

# Why Healthy People 2010 will fail and what to do about it

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# Health disparities

- Worse health related to lower socioeconomic position and/or membership in historically disadvantaged groups
- Typically results from cumulative deprivation, (across the life span and generations) in multiple domains, e.g. material, social, and human, at multiple levels, e.g. individual, families, communities
- Disparities emerge, develop, and persist within a messy web of history, ideology, economics, culture, and societal policies and politics, etc - a complex adaptive system of recursive processes, feedback loops, and non-linear effects

# Healthy People 2010 Goals

- **Goal 1:** Increase quality and years of healthy life
- **Goal 2:** Eliminate health disparities

# HP 2010 progress: white-black health gaps 1999-2004

<b>Health Measure</b>	<b>1999</b>	<b>2004</b>	<b>5-year change</b>
Life expectancy from birth (yrs)	5.9	5.2	0.7 (12%)
Infant mortality (per 1,000)	8.8	7.6	1.2 (14%)
Fair/poor health status (%)	6.6	6.0	0.6 (9%)

# National efforts are narrow

- Behavioral determinants e.g. smoking, diet, activity, sexual behavior, alcohol, and drug use (to the exclusion of upstream structural factors e.g. poverty, segregation, and institutional racism)
- Individual interventions (to the exclusion of population-based strategies)
- Health care/public health (to exclusion of other national policies that disproportionately affect the health of disadvantaged groups)

# Need a coordinated, comprehensive adequately funded national strategy

- All policies that affect health need to be aligned with our national goal of eliminating health disparities e.g., tax reform, child care, welfare, housing, criminal justice, education, job training etc.
- Policies must be adequately funded and coordinated

# Where to start?

- Centrality of target
- Scientific evidence
- Political feasibility
- Measurable short-term effects
- Economics

# Two examples

- **Early child development:** Addressing *upstream* causes - eliminating disparities in early life
- **Enhanced primary care for disadvantaged patients:** Providing primary care with the tools to address *downstream* effects of disadvantage

# Centrality of education

- Education is a key determinant of adolescent pregnancy, crime, future employment, income, health behaviors, and many health outcomes
- Among the most powerful determinants of population health
- There are big gaps in educational achievement by race and SES
- Achieving the goal of NCLB represents one of the most powerful means for addressing health disparities across the life span

# Centrality of early education

- Educational disparities, e.g. school readiness, begin *prior to kindergarten*
- There is little empirical evidence that NCLB can succeed without addressing the school readiness gap
- Closing the school readiness gap is a necessary, but not sufficient condition for the success of NCLB and probably for eliminating health disparities over the life course

# Scientific evidence

- Cognitively and emotionally nurturing environments during first three years promotes brain maturation and the development of key skills critical to learning
- There is strong scientific evidence for the effectiveness of early childhood interventions

# Key studies

- High quality randomized controlled trials with long-term follow-up of early child interventions months e.g. Abecedarian and Perry interventions
- Multi-city randomized controlled trial of early pre-K, e.g. Early Head Start
- Evaluation of state-wide pre-K (Oklahoma) regression-discontinuity design based on birth day

# Political feasibility

- There has been bipartisan consensus behind the core principle of *No Child Left Behind*: All children regardless of race, ethnicity, SES, language, or disability will be proficient in reading and math by 2014
- There is potential for political consensus regarding the need to close the gap in school readiness – poor children seen as deserving
- Reducing the gap at the starting gate is compatible with American values such as fair competition

# Measurable short-term effects

- There are reliable and valid measures for early child development
- Effects will be evident within a few years
- Tracking disparities in child development represents a valuable means for assessing local, state or national health and “non-health” policies on health disparities

# Economics

- Years of education per capita are strongly related to GNP (and national health)
- Investment in high quality child care and early education though expensive is cost-saving (reduction teen pregnancy, crime, welfare dependency, and increase in tax base)

# Centrality of primary care

- Hub of the health care system
- Gateway to specialized care with ramifications throughout system in all directions
- Coordinator of care across providers and across the life span

# Mismatches between need and resources

- **Primary care:** Demands exceed resources
- **Practice:** Resource-poor practices serve the neediest patients
- **Patient:** Patients with greatest needs receive the least care

# Primary care crisis

- Large declines in US medical school graduates going into primary care
- Demoralization among primary care physicians
- Hamster wheel - increasing pressure to see more patients per hour while also doing more during each patient visit

# Safety net fraying

- Medicaid payments to private physicians are far lower than Medicare or commercial payments resulting in low physician participation and shorter visits
- 50% of CHCs operate on the verge of fiscal insolvency
- “Minority practices” - the 20% of practices that serve 80% of minority patients - report inadequate resources to provide quality care

# Effects on disadvantaged patients

- Less likely to have regular source of care
- Have fewer office visits
- Receive less preventive care
- Use fewer evidence-based treatments
- Experience worse outcomes e.g. control of disease process, functional status, avoidable hospitalizations, and mortality.

# The 15-minute visit

- Primary care has outgrown the 15-minute visit - a relic of procedural-based fee-for-service (FFS) payment
- Not designed for team-oriented, population-based, continuous, coordinated, and comprehensive care
- Woefully inadequate for disadvantaged patients with complex biopsychosocial health care needs

# Enhanced resources

- Adequate infrastructure: HIT and personnel to support quality improvement, population management, and outreach
- Visit lengths (and reimbursement) that are adjusted to needs of patients
- Non-visit based care
- Team-based care
- Navigation through a broken system
- Language and cultural translation

# Enhancing resources

- Direct investment
- Enhance FFS payments
- Adjust capitation payments
- Patient-centered medical home

# Direct investment

- NYC - Primary Care Information Project (PCIP) – free EMRs for 1,300 physicians e.g. practices >30% Medicaid
- HRSA/BPHC Health Disparities Collaborative – Electronic registries and training in the chronic care model for CHCs

# Enhance FFS payments

- Fix disparity in Medicaid vs. other payers
- Adjust billing codes to account for the needs of the *individual patient* e.g. low SES, limited English proficiency, low health literacy, refugee status, etc.
- Adjust third party payments based on the sociodemographic *characteristics of the practice* (currently adjusted based on region, specialty, GME) e.g. UK deprivation payments

# Capitated and adjusted

- Fixed payment per patient (rather than per visit) thus allowing practices flexibility in creating care models that suit the needs of disadvantaged patients
- Payments must be adjusted based on the actual cost of delivering high quality care to disadvantaged populations, *not* based on historical cost data that reflects suboptimal care

# Patient-centered medical home

- Joint principles endorsed by AAFP, AAP, ACP, and AOA
- Practices (not physicians) receive per patient payments for first contact care, continuous, and comprehensive care in addition to standard visit payments
- Care is team-based, holistic, coordinated, high quality and accessible

# Payment for medical home

- Intended to cover true costs of primary care
- Hybrid of FFS and capitation
- Payment “should recognize case-mix differences in patient populations being treated within the practice”

# Scientific evidence

- Link between primary care and population health
- Link between primary care and socioeconomic and racial disparities in care
- Link between medical home and absence of disparities
- Emerging evidence for specific primary care interventions to address disparities

# Political feasibility

- Primary care enjoys bipartisan support
- CHCs enjoy bipartisan support
- Support for medical home growing

# Measurable short term effects

- Changes in HEDIS measures for disadvantaged patients
- Medical home premised on accountability for improved quality

# Economics

- Primary care reduces overall health care costs
- Medical home for Medicaid recipients saves money e.g. Erie County and North Carolina experiences
- CHCs reduce health care costs
- Economics of enhanced primary care?

# Conclusion

- Eliminating health disparities will require a coordinated, adequately funded national strategy
- Eliminating disparities in early child development and investment in primary care for the poor represent necessary, but not sufficient, policies to achieve the HP 2010 goal