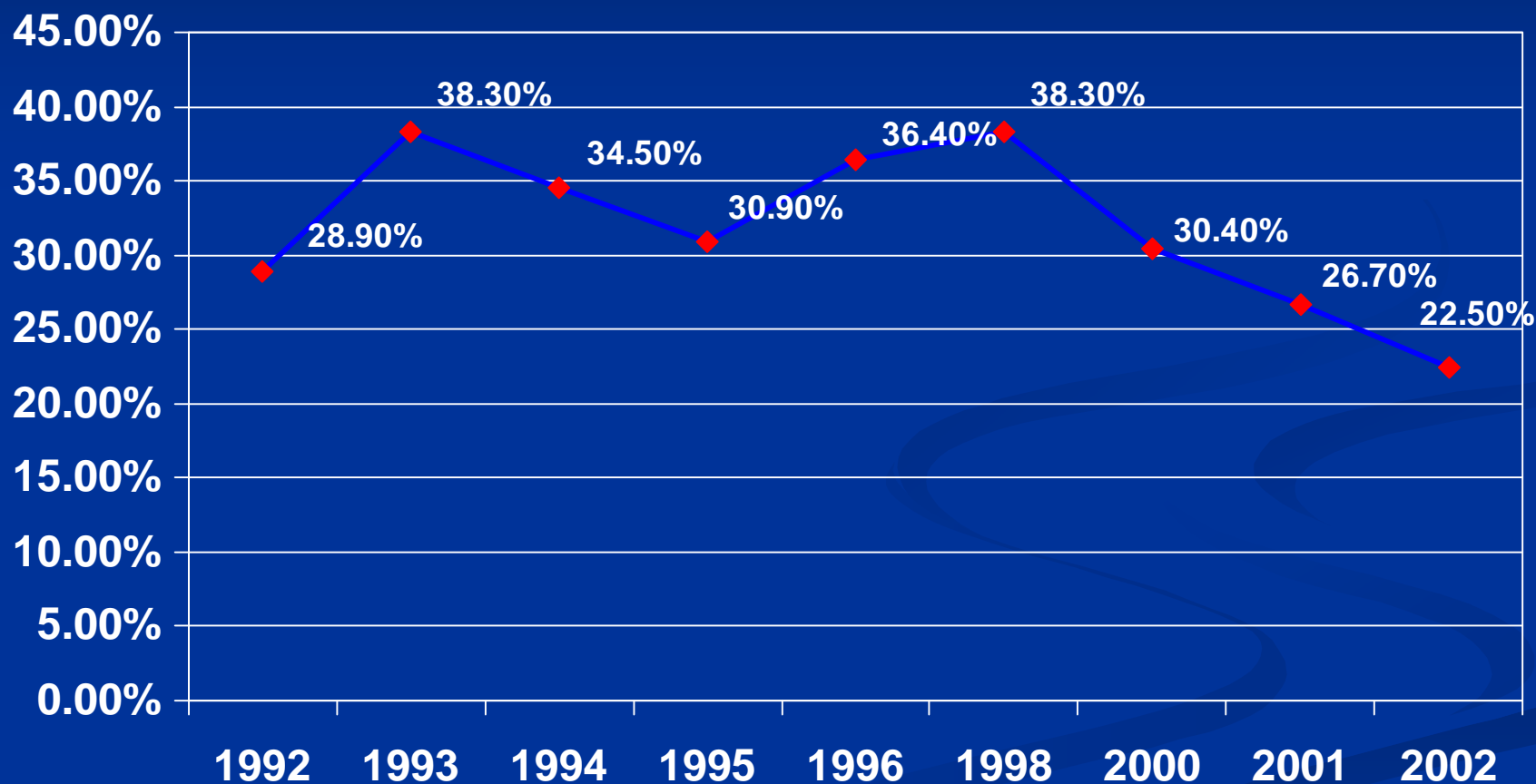
## Adult Percent Obese: By BMI

### BMI $\geq 30$



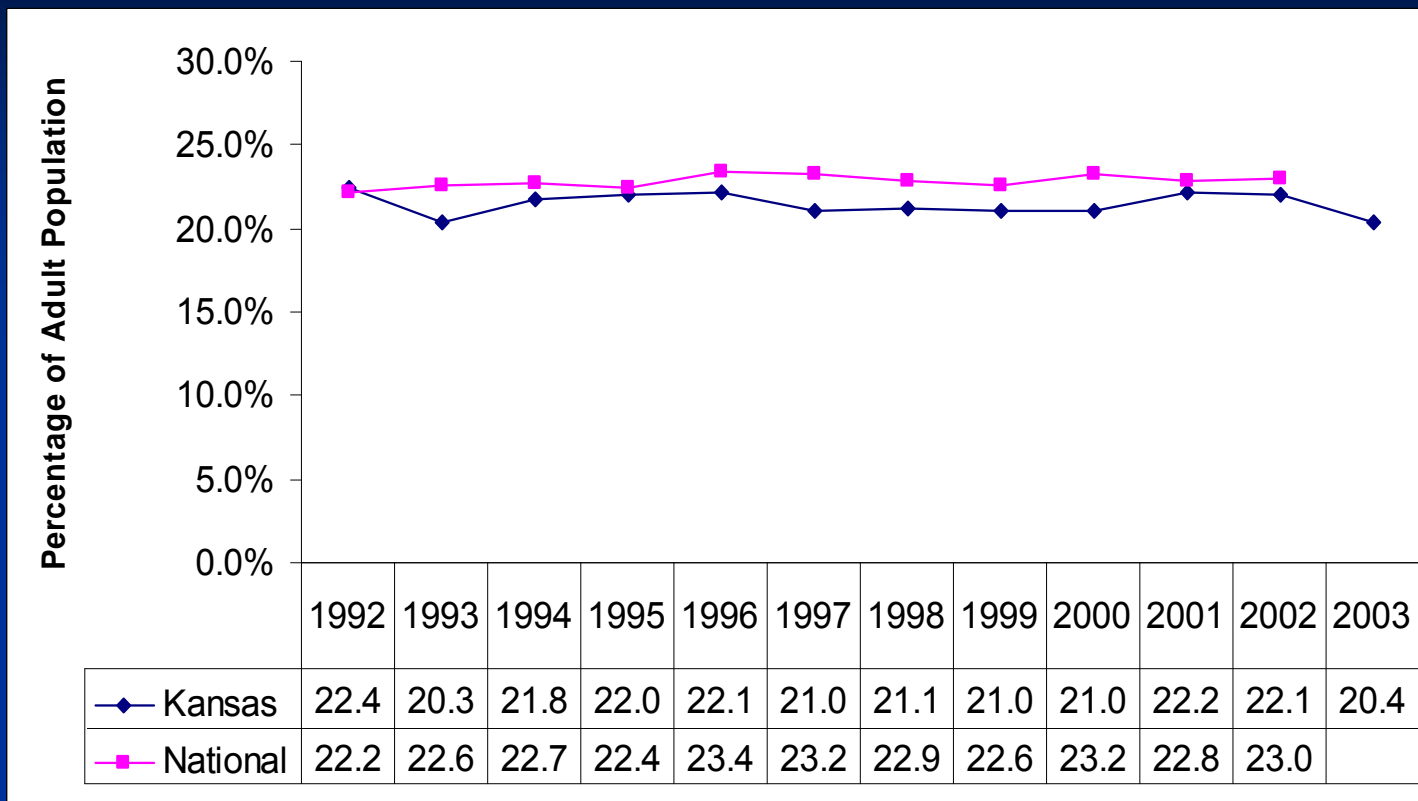
Kansas Department of Health & Environment  
Behavioral Risk Factor Surveillance System

# 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

# Current Cigarette Smokers in Kansas 1992 - 2003

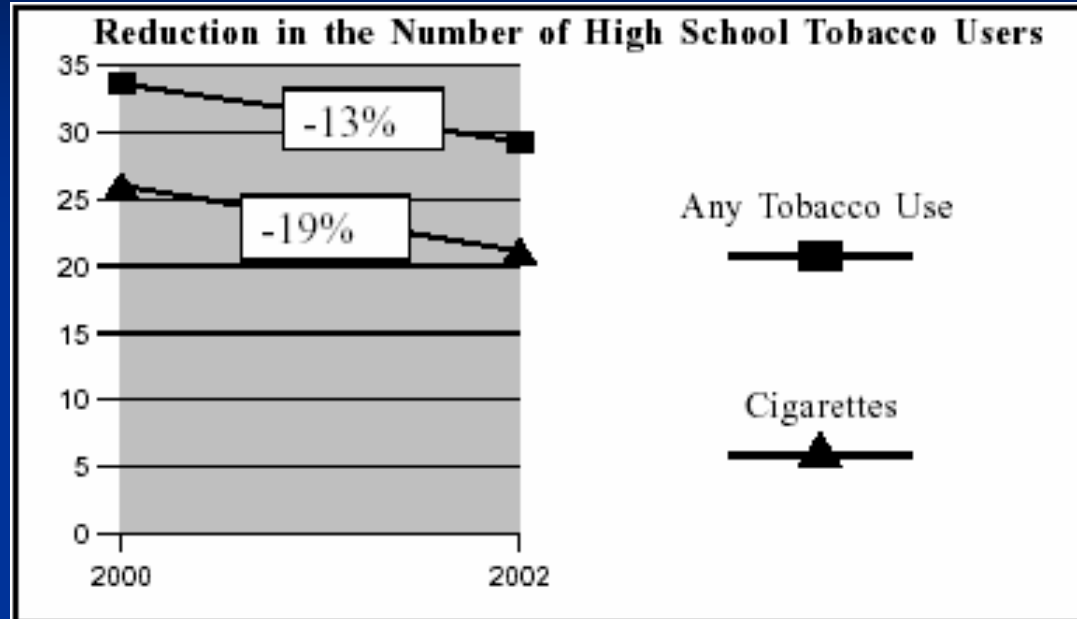


- **Prevalence of cigarette use among adults in Kansas has remained relatively unchanged. This trend is similar to the trend in the United States.**
- **Prevalence of cigarette use in Kansas is highest among individuals of low education (36.4% for less than high school) and low income (28.6% for < \$15,000 annual household income)**

Source: 1992-2003 Behavioral Risk Factor Surveillance System , Office of Health Promotion, Kansas Department of Health and Environment

National data : 1992-2003 Behavioral Risk Factor Surveillance System , Centers for Disease Control and Prevention.

# 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.

Source: 2000-2003 Behavioral Risk Factor Surveillance System, Office of Health Promotion, Kansas Department of Health and Environment

2000 and 2002 Kansas Youth Tobacco Survey, Office of Health Promotion, Kansas Department of Health of Environment



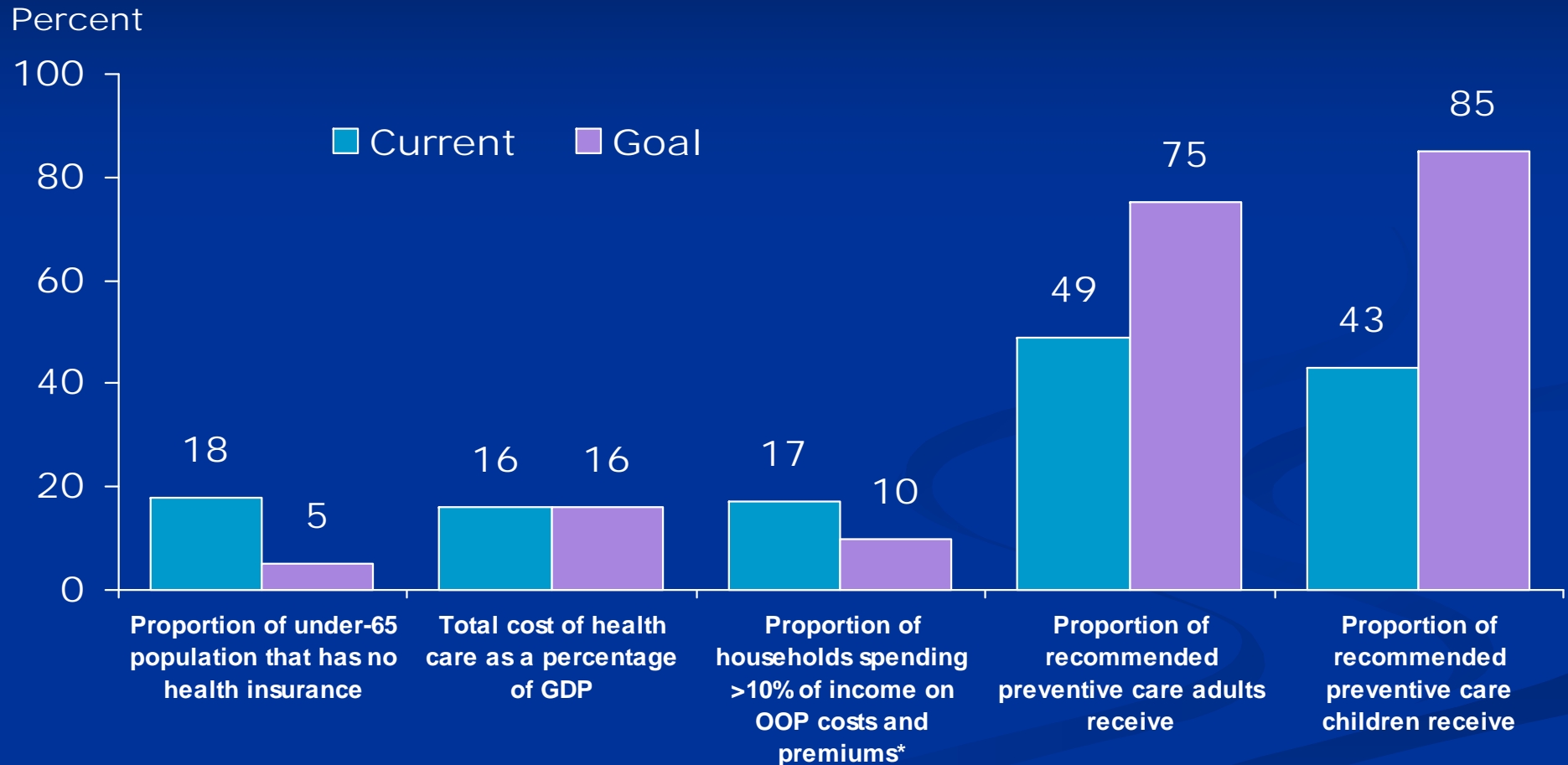
# Recommendations

# 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

# 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?"

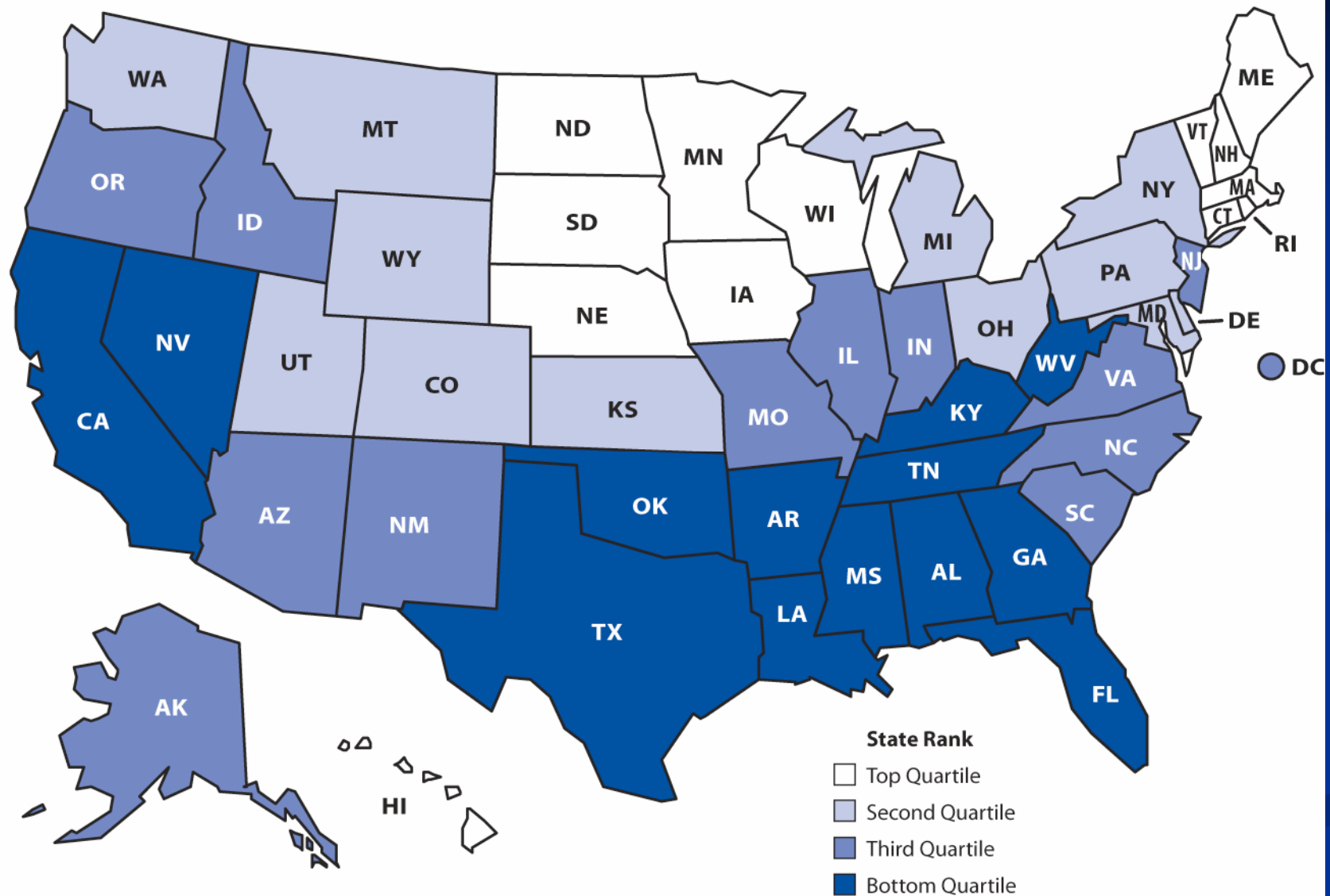


Note: Goal percentages represent median responses.

\* Or 5% of household income for low-income households; OOP = "out-of-pocket".

Source: Commonwealth Fund Health Care Opinion Leaders Survey, Jan. 2007.

## State Ranking on Overall Health System Performance



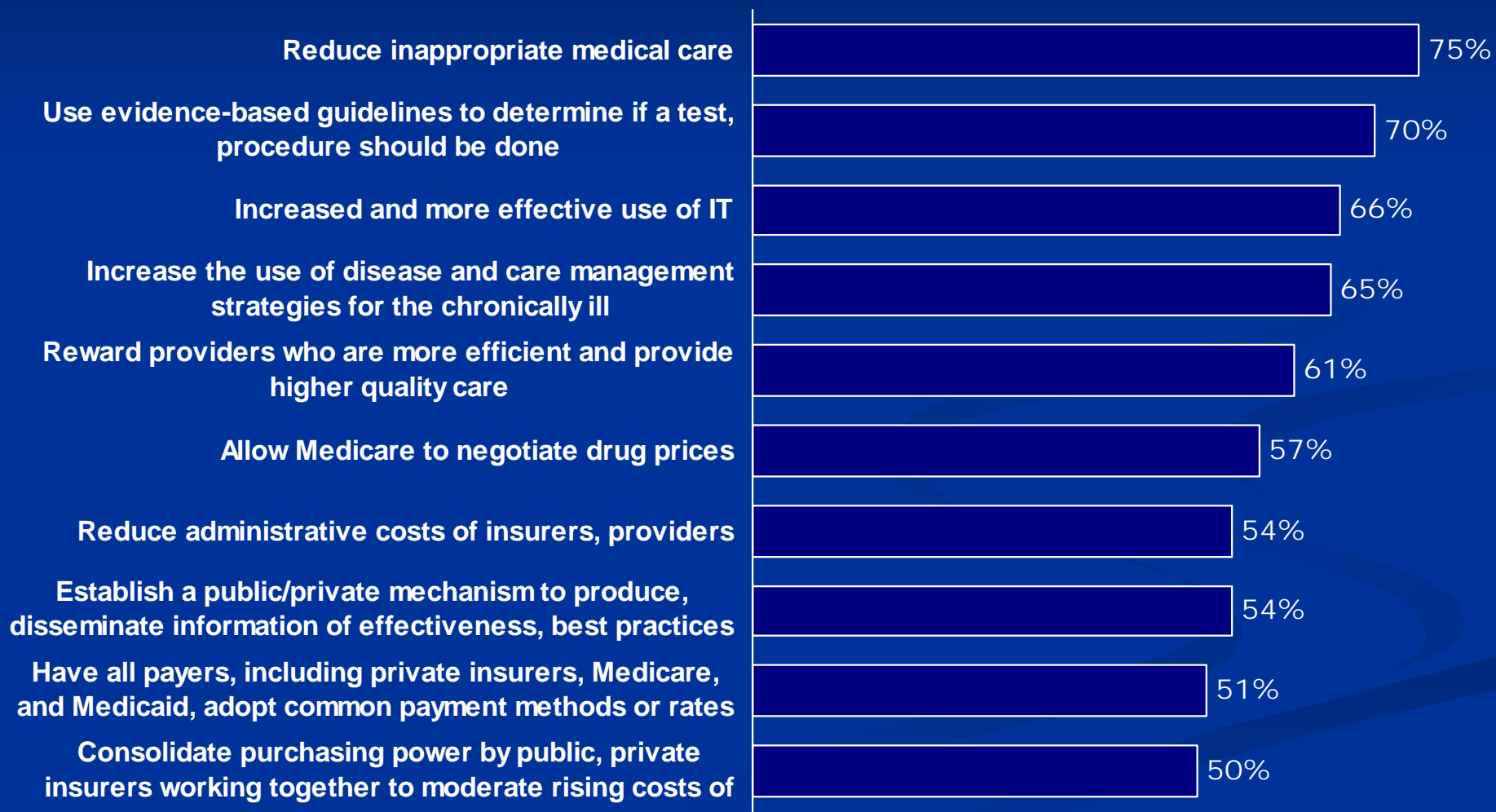
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007



# 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"



Note: Based on a list of 19 options.

Source: The Commonwealth Fund Health Care Opinion Leaders Survey, Jan. 2007.

# 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