The Economic Costs of Health Disparities

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Eva Noles Recognition Ceremony
Roswell Park Cancer Center
Buffalo, New York
U.S. Health Costs are Escalating

In 2009, the U.S. health spending increased by 5.7% from the previous year reaching 2.5 trillion dollars – this is the largest one-year increase of the health expenditures in the GDP since the 1960s (Truffer et al., 2009)
U.S. GDP - 2009

- Education: 16%
- Pensions: 15%
- Health: 17%
- Defense: 14%
- Welfare: 12%
- Other: 26%
Health Expenditures as a Share of GDP, OECD* Countries, 2008

* Organization for Economic Co-Operation and Development (OECD)
U.S. Health Expenditures Compared to Other OECD Nations

- U.S. governmental share of health expenditures is the smallest among OECD countries - 46.5%, compared to the average of 72.8%
- The amount of U.S. health spending is the highest – among western countries
- In 2009 U.S. Health spending accounted for more than 17% of our Gross Domestic Product (GDP) – highest of all OECD countries (average of 9%)
- U.S. health spending \textit{per capita} ($7,538) is the highest and is double the OECD average

Source: Organization for Economic Co-Operation and Development (OECD)
U.S. Health Status and Risk Factors Compared to Other OECD Nations

• Between 1960 and 2007, life expectancy in the U.S. increased by 8 years compared to the average increase of 11 years in other OECD countries.

• In 2007, average life expectancy in the U.S. was 77.9 years - 1 ½ years less than the average of other OECD countries.

• In 2006, infant mortality in the U.S. was 6.7 per 1,000 live births – higher than the OECD average of 4.7.

• In 2008, the U.S. had the highest obesity rate among OECD countries - 33.8%.
U.S. Health Resources Compared to Other OECD Nations

• U.S. has fewer physicians per capita – 2.4 practicing physicians per 1,000 population: below the OECD average of 3.2

• In 2007 the ratio of hospital beds in the U.S. was 2.7 per 1,000 population - lower than OCED average of 3.6 per 1,000.

• In 2008 there were 10.7 nurses in the U.S. per 1,000 population, just slightly above OECD average
Factors Affecting The Nation’s Health Workforce

• Baby Boomers are slated to begin retiring in 2011
• The number of Americans over 65 is expected to soar from 37 million in 2006 to 88 million by 2050, (DHHS, Administration on Aging, 2008)
• Rapid developments in medical technology
• Higher utilization of services
• The Patient Protection and Affordability Act – 32 million more Americans with health insurance
Number of People Age 65 and Over
U.S., 1900-2050

Source: U.S. Census Bureau, Decennial Census, Population Estimates and Projections
The Patient Protection and Affordable Care Act

Commits $940 billion over 10 years to expand coverage to nearly 32 million uninsured Americans including:

1. Mandatory acquisition of health insurance by 2014
2. Creation of a new insurance marketplace, resulting in expanding access to coverage and formation of state-based exchanges
3. Sweeping insurance market reforms:
   – New regulations imposed on health plans, preventing insurers from denying coverage for any reason
4. Fundamental changes to Medicare, expansion of the Medicaid program, and reform of Part D
5. Health IT, prevention and wellness initiatives across the health care system
Who Will Provide Care? Projected Critical Shortage of Health Professionals

By 2025 the U.S. will need additional

160,000

250,000

1,000,000
Trends in Life Expectancy at Birth by Race for Males 1900 to 2003

Source: Congressional Research Center, 2006
Trends in Life Expectancy at Birth, by Race for Females 1900 to 2003

Source: Congressional Research Center, 2006
National Attention to Health Disparities
Health Disparities

• Higher morbidity and mortality for minorities has been recognized for decades
• Healthy People 2000 was the first national initiative to target the reduction and eventual elimination of health disparities with its three overarching goals:
  (1) Increase the span of healthy life
  (2) Reduce health disparities, and
  (3) Improve access to preventive services
A study commissioned by The Joint Center for Political and Economic Studies, 2008

Conducted by Thomas LaVeist And Colleagues from the Johns Hopkins University and the University of Maryland
Study’s Methods

The cost of health disparities were estimated using three measures:
1. Direct medical costs of health inequities
2. Indirect costs of health inequities
3. Costs of premature death
Findings

• Between 2003 and 2006 the combined costs of health inequities and premature deaths in the U.S. were $1.24 trillion

• Eliminating health disparities for minorities would have reduced direct medical care expenditures by $229.4 billion for the years 2003-2006

• Between 2003-2006, 30.6% of direct medical care expenditures for African Americans, and Hispanics were access costs due to health inequities

• Eliminating health inequities for minorities would have reduced indirect costs associated with illness and premature death by more than one trillion dollars between 2003-2006
Costs of Health Inequities Impact...

- Individuals
- Families
- Communities
- Healthcare Organizations
- Employers
- Health Plans
- Government and State Agencies
Individual

Missed Workdays

Job Loss/Demotion

Lower Household Income

Employer

Loss of Health Insurance

Government

Loss of Tax Revenues

Higher Proportions of Welfare Recipients

Higher Percentage of Uninsured

Healthcare Organizations

Loss of Productivity

Higher Insurance Cost

More Costly Care

More Uncompensated Care
Most Minorities are Vastly Underrepresented in the U.S. Health Professions

<table>
<thead>
<tr>
<th>Minorities in the General Population</th>
<th>Minorities in the Health Professions</th>
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<tbody>
<tr>
<td>Native Americans</td>
<td>Pharmacy 10%</td>
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<tr>
<td>Native Hawaiians</td>
<td>Medicine 9%</td>
</tr>
<tr>
<td>Blacks</td>
<td>Nursing 9%</td>
</tr>
<tr>
<td>Hispanics</td>
<td>Dentistry 7%</td>
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Source: U.S. Bureau of Census, 2009
HRSA, 2008
AMA, 2006
ADEA, 2009
AJPE, 2008
The Case for Workforce Diversity

- Increased access to care
- Increased quality of care
- Provide a more linguistically and culturally competent workforce
- Increased research creativity and problem-solving
- Provide “home grown” options for workforce shortages
- Decreased rate of medical errors and malpractice costs
Contact Information
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