

## Health Care Disparities: The Impact on Health Systems

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Temple University School of Medicine  
Chair, Department of Family and Community Medicine  
Associate Dean, Academic Affiliations

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### Who am I?

- Generalist
- 35 years of practice in the inner cities of Wilmington and Philadelphia
- Bilingual – Spanish
- Chair, Delaware Delegation to the AMA
- Former Chair, AMA Council on Legislation
- Throw no stones!!

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### Health System Reform

- Where are we?
- Positive effects on disparate populations
- Negative effects on disparate populations

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## Where are we?

- Baucus Bill – passed Senate Finance
- HELP Bill – ? Status
- HR 3961-2 – 62 passed  
61 to be debated wk of 11/16

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## Positive Effects

- The number of uninsured individuals may drop from 50 million to 5-10 million
- These now covered individuals will now have coverage for:
  - Preventive care
  - Early treatment
  - Testing
  - Medications
- Hopefully, they will also have access
- The nation's health care costs should go down
- The nation's health statistics (quality) should improve
- We should be able to demand value from the health care system

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## Negative Effects – Primary Care Access

- As in Massachusetts the demand for primary care services may overwhelm the system
- Primary care is addressed in the reform measures, but will the incentives be sufficient to overcome the shortages:
  - Primary care physician salaries 30-40% less than the next tier of specialists
  - Students graduate with \$150-200K in debt
  - Patient centered medical home is addressed in the bills, but will the added services be adequately compensated?

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## Negative Effects – DSH

- Disproportionate Share Hospital (DSH) program to be abolished (or funding significantly decreased) – What will be the fate of those hospitals?
- DSH hospitals generally serve populations who experience health disparities
- DSH hospitals currently receive subsidies to make up for the low rates that Medicaid pays
- After reform Medicaid and Medicare (MA/MC) payments will be reduced because hospitals are anticipated to have less bad debt with more patients insured
- DSH hospitals often have few uninsured but many under-insured (MA and MC); so, their revenues could drop to unsustainable levels

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## Negative Effects – Pay for Performance

- Value-based purchasing (P4P) – great in theory – may be devastating in practice for minority populations
- Providers will be paid based on outcomes
- The outcomes of minority populations are often not as favorable as other groups – P4P will need to be risk-adjusted
- The risk-adjustment tools available are not robust enough to adjust for the complexities of disparate populations (both environmental and genetic)
- If the providers of minority populations outcomes are below those who care for other populations, they may be ranked in a lower tier of providers – this will increase the out of pocket costs to their patients resulting in worse adherence and even worse outcomes.

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## Negative Effects – Limited English Proficiency

- Language barrier – the costs of translation services are not reimbursed
- Will P4P and services for patients with limited English proficiency drive providers away from these populations and limit access and thereby many of the benefits of reform?

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## Negative Effects – Undocumented Aliens

- Of the 5-10 million that will continue to be uninsured many/most are undocumented aliens
- Covering these individuals or even allowing them to purchase health insurance in the post reform era has been a political poison pill
- These individuals still require care
- They will still turn to the Emergency Room for care
- They cannot be turned away (EMTALA)
- They reside in the service areas of hospitals that care for minority populations
- Thus, these hospitals will continue to be stressed by the burden of the uninsured and with lower revenues – how will they survive?

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## Summary

- We must have health system reform
- But it must be done with care
- A major purpose is to eliminate/reduce disparities
- We must avoid unintended consequences that may worsen disparities
- A robust primary care infrastructure with properly aligned incentives is crucial

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## Questions?

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## The Epidemic of Gun Violence and Reform

Health Disparities, Financing, and the Law:  
From Concept to Action  
Temple University  
November 2009

Marla Davis Bellamy, JD, MGA  
Executive Director  
Anti-Violence Partnership of Philadelphia

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### Scope of the Problem

- Among African-Americans between the ages of 10 and 24, homicide is the leading cause of death.

- In the same age range, homicide is the second leading cause of death for Hispanics, and the third leading cause of death for American Indians, Alaska Natives, and Asian/Pacific Islanders.

- Homicide rates among African-American males 10-24 years of age (58.3 per 100,000) exceed Hispanic Males (20.9 per 100,000) and non-Hispanic White males in the same age group (3.3 per 100,000)

*Centers for Disease Control and Prevention, National Center for Injury Prevention and Control 2007.*

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### Pennsylvania Problem

- Pennsylvania leads the nation in the rate of black homicide victimization according to an analysis of unpublished Federal Bureau of Investigation (FBI) Supplementary Homicide Report (SHR) data released in January 2009 by the Violence Policy Center (VPC).

- The top five states with each state's corresponding black homicide victimization rate are: 1) Pennsylvania, 36.86 per 100,000; 2) Michigan, 33.40 per 100,000; 3) Indiana, 32.65 per 100,000; 4) Kansas, 32.47 per 100,000; and, 5) Nevada, 32.26 per 100,000.

- This is the third year that the VPC has issued the report and the second time in three years that Pennsylvania has topped the ranking.

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### Philadelphia Problem

- According to the FBI Crime Report in 2007 Philadelphia experienced 21,180 violent crimes.
- The Pennsylvania Safe School Advocate Annual Report for 2007-2008, revealed that in 2007-2008 the Phila. School District reported 14,743 acts of violence.
- In 2008, 314 U.S. Soldiers died in Iraq and 332 individuals died in Philadelphia.

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## Dr. John Pryor




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### “Saving the Wounded in two American Wars”

- “There is a war at home raging every day, filling our trauma centers with so many wounded children that it sometimes makes [Baghdad](#) seem like a quiet city in [Iowa](#)... Imagine, for a moment, if this (a crack house shooting with seven dead) had occurred in a suburban shopping mall or if a Marine unit in Iraq had been involved. There would be shock, outrage, 24-hour news coverage, Senate hearings and a new color of ribbon to wear. That double standard, that triage of compassion and empathy, is why the war on the streets continues unabated.” –Dr. John Pryor

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The U.S. Centers for Disease Control has declared that America's level of violence and its incidence of homicides are among the most critical national public health problems.

Violence is destroying the health of our communities. However, because it is a learned behavior, it is preventable.

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### Population-Based Prevention Solutions

- The Community Coalition in South Los Angeles worked to close over 400 liquor stores and documented a 27% reduction in crime and violence within a four-block radius of each closed store. *Prevention Institute. The Built Environment and Health: 11 Profiles of Neighborhood Transformation, July 2004.*

- The CeaseFire Chicago community based public health approach to reduce shootings and killings has shown reductions from 41% to 73%, and a 100% drop in retaliation murders. Further, cities with more coordination and attention to preventing violence have achieved lower violence rates than cities without. *Prothrow-Stith, Murder is No Accident Jossey-Bass, 2004.*

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### Community Level Prevention Saves Lives and Money

- An economic analysis revealed that an investment of \$10 per person in community level initiatives aimed at reducing tobacco consumption, improving nutrition and increasing physical activity results in a return on investment within two years and an estimated savings of over \$15 billion nationally within 5 years.

*Trust for America's Health. Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities. July 2008.*

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**Anti-Violence Partnership of Philadelphia (AVP)**

- Crisis intervention
- Court support services
- License therapists provide counseling services
- Conflict resolution training in local schools

**Marla Davis Bellamy**  
Executive Director  
Anti-Violence Partnership of Philadelphia  
[mdavis@avpphila.org](mailto:mdavis@avpphila.org)  
(215) 567-6776

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## PROPOSALS FOR REFORM: The Working Poor

**Barry Furrow**  
Professor of Law  
Earle Mack School of  
Law @ Drexel University

2009 Health Disparities Conference  
Health Disparities, Financing, and the Law:  
From Concept to Action  
Temple University  
Philadelphia, Pennsylvania  
November 13, 2009




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## WHY BOTHER WITH REFORM?

### BECAUSE WE HAVE PROBLEMS WITH:

1. **Access.** The U.S. health care system fails to provide access to health care for up to 46 million citizens (leaving aside hard working immigrants without legal status)
2. **Cost.** Our system, measured by other industrialized countries' systems, is expensive, particularly since we have so many uninsured.
3. **Quality.** The system is erratic, varies from region to region, and provides a very poor return on investment. Too much care is unproven.
4. **Poor Cost-Quality Linkages.**
5. **Portability Problems.** A Medicare beneficiary is in a universal health care system, able to get care anywhere in the U.S. A Medicaid beneficiary is locked into her state's system. A worker with employment insurance has some portability within his region, but is out-of-network once outside the area (and costs shoot up).

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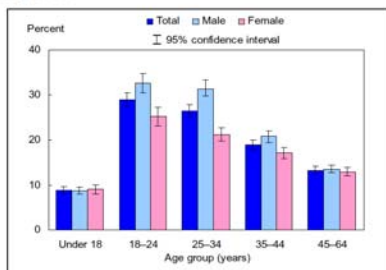
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## Percentage of Americans Without Health Insurance Coverage 2008

Figure 1.2. Percentage of persons under age 65 years without health insurance coverage at the time of interview, by age group and sex: United States, 2008




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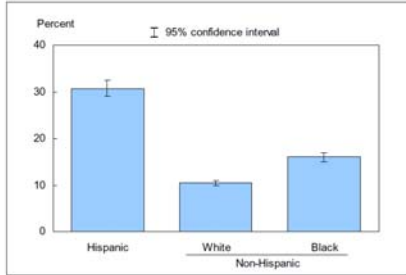
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### Lack of Coverage 2008

Figure 1.3. Age-sex-adjusted percentage of persons of all ages without health insurance coverage at the time of interview, by race/ethnicity: United States, 2008




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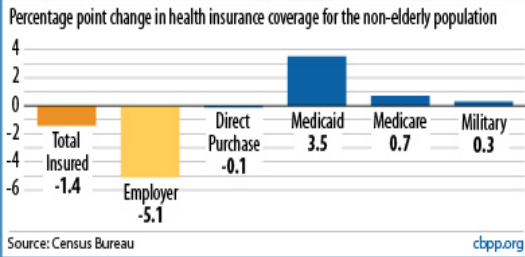
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### Coverage Shrinks

Figure 1: Change in Health Insurance Coverage by Type of Coverage, 2001 to 2008




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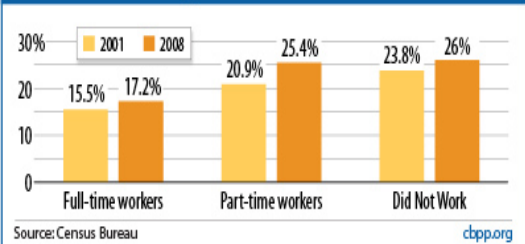
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### Uninsureds Grow

Figure 2: Uninsured Rate Increasing Both for Workers and Those Who Did Not Work




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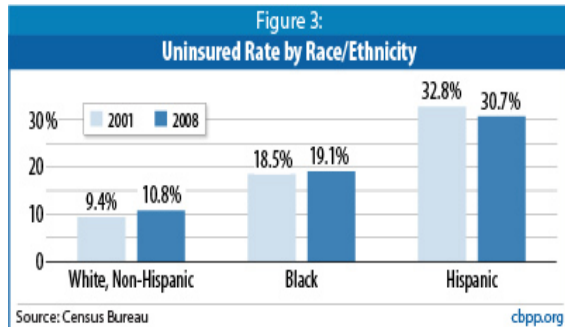
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## Race and Uninsured Status




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## Percentage of Those Failing to Get Needed Medical Care Due to Cost during past 12 months, US. 1997-2008

- 2008 6.5      Under 18 years      2.8
- 2007 5.8      18–64 years      8.8
- 2006 5.8      65 years and over      2.4
- 2005 5.3      All ages      6.5
- 2004 5.5      Males      5.9
- 2003 5.3      Females      7.1
- 2002 4.7      Hispanic or Latino      7.7
- 2001 4.7      Not Hispanic or Latino      6.0
- 2000 4.5      single race, white
- 1999 4.3      Not Hispanic or Latino,      8.3
- 1998 4.2      single race, black
- 1997 4.5

Source: <http://www.cdc.gov/nchs/nhis/released200906.htm#>

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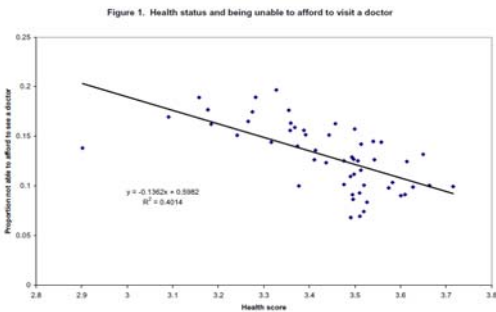
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## Health Status and No Doctor



Source: David Blanchflower, Happiness and Health Care Coverage, Dartmouth Discussion Paper, September 2009

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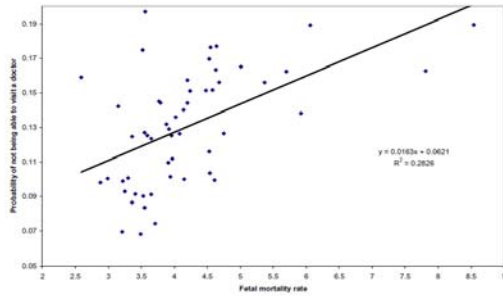
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## Fetal Mortality Rates and No Doctor

Figure 2. Fetal mortality rates and being unable to afford to visit a doctor



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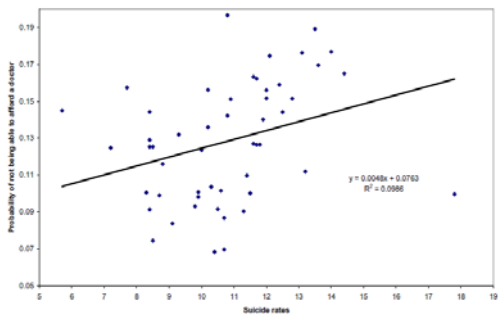
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## Suicide Rates and No Doctor

Figure 3. Intentional self-harm and being unable to afford a doctor



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## Unhappiness, Anxiety and No Doctor

**Lacking the ability to see a doctor because of inability to pay is a major and serious source of anxiety and unhappiness in the United States, even for those with high incomes.**

Source: David Blanchflower, **Happiness and Health Care Coverage**, Dartmouth Discussion Paper, September 2009

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### Private Insurance As Reform Target

Most health insurance is private insurance:  
80 % of 202 million insured -- 177.8 million  
persons -- have private insurance, with the main  
source employer-provided.

10% of those with private insurance, 26.6  
million, purchase through direct purchase.

83 million get insurance through government  
programs—Medicaid 39.6 million, Medicare 41.4  
million.

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### Small Businesses and the Dead Weight of Employment Based Health Insurance

United States has among the world's smallest small-business sectors  
(as a proportion of total national employment).

Claims about lower taxes, less stringent regulations, and freer labor  
markets have not yielded greater small-business employment here  
than elsewhere.

Across 22 rich countries, for every measure – including self-  
employment rates and the share of total employment in  
small enterprises – the United States consistently has the  
lowest or among the lowest proportions of employment in  
small businesses.

WHY?

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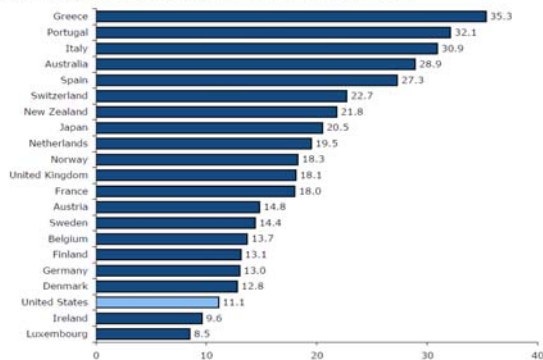
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### Employment-Based Insurance as a Barrier

FIGURE 2  
Manufacturing, Employment in Enterprises with fewer than 20 Employees, 2006



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## Reform in Stages

**Concept 1: Improve System Efficiencies**

Comparative Effectiveness Research → Practice Guidelines  
Patient Health Cards → Patient information on chip  
Computerized patient records → Portability

**Concept 2: Create Insurance Portability**

Urgent care centers covered by private insurance. → easing of pressures on emergency rooms  
Employment based insurance portability – how? Stalking horse for universal coverage in some form using expanded Medicaid or Medicare as model

**Concept 3: Control Cost Increases in System**

Pay for Performance → focus on quality, outcomes  
Bundled Case Management Fees → better patient outcomes  
Reduce fee-for-service medicine

**Concept 4: Solve Small Business Problem**

Mandatory Buy-in  
Or...Medicare For All. True portability.



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## House Bill 3962

**1. Public Option.** Creates a government-run plan to offer insurance coverage to compete with private sector insurance companies.

**2. Health Insurance "exchanges"** -- marketplaces where consumers can easily compare coverage and rates.

**3. Mandatory Coverage.** Requires nearly everyone to obtain health insurance coverage starting in 2013.

**4. Antitrust applies to insurers.** Ends blanket exemption for insurers.

**5. Federal Subsidies.** Federal financial help for lower and middle income consumers so they can obtain coverage.

**6. No Pre-existing Condition Bars.** Insurers may not deny or limit coverage because of pre-existing conditions.

**7. No Lifetime Limits on Coverage.**

**8. Expanded Medicaid coverage.**

**9. 5.4 percent surcharge** on adjusted gross incomes of more than \$500,000 for individuals and \$1 million for joint filers.

**10. Financial Penalties for noncompliance.**

[http://www.kff.org/healthreform/sidebyside.cfm?utm\\_source=kff&utm\\_medium=homepage\\_nn&utm\\_campaign=110309\\_sidebyside\\_houseleadership](http://www.kff.org/healthreform/sidebyside.cfm?utm_source=kff&utm_medium=homepage_nn&utm_campaign=110309_sidebyside_houseleadership)

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## Bill Costs and Benefits

- **Cost: \$1.05 trillion over 10 years.** (Estimate that Clinton's Health Security Act of 1994 would have cost \$950 billion).
- **Benefit: reduction in uninsured by 36 million.**
- **18 million still uninsured in 2019, 1/3 illegal immigrants**
- **Reduces deficit by \$ 104 billion over ten years.**
- **Paid by 5.4% surtax on high-income people — couples with adjusted gross incomes over \$1 million a year and individuals over \$500,000 = \$460 billion/10 years.**

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**2009 Health Disparities**  
**Temple University Health Alumni Association**  
 Philadelphia - November 13, 2009

**Thomas E. Getzen, Ph.D.**  
**Temple University, Dept. of Risk**  
**CEO, International Health Econ Assoc.**

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***Health Care is a Moral Issue***

- Finances are secondary.
- Access to expensive medical care will not eliminate health disparities.
- Costs will, eventually, come under control.

*– The question is, do we want to do that rationally, or to balance the budget on the backs of the poor and low-to-middle income workers.*

- Elimination of Disparities would Eliminate Disproportionate Access at the Top.

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disparities

**TABLE I.4** Annual Mortality Rate Among Middle-Aged Men

Income Category	Mortality Rate	
	White	Black
< \$ 9,999	0.918%	1.234%
\$10,000 – \$14,999	0.840%	1.123%
\$15,000 – \$19,999	0.706%	0.899%
\$20,000 – \$24,999	0.660%	0.867%
\$25,000 – \$29,999	0.591%	0.603%
\$30,000 +	0.542%	****

Source: G. D. Smith et al, American J. Public Health 86: 486-504, 1996.

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## Disparities are present

- In 1903, 1933, 1993, 2003 -- and probably in 2033.
- In China, Canada, Mexico, UK, Sweden, South Africa --and probably every other country.
- Inside Countries, States, MSA's --and sometimes but not always in families and communities.

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*Do you really want to share?  
Who do you care about?*

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### research

- **“Aggregation and the Measurement of Health Care Costs.”**

*HSR: Health Services Research*, October 2006.

- with Heinz Dommert **“On the Money: Making Forecasts What They Should Be.”** *HFM: Healthcare Financial Management Journal*, 2005.
- with Anna R. Schoenthal, **“Bariatric Surgery and the Financial Reimbursement Cycle.”** *Journal of Health Care Finance*, 2005.
- **“Economic and Demographic Trends Affecting Physician Supply and Utilization Signal an Impending Physician Shortage.”**  
with R Cooper, H McKee and P Laud. *Health Affairs* 2002.

- **“Forecasting Health Expenditures: Short, Medium and Long (long) Term.”**

*Journal of Health Care Finance* 2000.

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## Short

- Why any "reform" will look good in 2012.

## Long

- It's the economy, its that simple.

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## Trends

Short-run fluctuations --why the recession and inflation timing will make any "reform" program look good in 2012.

- Inflation
- Recession
- Underwriting Cycle
- Premium/Cost shifting & offsets

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## Inflation

Inflation moves HC\$ 1:1 over the long run.

But, short-run, only 1/3 picked up each year.

*Implication:* A surge in inflation in 2011 will "undercount" the medical cost increase in 2011 - 2012 - 2013.

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## Recession (GDP)

- LR income (GDP) effects dominate.

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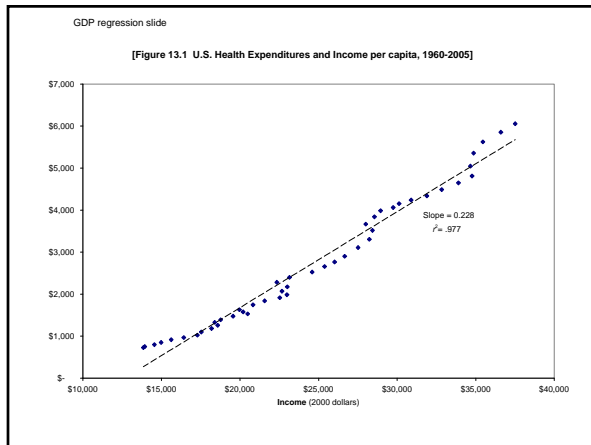
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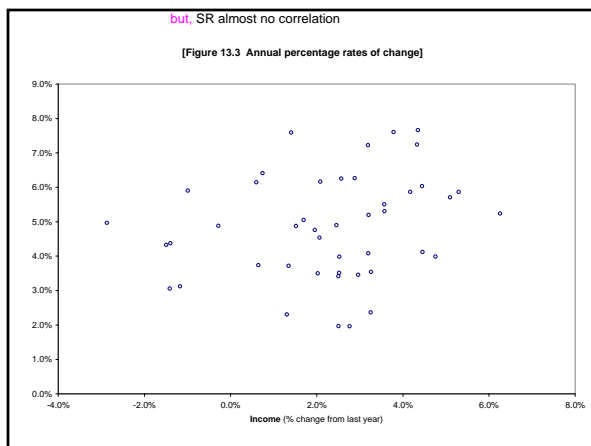
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## What does this “lag” mean?

- Every recession causes a shortfall as funding falls below spending
- This creates a **deficit**.
- There is a partial reversal over five to ten years as the wages & employment recover and then (slowly) start to expand.

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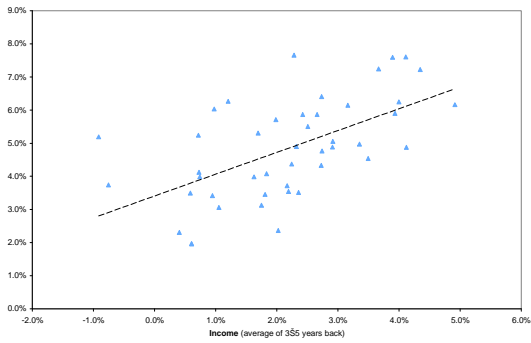
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Correlations slide

[Figure 13.4 Annual percentage rates of change (lagged moving average)]



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## WHY?

Budgets are already set for 2010--what happens now cannot change much.

Multi-year employment contracts.

Generally slow inertial adjustment of Health Care.

*Implication for Reform:* **Recession** has just begun to depress HC spending, will continue to do so through 2010, 2011, 2012, 2013.

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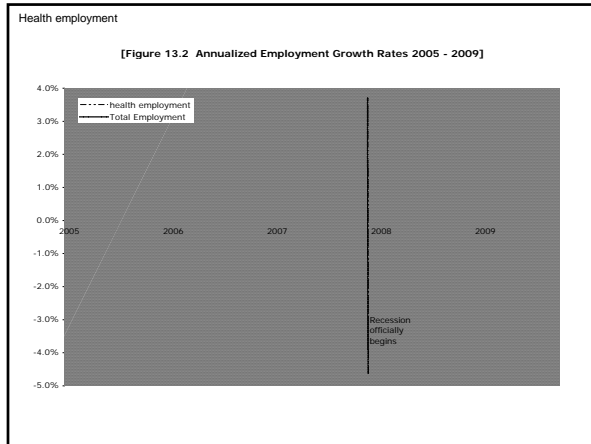
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Long-Run?

- Its all about the money---

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Long Run ---

*There must be a limit, eventually, somewhere,  
we will run out of money to spend.*

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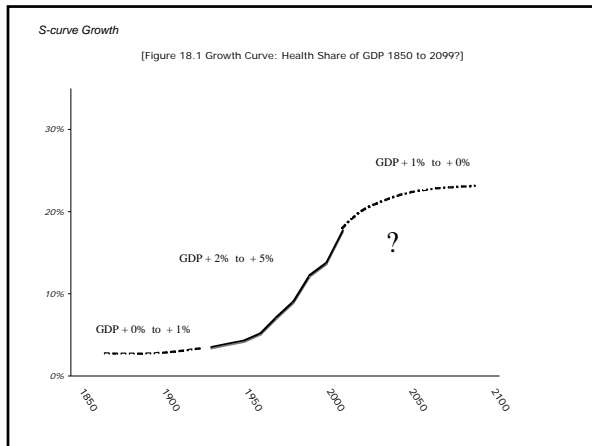
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*What to Pray for?*

- **A process that works.**
- **Politicians that care about all people.**
- **Economic stimulus that is more effective than most cardiac stimulation.**
- **A medical profession that acts responsibly.**
- **People who wake up and want reality, rather than to continue dreaming or live in re-runs of the 1950s.**

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\*\*\* Thank You! \*\*\*

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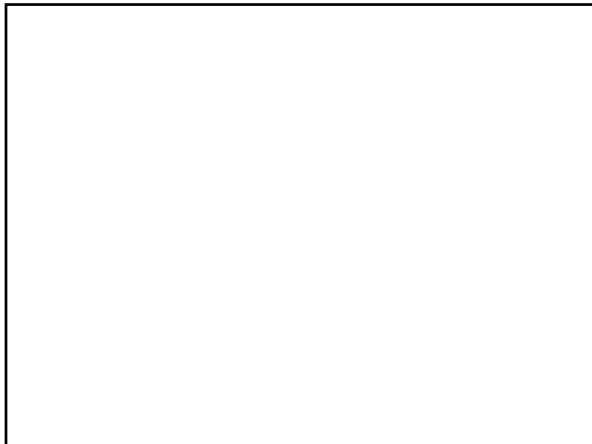
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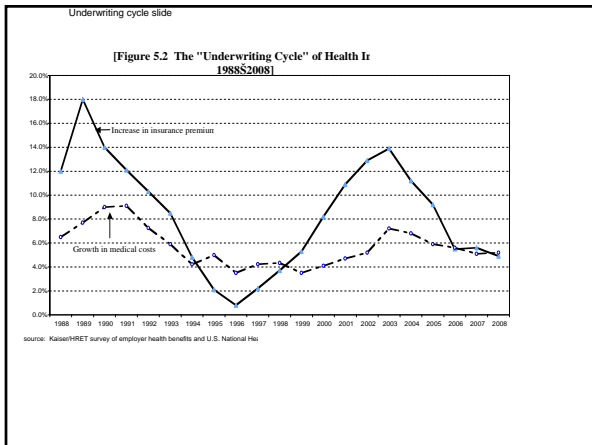
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### Premium-shifting

Continued employer "Premium Cutting" by shifting cost to employee co-pays, contribution%, deductibles, etc.

Pressure from need to balance Medicare, Medicaid cuts.

implication: ???

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