# PAYING FOR POPULATION HEALTH IMPROVEMENT

David Kindig MD, PhD

IOM Population Health Roundtable

Workshop on Resources

February 6, 2014

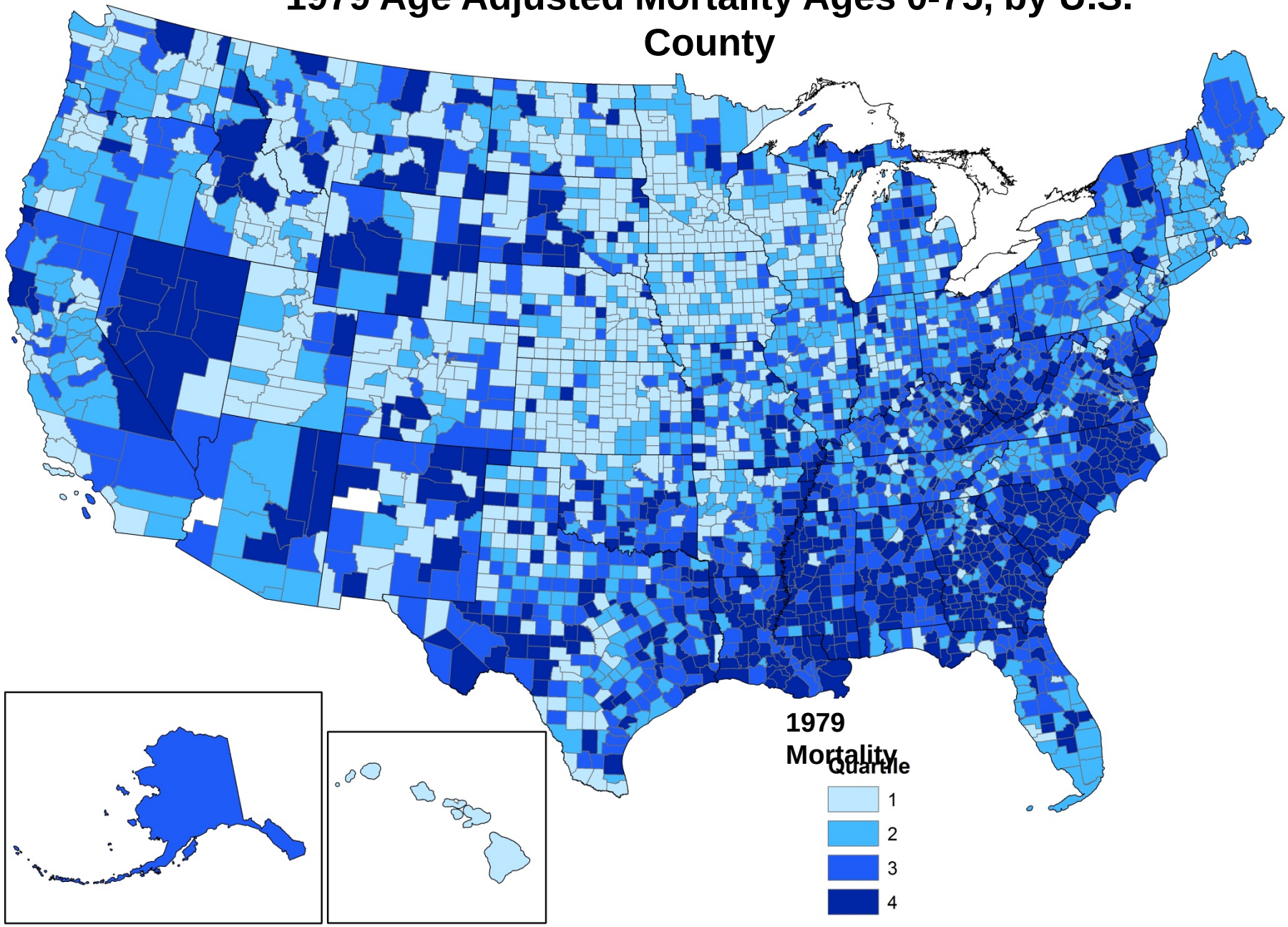
# Paying for population health improvement

1. How much do you need and where would you put the money?

2. Where would you get it from?

3. Can local investment guidance be developed?

# 1979 Age Adjusted Mortality Ages 0-75, by U.S. County



# 2008 Age Adjusted Mortality Ages 0-75, by U.S. County

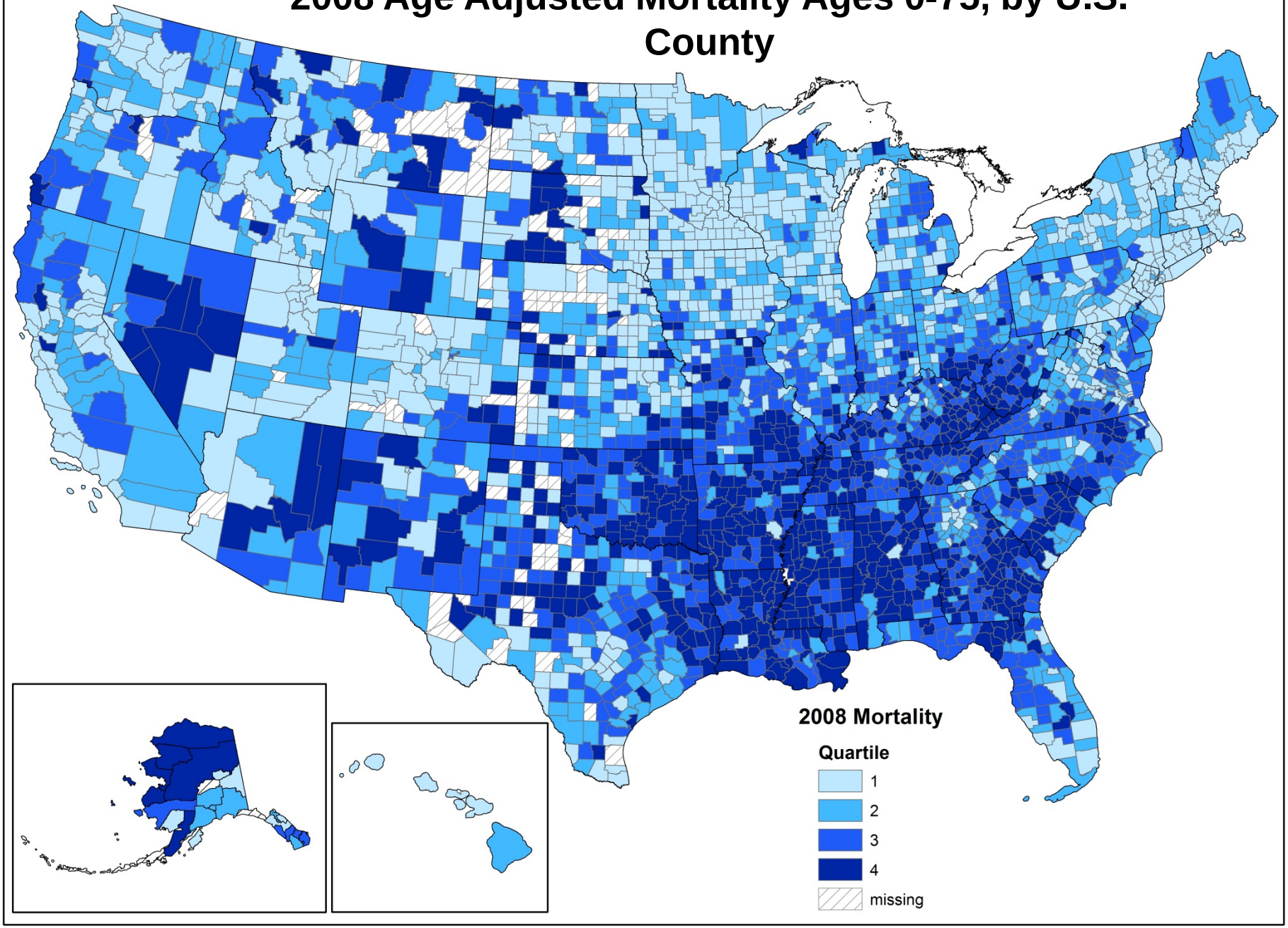
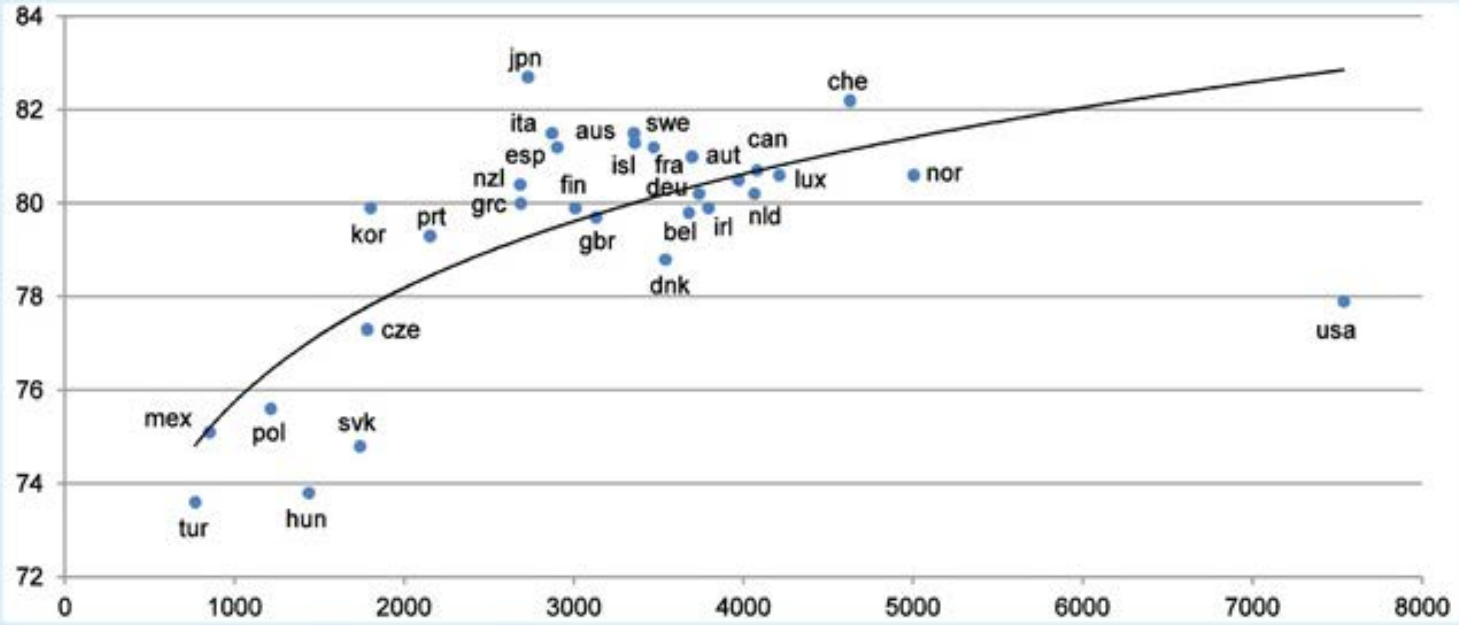


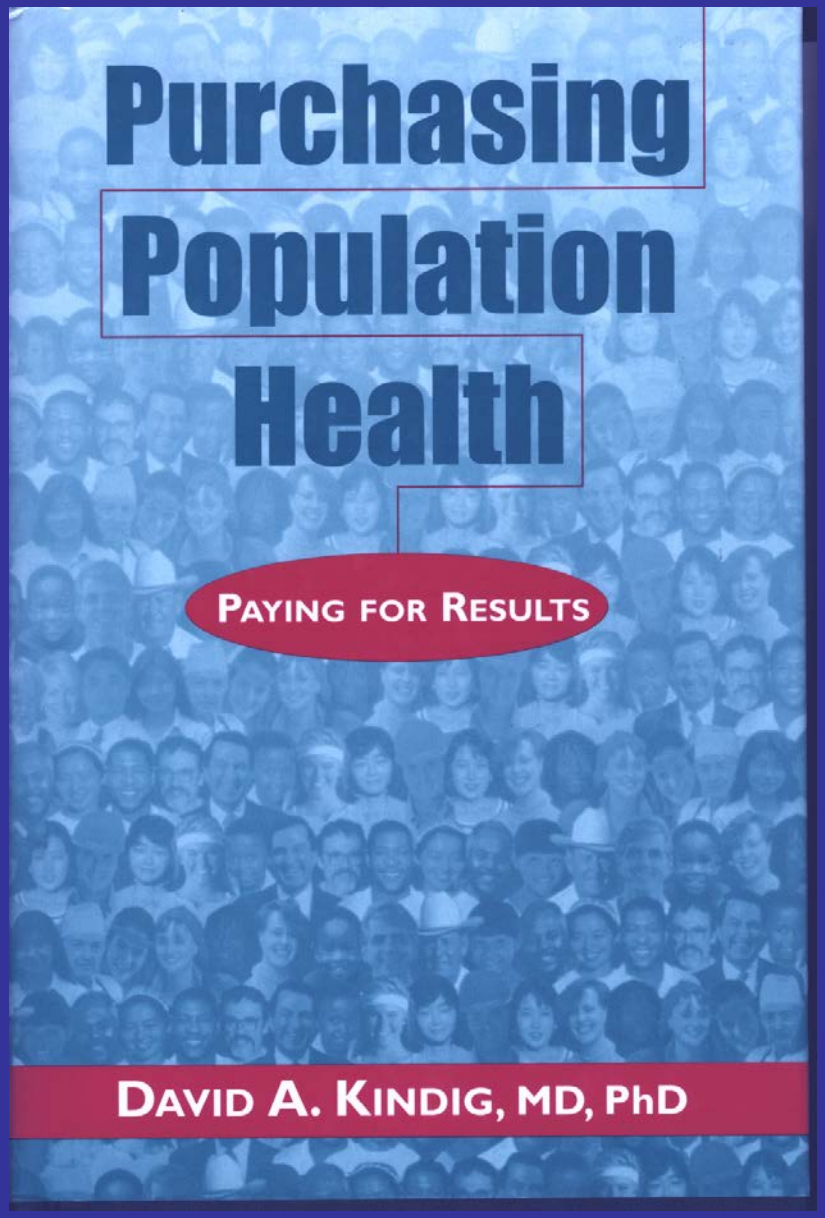
FIGURE: Life Expectancy at Birth (yrs), Health Spending by Country




Total expenditure on health per capita, U.S. $PPP

FIGURE KEY: aus is Australia, aut is Austria, bel is Belgium, can is Canada, che is Switzerland, cze is the Czech Republic, dnk is Denmark, fin is Finland, fra is France, deu is Germany, grc is Greece, hun is Hungary, irl is Ireland, isl is Iceland, ita is Italy, jpn is Japan, kor is Korea, lux is Luxembourg; mex is Mexico, nld is the Netherlands, nzl is New Zealand, nor is Norway, pol is Poland, prt is Portugal, svk is the Slovak Republic, tur is Turkey, esp is Spain, swe is Sweden, gbr is the United Kingdom, and usa is the United States.

SOURCE: Organisation for Economic Co-operation and Development 2010, "Health Care Systems: Getting More Value for Money."


Purchasing
Population
Health
Paying for Results
David A. Kindig, MD, PhD

“The fundamental assertion of this book is that population health improvement will not be achieved until appropriate financial incentives are designed for this outcome.”

Kindig 1997

# Roundtable Drivers

**Goals and metrics**

**Resources**

**Science-informed interventions**

**Policies**

**Communication & movement-building**

**Partnership**

# “Resources” for this Roundtable

Resources refers to many different kinds of essential ingredients needed to support the improvement of population health.

- financial
- human (workforce and training)
- informational (data, technology)
- community assets such as social capital and cultural diversity

# “Resources” for this workshop

This workshop will focus on financial resources, and especially on varied private sector funding sources and mechanisms that can help alter the social and environmental determinants of health.

# Outline of presentation

1. To improve overall health and reduce or eliminate health disparities, significant new and reallocated resources of many kinds will be required.

2. While philanthropy and public pilot funds are critical for testing new sources and ideas, developing and aligning dependable long-term revenue streams is essential.

3. We can start by reallocating savings from ineffective health care expenditures, but will need to expand health in all policy investments as well – especially by finding the sweet spots where core missions of other sectors align with health improvement objectives.

4. New evidence is badly needed regarding relative cost effectiveness of different investments, but we can’t wait decades to act.

5. This Roundtable could add value by leading the call for the development of optimal cross-sectoral financial investment or policy strength benchmarks, that are tailored to individual community outcomes and determinants profiles.

# PART 1: HOW MUCH IS NEEDED, AND FOR WHAT INVESTMENTS?

“How much, then, should go for medical care and how much for other programs affecting health, such as pollution control, flouridation of water, accident prevention and the like.

There is no simple answer, partly because the question has rarely been explicitly asked.”

Victor Fuchs, 1974

# Do they really mean *HEALTH* expenditures?

Our national health accounts report expenditures of $2.7 trillion, but they really only count health care and governmental public health. The total cost of health is (much?) greater if the costs of the nonmedical determinants are included.

Kindig Health Affairs blog 2011

# We *do not know* today what the total HEALTH budget needs to be

It would include:

- adequate resources for public health and less health care spending (do we agree with the IOM that “parity” with OECD health spending is the goal?)
- plus that share of other sector investments that are health promoting (education, housing, economic development)

# What is needed for governmental public health: From the IOM Investing in a Healthier Future 2012

- Trust for Americas Health 2008
  $20 billion shortfall
- IOM 2012 “more conservative” doubling
  from $11.6 billion to $24 billion

# Ratio of social service spending to medical care spending

European OECD 2.0

United States 0.9

Bradley BMJ 2010

# America's Health Dividend

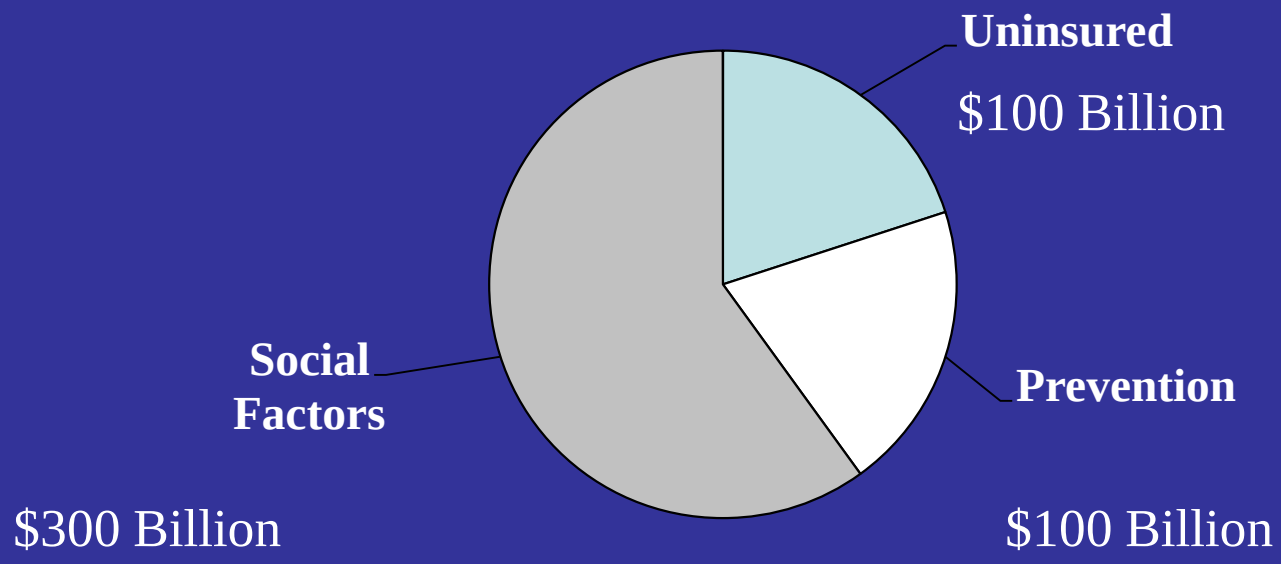
45% of the waste in health care accrues to the public sector = $337B…

To be reallocated to…..

- $168B in debt reduction
- $104B in education programs like universal pre K and smaller class sizes, smoking education, Head Start
- $61B in Infrastructure like Safe Streets, Job Corps, Food Stamps

# If I were czar and had to work with existing resources…

I would take the 20% of health care expenditures that are thought to be ineffective ($500 billion), and reallocate as below:



# Different places need different investments

| | NORTH DAKOTA 9 | UTAH 6 |
|---|---|---|
| • Lack Health Ins | 9 | 28 |
| • Smoking | 34 | 1 |
| • HS Grad | 3 | 26 |
| • Binge Drinking | 49 | 2 |
| • Air Qual | 3 | 25 |

# “Is community-level financial data adequate to assess population health investments?”

Casper and Kindig

Prev Chronic Disease 2012

This Roundtable should take the lead in getting such estimates developed so we know WHAT OUR HEALTH BUDGET NEEDS TO BE.

# Roundtable Drivers

**Goals and metrics**

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# PART 2: WHERE CAN NEW INVESTMENTS COME FROM?

# Sources of dependable financial support

1. From savings from health care: Community Benefit reform and ACO shared savings… or IOM taxes on health care?
2. Health in All Policies -- more health from what we are already spending in other sectors, including community development opportunities
3. Government and foundations
4. Businesses understanding the “business case”

Kindig and Isham 2014 in press

# Community Benefit is not primarily charity care

- 25% for charity care
- 5% for community health improvement

- Almost 60% reported is for Medicaid discounts or other money losing services.
- This is probably a $100 Billion per year IRS requirement that could be redirected in more health promoting ways.

# Sweet spots for business

- attracting and retaining talent
- employee engagement
- human performance
- health care costs
- product safety
- product reliability
- sustainability
- brand reputation

# Dependable revenue streams

We need to move beyond grants and short term appropriations.

We need to move to dependable formula sources like crop subsidies or mortgage interest deductions or Medicare medical education payment.

For those in other sectors, like early childhood support, we need to add our political clout to their efforts for win-win opportunities.

# Ray Baxter on Efficiency

PREVENTING CHRONIC DISEASE
PUBLIC HEALTH RESEARCH, PRACTICE, AND POLICY



Volume 7: No. 5, September 2010

SPECIAL TOPIC

## Making Better Use of the Policies and Funding We Already Have

**Raymond J. Baxter, PhD**

*Suggested citation for this article:* Baxter RJ. Making better use of the policies and funding we already have. Prev Chronic Dis 2010;7(5):A97. http://www.cdc.gov/pcd/issues/2010/sep/10_0055.htm. Accessed [*date*].

PEER REVIEWED

### Abstract

The potential for population health reform could be enhanced by assessing whether we have made the most of policies and resources already available. Opportunities to promote population health independent of major changes in resources or public authority include the following: enforcing laws already in effect; clarifying and updating the application of long-standing policies; leveraging government's and the private sector's purchasing and investment clout; facilitating access to programs by everyone who is eligible for them; evaluating the effectiveness of population health programs, agencies, and policies; and intervening to stop agencies and policies from operating at cross-purposes.

Back to top

TABLE OF CONTENTS

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# PART 3: MOVE BEYOND DETERMINANT BENCHMARKS TO INVESTMENT BENCHMARKS

# What Works for Health
## Policies and Programs to Improve Wisconsin's Health

Home | About this Database | Health Behaviors | Clinical Care | Social & Economic Factors | Physical Environment

Search Policies & Programs

Search

exact match

Display All Policies & Programs

Contribute Content

### An Evidence-based Resource: Policies and Programs to Improve Wisconsin's Health

What Works for Health is a database of policies and programs that can improve health. These policies and programs address key health factors that, in turn, improve health outcomes. This database is based on a wide scan of analyses assessing evidence of effectiveness. We summarize research about what does and does not work to help different stakeholders (such as public health practitioners, community organizations, businesses, schools, and others) identify policies and programs that could improve health.

### Policies and Programs

The research underlying this site is based on a model of population health that emphasizes the many factors that can make communities healthier places to live, learn, work, and play. For each health factor, this database reviews policies and programs, describing expected outcomes, implementation in Wisconsin and elsewhere, resources related to effectiveness and implementation, potential reach and impact on disparities, and other key information. It also provides opportunities to learn from communities that use these policies and programs.

To find a policy or program *click on a health factor* (in the blue boxes below), *search by keyword* (see top of left column), or *search* by one or more of the following: decision maker; evidence rating; potential population reach; or impact on disparities.

BACK TO MAP

Areas to Explore On Off

| | Dane County | Error Margin | Wisconsin | National Benchmark* | Trend | Rank (of 72) |
|---|---|---|---|---|---|---|
| **Health Outcomes** | | | | | | **15** |
| Mortality | | | | | | 5 |
| Premature death | 4,627 | 4,411-4,843 | 5,878 | 5,317 | | |
| Morbidity | | | | | | 29 |
| Poor or fair health | 9% | 7-11% | 12% | 10% | | |
| Poor physical health days | 3.1 | 2.7-3.5 | 3.2 | 2.6 | | |
| Poor mental health days | 2.8 | 2.4-3.2 | 3.0 | 2.3 | | |
| Low birthweight | 6.2% | 6.0-6.4% | 7.0% | 6.0% | | |

# Different places need different investments

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# Improving Population Health

**Policy. Practice. Research.**

Editor: David A. Kindig, MD, PhD

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08/31/2011

## Locally Customized Population Health Policy Packages?

By David A. Kindig, MD, PhD

In my last post I suggested that those who allocate resources must provide ample guidance to ensure that local level health improvement strategies actually align with the best available evidence. I mentioned the University of Wisconsin What Works data base as well as the approach that the previous administration allocated its State Health Improvement Plan (SHIP) resources in the state of Minnesota. But I indicated that What Works is not tailored to individual communities and that the Minnesota example is limited to health behavior interventions, not all population health determinants.

We know from the *County Health Rankings* and our own experiences that communities vary widely in both their health outcomes and the factors or determinants of those outcomes. There are many examples of both high and low ranking counties which vary on their determinant profile…some have high health care quality and access but poor behaviors, others have high social factors like education and income but poor air and water quality. Given limited resources, it is critical that investments be made carefully to have the most impact.

5. This Roundtable could add value by leading the call for the development of optimal cross-sectoral financial investment or policy strength benchmarks, which are tailored to individual community outcomes and determinants profiles.

COMMENTARY

# A Pay-for-Population Health Performance System

David A. Kindig, MD, PhD

# Solid partnerships and real resources

"What is required is a coordinated effort across determinants between the public and private sectors, as well as financial resources and incentives to make it work."

Kindig JAMA 2006

# A Community Health Business Model That Engages Partners in All Sectors is Necessary for Population Health Improvement

Kindig and Isham in press 2014

# THE Population Health Question

In a resource limited world (nation, community) what is the optimal *national and local* per capita investment, and policy "strength", across sectors (health care, public health, health behaviors, social factors like education and income, physical environment) for improving overall health and reducing disparities?

# Roundtable Drivers

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*"My question is: Are we making an impact?"*