

## **Beyond Insurance: Public Policy to Improve Health**

Much of the debate about health policy in the United States is focused on the availability of health insurance coverage and the relatively large proportion of persons who are uninsured. While solving the problem of the uninsured is an important objective, doing so would have little effect on the health of the population, as there is a weak connection between health insurance and health. Insurance alone is unlikely to significantly improve the health of the population or narrow health disparities within the population. Moreover, many of the major causes of poor health such as smoking, obesity, and physical inactivity are largely unaffected by health insurance.

The overwhelming focus on the uninsured in the health policy debate comes at the expense of other potentially important policies that could significantly improve health. Arguably the most important problem with the US health care system is that we spend approximately twice as much as most developed nations on health care and have little to show for the extra spending as there is little difference in population health between the US and other developed nations. Indeed, the US often ranks relatively poorly on many measures of population health.

In light of this imbalance in the health policy debate in the US, the Institute of Government and Public Affairs and the College of Medicine of the University of Illinois sponsored a conference entitled, *Beyond Health Insurance: Public Policy to Improve Health*. The purpose of the conference was to make available to the public new research by prominent scholars that identified policies that can significantly improve the health of the US population. The conference focused on four areas: reducing racial and ethnic health disparities, preventing disease and promoting good health, developing and regulating pharmaceuticals and consumer information.

### **Reducing Racial and Ethnic Disparities in Health**

David Williams of Harvard University opened the conference with a superb review of the extent and potential causes of racial and ethnic disparities in health in the US. He presented an avalanche of evidence that demonstrated that there are large and persistent disparities in health. Dr. Williams argued that racial health disparities are the result of widespread and fundamental disadvantage in the social and economic environment. Consequently, to eliminate these disparities, Dr. Williams called for a broad spectrum of policies to address disadvantage in education, employment and other underlying factors that affect health.

Amitabh Chandra of Harvard University presented his research on a narrower, but vitally important aspect of racial health disparities. He and colleagues studied racial disparities in the treatment and outcomes of patients in hospitals. Chandra and colleagues found considerable variation in quality, but that quality differed considerably by unit within the hospital. This fact makes it unlikely that observed racial disparities can be eliminated easily by focusing on the relatively small number of hospitals that treat the majority of black Americans.

The last speaker in this session was Kevin Fiscella of Rochester University. Dr. Fiscella echoed David William's call for a comprehensive approach to eliminating disparities that goes beyond the narrow focus of current policy. In particular, Dr. Fiscella called for greater investments in early childhood education and a more robust system of primary care.

### **Preventing Disease and Promoting Good Health**

Day two of the conference began with a session focused on preventing disease and improving health. Moving beyond health insurance requires that the US think about new ways to spend our health care dollars to improve health. Toward this end, George Miller, Charles Roehrig and Paul Hughes-Cromwick set out to measure how much we currently spend on prevention and wellness. Their idea is simple: resources are limited and diverting spending from treatment to prevention may pay big dividends in terms of improving health. These authors show that the US spends about 8.4% of its health care dollars on prevention. Moreover, they suggest that reallocating dollars toward prevention seems prudent given the current imbalance between spending on treatment and spending on prevention.

Dr. Karen Norberg reported on some fascinating research on the link between genetic influences of alcohol and public policies. She showed that minimum drinking age laws had long term, beneficial effects and that these effects differed by whether a family was predisposed, ostensibly because of a genetic link, to alcohol problems. The upshot of this research is that public policies to improve health behaviors can be important and that there seems to be a gene-environment interaction.

An approach to improving health that is gaining in popularity is to make more use of information technology. Many argue that more widespread use of information technology will significantly increase the quality of care. Jim Rebitzer and colleagues assessed this proposition by focusing on the consequences of physician's adopting a prominent computer based decision-support tool that recommends treatment protocols. They show that such tool can enhance the diffusion of new knowledge. However, incentives to invest in such technology are inadequate. The authors argue that the government will need to step in to guiding and facilitate investments.

Dr. Ken Thorpe closed the session on preventing disease and improving health by noting that progress in improving health will come when efforts are focused on the big problems—the increasing incidence and treatment of chronic disease. Dr. Thorpe calls for greater use of disease management programs and a transformation of the delivery of care that focuses on preventing and treating more cost effectively chronic disease.

### **Developing and Regulating Pharmaceuticals**

The growing importance of pharmaceuticals in preventing and treating disease has been widely noted and the second session of the conference focused on developing and regulating pharmaceuticals. One of the most important developments in this area is direct-to-consumer (DTC) advertising. How does such advertising affect racial and ethnic disparities in health? This is the question that Donald Kenkel and colleagues at Cornell University tackle. Specifically, they show that DTC advertising is seen more by older adults, women and those from low SES backgrounds. The last finding raises the possibility that DTC advertising may help eliminate health disparities by class (and race). Kenkel and colleagues suggest the calls to limit such advertising similar to those from the Institute of Medicine may have an unintended consequence of worsening health disparities.

The health benefits of prescription drugs is a question of primary concern given the growing amount of money spent on prescription drugs and the purported clinical importance of these products. Frank Lichtenberg and Gautier Duflos examined this question in the context of Australia. They find that using newer drugs (increasing drug vintage) increased life expectancy by 1.23 years and increased lifetime drug expenditure by \$12,976; the cost per life-year gained from using newer drugs is \$10,585.

John Cawley and John Rizzo studied the consequences of withdrawing a drug from the market, which is becoming increasingly common. The question they address is whether the reduced competition due to the withdrawal of a drug results in higher prices and market share for remaining drugs in that class or lower sales for all drugs in the class because of negative publicity of the withdrawal. Cawley and Rizzo find that “bad news” of drug withdrawal spillover to all drugs in that class and reduce use of these drugs.

The final presentation of the session was given by Tomas Philipson who along with colleagues examined the issue of the costs and benefits of granting patents. A novelty of this research was incorporating the effects of marketing. Expiration of patents resulted in very different consequences for drugs that had been marketed compared to drugs that had not been marketed. Heavily marketed drugs experienced much larger declines in use subsequent to the patent expiration, which coincides with a virtual end to marketing activities. If marketing activities have a beneficial effect, these positive aspects of monopoly may offset the negative consequences of higher monopoly prices.

### **Consumer Information**

The final session of the conference was concerned with the availability and quality of consumer information, which is a fundamental problem in health care. The first presentation was made by Heather Schofield who along with Sendhil Mulinathan studied the value of nutritional information. Schofield and Mulinathan show that consumers over-generalize the information found in health and nutrient claims and fail to differentiate between informative and uninformative health claims. Firms use the limited ability of consumers to “hijack” the nutritional information and increase sales. This combination of coarse thinking by consumers and message hijacking by firms can negatively impact health by persuading consumers that unhealthy products are healthy.

The next presentation addressed the issue of report cards. Jesse Schold noted that the “ship has sailed” on the issue and that report cards are going to become more and more common. However, Dr. Schold raised several notes of caution with respect to report cards. Specifically, he noted that report cards can decrease access for the sickest patients and make providers target the wrong outcomes—those measured by the report card instead of better overall health. He recommends that much greater efforts go into devising report cards.

One of the great advancements in science has been the mapping of the human genome. Along with this advance comes the possibility of personalized medicine and pharmacogenomics. Amilia Issa described the benefits and problems associated with pharmacogenomics. Benefits include better screening for disease, fewer adverse drug reactions, better patient compliance and better health at lower costs. However, Dr. Issa notes that the regulatory and financial systems that are integral to health care have not kept pace with the science. Therefore, there needs to be concerted effort among insurers and other third party payers, the government (FDA) and providers to design an effective, value-based system of personalized medicine.

The session on consumer information and the conference itself ended with a presentation by Richard Frank on decision making and information. Dr. Frank described how health care decisions are complex and emotionally charged and that such characteristics make it likely that a consumer will prefer the status quo because it avoids making the wrong decision. He also notes that context and the way information is presented matters. Dr. Frank recommends changing the choice context by using defaults, by grouping choices and encouraging delegation of decision making. Most of all, he recommends acknowledging and incorporating what is known about the

imperfect decision making of consumers into the presentation and communication of health information.