The Problem is Poverty
Why Poverty and Income Inequality Are at the Core of America’s High Health Care Spending
When We Look at a Picture, What Do We See?

It Depends on Who is Doing the Looking
The Same Holds True for Healthcare

Is it a commodity or a right?

Efficient or inefficient?

Effective or ineffective?
To See It Differently We Have to Challenge Our Assumptions
Do We Really Know What We Know?

Did Paul Revere say “the British are coming?”

Did Eve eat an apple?

Did Vikings wear horns on their helmets?
The One Trillion Dollar Question

Do we really know what causes excessive healthcare spending?

Is it waste and inefficiency?

Or is there another explanation?
The Man Who Got It Right

Richard “Buz” Cooper, M.D.

- 1936-2016
- Chief, Division of Hematology and Oncology, at the Hospital of the University of Pennsylvania
- EVP and Dean, Medical College of Wisconsin
- Senior Fellow, Leonard Davis Institute of Health Economics, University of Pennsylvania
- Director, Center for the Future of the Healthcare Workforce,
- New York Institute of Technology

A “Voice in the Wilderness”
Multiple publications questioning COGME’s prediction of 100,000 too many doctors

There is a shortage of specialists – is anyone listening?

Academic Medicine (2002)

...and many others
Dr. Cooper the “Contrarian” Now is Backed By:

- The American Medical Association (AMA)
- The Council on Graduate Medical Education (COGME)
- The Association of American Medical Colleges (AAMC)
- Over 20 state medical associations
- Over 20 state hospital associations
Current Physician Shortage Projections

- **21,800 too few physicians today**
- **65,500 too few physicians by 2020**
- **90,400 too few physicians by 2025**

Shortage in primary care will reach 31,100 by 2025 while demand for specialists will exceed supply by 63,700 by 2025

Source: AAMC, March 2015
I Hate to Say We Told You So, But…

“Without More Doctors, Universal Access is a Moot Point,”

HealthWeek, May 20, 1991
According to Conventional Wisdom, What Causes Excessive Health Care Spending in the United States?

Hint: It sounds like a snake

Supply-Sensitive Services
(i.e., doctors and hospitals)
Roemer’s Law of Supplier-Induced Demand (1958)

Capacity creates demand: “A built bed is a bed filled”

Victor Fuchs finds a close association between the number of surgeons and the amount of surgery
An Unusual Superpower

David Dranove and Paul Wehner find a close association between the number of OB/GYNs and the number of deliveries.

Those OB/GYNs are awfully persuasive!

306 hospitals referral regions where most residents get most of their care
A Startling Revelation

Some regions spend more treating patients than others – and obtain worse results
And The Pugly
A Startling Conclusion

Almost one in three dollars spent on healthcare is wasted

That’s about \textbf{ONE TRILLION} dollars!
How the Healthcare Dollar is Spent

The Nation’s Health Dollar ($2.9 Trillion), Calendar Year 2013: Where It Went

Source: CMS Office of the Actuary
A Startling Solution

Get physicians in Milwaukee and Newark to practice like physicians in Green Bay and Grand Junction and healthcare spending could be reduced by 30%
Also, If Physicians and Hospitals are the Problem…

Reduce the number of doctors and hospitals, or limit their number, and replace “fee-for-volume” with “fee-for-value”
“…given the waste and inefficiency of physician practices, the nation does not need more physicians. Congress should resist efforts to increase the number of residency positions funded by Medicare.”

Source: Improving Quality and Curbing Healthcare Spending: Opportunities for Congress and the Obama Administration. Dartmouth Institute for Health Policy and Clinical Practice. 2008

Instead, manage physicians to reduce waste
What Do You Really Think About America’s Doctors?

“If we sent 30 percent of the doctors in this country to Africa, we might raise the level of health on both continents.”

- Elliott Fisher, Dartmouth Atlas of Healthcare
What the “Experts” Think Matters

Resident Physician Shortage Reduction Security Act of 2007

“A bill to amend title XVIII of the Social Security Act to provide for the distribution of additional residency positions, and for other purposes”
So the Next Time You Can’t Schedule a Physician Appointment, Think:

“Supply Sensitive Services”
But Back to Poverty – Who Else Didn’t Make the Poverty/Spending Connection?

- **Tom Daschle**: Top Obama adviser on the ACA
- **Ezekiel Emanuel**: Top Obama adviser on the ACA
- **Glen Hubbard**: Top Romney healthcare adviser
- **Peter Orszag**: Director of the Office of Management and Budget
- **Donald Berwick**: First Obama director of CMS
- **John Podesta**: Clinton White House Chief of Staff
- **Uwe Reinhardt**: Noted healthcare economist

All wrote on controlling healthcare costs: **NONE** addressed the effect of poverty
But Isn’t It Obvious Newark is Not Like Green Bay?

Yes.

And No.
Yes, Newark is Poorer Than Green Bay

And We Have Known for Years Poor People are Sicker Than the Better Off and Require More Services
Low Income = Poor Health

Source: “Poverty and the Myths of Health Care Reform,” Buz Cooper MD
Poor Health Among the Poor Gets Worse Over Time; Good Health Among the Wealthy Stays Good

“A car that has been allowed to rust will require endless repairs and may never truly hum again.”

- Buz Cooper
But We Have Not Always Known Poorer People Cost More to Treat

In fact, for a long time, that was not the case

“Few antibiotics existed, patients with bad knees or hips were given a cane, cardiac arrest was simply another word for dead, and care was cheap”

But by 2008, Medicare spending was 30-40% greater among poor beneficiaries than wealthy ones
But Dartmouth Still Disputes The Poverty Connection

Dartmouth acknowledges that low income people are sicker and require more care, yet claim “regional differences in poverty and income explain almost none of the variation (in spending)”
Why Does Dartmouth Discount the Role of Poverty?

1. Because they used Medicare as the metric, which does not reflect patterns of healthcare spending overall.

2. Income levels of seniors do not reflect their socioeconomic status to the same degree that incomes do for working age adults.

3. Most important, Dartmouth’s HRRs are not the appropriate benchmark. The 1.6 million people in Manhattan and the 10 million in Los Angeles are grouped together.
All of Our Heads Have Been in the Sand

Poverty is something that as a society, we don’t want to talk about.

But it persists.
People Living in Poverty

Source: “Poverty and the Myths of Health Care Reform,” Buz Cooper MD
Poverty – The US vs. the OECD

Source: “Poverty and the Myths of Health Care Reform,” Buz Cooper MD
The “Poverty/Utilization Nexus”

Three Examples:
Manhattan
Milwaukee
Los Angeles
Manhattan:
“You Should Take the A-Train”

Source: Richard Cooper, M.D. – Poverty and the Myths of Healthcare Reform
Manhattan: “You Should Take the A-Train”

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Source: Richard Cooper, M.D. – Poverty and the Myths of Healthcare Reform
Two Milwaukees, Two Americas

Percent of population living in segregated areas: 51.4%

<table>
<thead>
<tr>
<th>Black poverty rate:</th>
<th>White poverty rate:</th>
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<tbody>
<tr>
<td>38.4%</td>
<td>7.6%</td>
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<table>
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<tr>
<th>Black unemployment rate:</th>
<th>White unemployment rate:</th>
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<tbody>
<tr>
<td>16.3%</td>
<td>5.9%</td>
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<tr>
<th>Median income in black segregated zip codes:</th>
<th>Median income in white households:</th>
</tr>
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<tbody>
<tr>
<td>$22,000</td>
<td>$62,697</td>
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Three-quarters of all people that a white person sees on the street in the Milwaukee metro area are white, and 60% of people a black person sees are black

Source: Wall Street Journal
The Milwaukee Poverty Corridor

Figure 2.5. Geographic Distribution of Household Income, Disability, and Hospital Utilization in the Milwaukee Area, 2010

Source: “Poverty and the Myths of Health Care Reform,” Buz Cooper MD
What Happens When You Remove the Poverty Corridor?

Hospital utilization is virtually the same as other Wisconsin HRRs

Source: “Poverty and the Myths of Health Care Reform,” Buz Cooper MD
“Those who reside in Milwaukee’s poverty corridor are left with meager resources, poor health, and no clear way out. Yet if Milwaukee were able to lift the lives of its poor and near-poor residents, hospital utilization could decrease by as much as 35%.”

“If hospitalization throughout Milwaukee could be the same as that in the wealthiest areas, enough would be saved to build a new baseball stadium every two years.”

Source: “Poverty and the Myths of Health Care Reform,” Buz Cooper MD
“I Love L.A.!”

Poverty and glitz, side by side

“Look at that mountain
Look at those trees
Look at that bum
Man, he’s down on his knees”
There are More People in Poverty in L.A. Than There are People in Some States

*Well over 3 million*, using the OECD Relative Poverty Rate:

50% of the median disposable household income in the U.S. overall, adjusted for family size

\[ \text{\textdollar}30,200 \text{ or less for a family of 4} \]

*Official level is \textdollar 22,000*
Zones of poverty in L.A. cannot be as cleanly separated as in Manhattan and Milwaukee

“*Their tentacles reach in every direction*”

So examining zip codes does not show the real picture
But What If All Incomes Were “Equalized”?

What if all areas of L.A. had an average household income of $75,000 or higher?

“The answer is that healthcare utilization among working-age adults would decrease by 31%.”

*Hurray for Hollywood!*
You Really Ought to Give Iowa a Try

The Dartmouth Atlas offers:

* Mason City, Iowa
* Dubuque, Iowa
* La Crosse, Wisconsin

As the standard to judge healthcare spending
In What Part of LA...

...is hospitalization the same as it is in Mason City, Dubuque, and La Crosse?

In those zip codes where the median household income (adjusted for cost of living) is the same.

“It seems unlikely that physicians and hospitals would selectively use excessive care for patients who have few financial resources.”

Source: “Poverty and the Myths of Health Care Reform,” Buz Cooper MD
# Hospital Utilization and Poverty

<table>
<thead>
<tr>
<th>Region</th>
<th>Percent of Households in Region with Incomes &lt;$35,000</th>
<th>Ratio of Hospital Utilization in the Poorest vs. Richest Quintiles</th>
<th>Percent Decrease in Hospital Utilization if Rates throughout Each Region were the Same as in the Affluent Quintile</th>
</tr>
</thead>
<tbody>
<tr>
<td>NY: New York Subway</td>
<td>41.2%</td>
<td>3.34</td>
<td>45%</td>
</tr>
<tr>
<td>CA: Los Angeles County</td>
<td>32.3%</td>
<td>1.93</td>
<td>37%</td>
</tr>
<tr>
<td>WI: Milwaukee</td>
<td>21.5%</td>
<td>1.75</td>
<td>31%</td>
</tr>
<tr>
<td>CA: San Diego County</td>
<td>19.5%</td>
<td>1.76</td>
<td>30%</td>
</tr>
<tr>
<td>CA: Alameda, Contra Costa counties</td>
<td>8.4%</td>
<td>1.85</td>
<td>27%</td>
</tr>
<tr>
<td>CA: San Francisco, San Mateo counties</td>
<td>3.4%</td>
<td>1.81</td>
<td>23%</td>
</tr>
<tr>
<td>CA: Orange County</td>
<td>2.1%</td>
<td>1.35</td>
<td>15%</td>
</tr>
<tr>
<td>CA: Santa Clara County</td>
<td>0.0%</td>
<td>1.31</td>
<td>9%</td>
</tr>
</tbody>
</table>

Source: “Poverty and the Myths of Health Care Reform,” Buz Cooper MD
The Wrong Diagnosis Means the Wrong Treatment Plan

“The political response to high healthcare spending has been to reengineer the delivery system and change the reimbursement system rather than address the underlying socio-economic factors.”

“The fault, dear Brutus, is not in our system, but in our humanity.”

Source: “Poverty and the Myths of Health Care Reform,” Buz Cooper MD
The “Quality-Industrial Complex”

Devoted to the idea that physician practice variations, physician supply, physician self-referral, physician specialists, fee-for-service payments, and inefficiency are the root causes of excessive spending.
Most of Us Are “All-In”

- Accountable care organizations
- Bundled payments
- P4P
- MACRA
- Integration, consolidation, corporatization
- Clinical practice guidelines
- Performance rankings
- Readmission penalties

But what if we are only “Managing at the Margins?”
The Long-Term Benefits Are Still in Question

Rates of 30-day hospital readmissions were no different in ACOs than in control populations.

Follow-ups of ACOs caring for more than 600,000 Medicare beneficiaries found overall savings of, at best, a few percent.

If waste and inefficiency are responsible for 30% of healthcare spending, why can’t those who have organized themselves around being more efficient achieve meaningful savings? Surely savings of, say, 10% should be easy.

Dartmouth itself dropped out of its ACO.
Are We Disadvantaging the Disadvantaged?

Harvard analysts found that the odds of being punished for excess readmissions was more than double at safety-net hospitals compared with others.
Solution Number One

Address Poverty
In a Given Year, 1.3 to 3 Million People Are Homeless in the US; 650,000 on a Given Night

Between shelters, emergency rooms and jails, it costs about $40,000 a year for a homeless person to be on the streets

Simply housing the homeless reduces healthcare costs by 60%

“Treating a homeless man’s frostbitten toes is surely a waste when a pair of shoes could have prevented it.”

Source: “Poverty and the Myths of Health Care Reform,” Buz Cooper MD
A Matter of Commitment

It is not clear that defeating poverty is a war America wants to win.

Anti-poverty spending as a percentage of GDP is less today than in 1980 and is half the average of other OECD countries.
It’s Not All About the Government: Growth is the Key

“Had economic growth continued to lift the incomes of low-skilled workers at the same rate after 1965 as before, and had gains from economic growth been distributed more evenly, poverty rates would be much lower today.”

Source: “Poverty and the Myths of Health Care Reform,” Buz Cooper MD
“Clearly, there are many examples of waste and inefficiency in the US healthcare system.”

“A commitment to improving quality and efficiency has long been integral to medical professionalism, and serious efforts by dedicated health care professionals must be recognized and encouraged.”

Source: “Poverty and the Myths of Health Care Reform,” Buz Cooper MD
The Socioeconomic Determinants of Health

Population Health Management & Federally Qualified Health Centers

Fashioned specifically for the poor—“enabling services” such as case management, assistance with transportation, and translation
Population Health Management: A New Paradigm

From individuals roaming in the woods to a “good shepherd” approach
What is Population Health Management?

Three Key Elements:

• Information based clinical decision making
• Primary care led clinical workforce
• Patient Engagement and Community Integration
New Survey Shows Metrics

- 85% of hospitals have a strong or total commitment to population health
- More than 90% of hospitals believe population health follows their mission
- Less than 20% of hospitals believe they have the finances to implement population health initiatives

Source: The Health Research & Educational Trust, the Association for Community Health Improvement, and the Public Health Institute
Reducing “Frequent Flyers”

• 5% of population that accounts for 51% of the costs

• Population health managements seeks to find and address the “hot spots”
FQHCs: America’s Safety Net

- See over 24 million patients a year (twice the number from 2000)
- 9,000 sites of service
- Urban & rural
- Save the system $24 billion a year
- Supported by both sides of the aisle
- Employ over 170,000 staff (doubled since 2005)
- Celebrated 50th anniversary in 2015
The Tipping Point

Income inequality is back in the news.

More states to expand Medicaid?
Some Good News

The poverty rate decreased, incomes went up
But the Job is Far From Finished

The last word goes to Dr. Cooper:

“Cultural narratives create belief systems that drive policy. Health care is ensnared on the narrative of waste and inefficiency, while the narrative of poverty, income inequality, and health care spending languishes.”

“It is time for creative minds to embrace it and search for realistic solutions.”

Source: “Poverty and the Myths of Health Care Reform,” Buz Cooper MD
Continue the Conversation

A Raised Hand – Blog by Kurt Mosley

Follow on Twitter: @Kurt_Mosley

A Raised Hand by Kurt Mosley

A discussion on emerging healthcare trends

The Poverty of Healthcare
May 27, 2016

My dear grandmother once told me “money is honey, but health is wealth.” Truer words have not been spoken, but today wealth is becoming an important factor in the health of the American public. When discussing what makes people in the United States healthy or unhealthy, most Americans would likely say diet, exercise, obesity, social indiscretions, or genetics, but not poverty.

In the United States, we spend $3 trillion a year on health care. Half of the $3 trillion can be traced back to just 5% of the population, who are mostly chronic care patients. So the question is where do these chronic care patients come from? The majority of the time the answer is from impoverished communities.
If you have any questions, please contact Kurt Mosley at:

Kurt.Mosley@amnhealthcare.com

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