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Assessing Need and Demand for Health Care

Gerard F. Anderson, PhD
Johns Hopkins University

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Section A

Rational, Incremental, and Garbage Can Models

Three Perspectives on the Policy Process

- Rational
  - Eightfold Path
  - Multiple variants on Eightfold Path
    - Some describe particular policy processes better than others
- Incremental
- Garbage can

Incrementalism

- Not a fundamental re-analysis of policy options
- Small, marginal adjustments to policy

Examples of Incrementalism

- Budgetary process

Rationale for Incrementalism

- Easier to do than rational approach
- Rational process is time consuming

Incrementalism Does Not Explain New Initiatives

- Some new ideas expand rapidly
  - Public health preparedness

Garbage Can Model of Policy Process

- Problematic preferences
- Unclear technology
- Fluid participation

Problematic Preferences

- People seldom have well-reasoned preferences
- Organizations, especially nonprofit organizations, seldom have a single set of objectives
- Politicians rarely state their policy objectives clearly

Unclear Technology

- No one controls all aspects of the political process or even knows all the important participants
- No one controls all aspects of a large organization or knows all the participants
- Cannot predict outcomes with certainty

Fluid Participation

- Decision makers enter and exit the policy process
- Junior staffers are often frustrated with decision makers' lack of knowledge about the issue

Garbage Can

- Problems, solutions, participants are fluid
- Opportunities to effect changes occur at unexpected moments
- Result depends on who is in the room and their priorities at that particular time

Limited Agenda

- Only a few items can be on the policy agenda at one time
- Key is to get your issue on the policy agenda

Processes That Influence the Garbage Can

- Problem recognition—what gets put on the agenda
- Policy proposals—available options; evaluation of alternatives
- Political process—who is elected

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Section B

Need and Demand

Six Terms Often Used by Public Health Advocates to Promote Change

1. Need
2. Access
3. Utilization
4. Equality
5. Equity
6. Disparities

Six Terms Often Used by Public Health Advocates to Promote Change

- Different people/different disciplines use these terms very differently
- Critical for identifying the problem

When Advocates Argue "We Need . . ."

- What do they mean by need and how can need be measured?
- How would you argue that one group is more "needy" than some other group or that fundamental change is "needed"?

Health Needs

- Health needs are often measured using the following:
  - Self-report
  - Health status indicators
  - Biomedical measures of health status
  - Geographic variations

Self-Reported Need

- Is your health status . . .
  - Excellent
  - Good
  - Fair
  - Poor
- One group might have a higher percentage of people with poor health status

Common Health Status Indicators

Physical Health	**Mental Health**	**Social Health**
Symptoms	Symptoms	Symptoms
Mortality	Psychological state	Social wellbeing
Morbidity	Perceptions	
Disability		
One group may have more symptoms than another group		

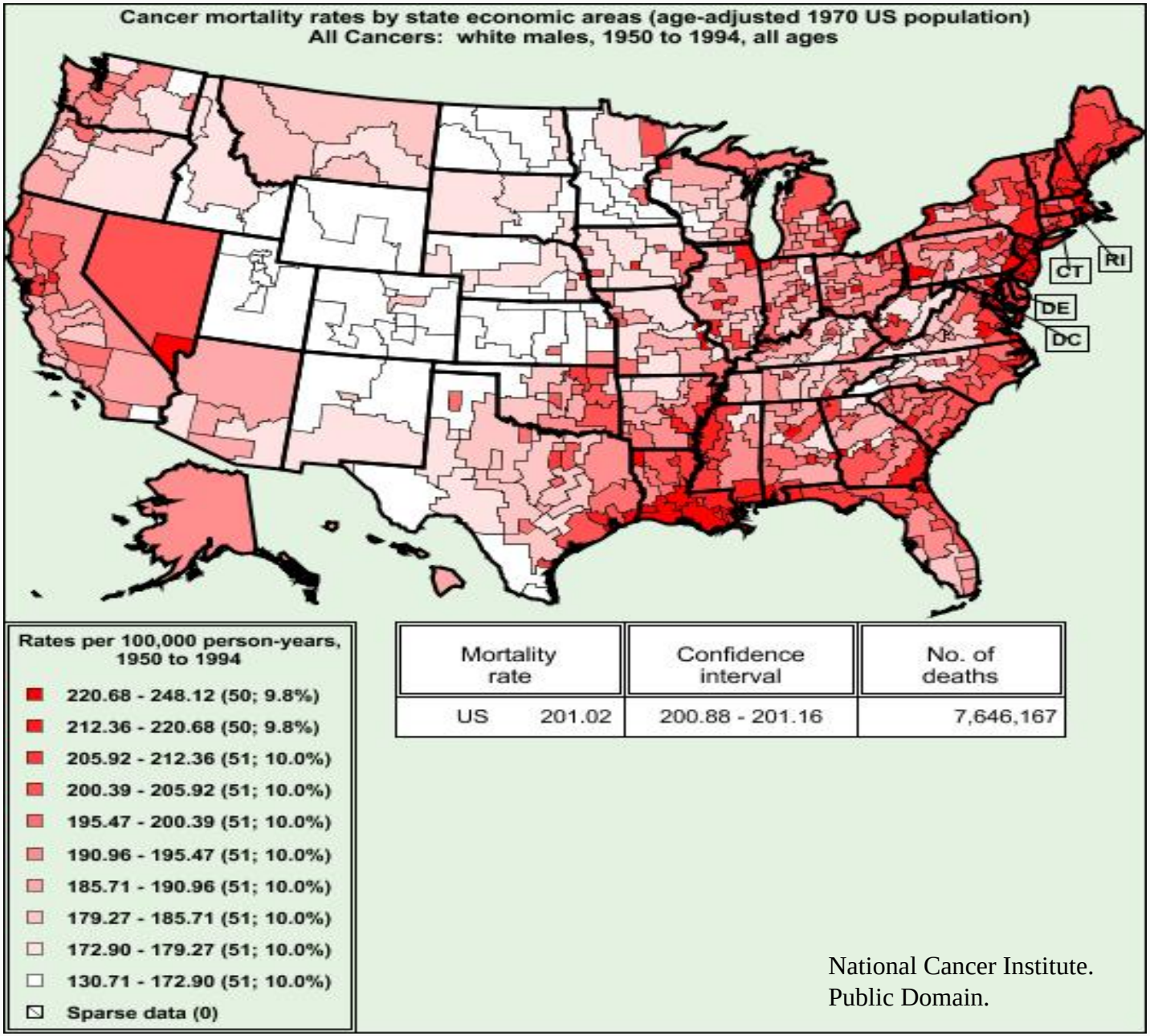
Biomedical Measures

- Body mass index
- Blood pressure
- Cholesterol
  - One group may be more obese than another group

Geographic Measures

- Some geographic regions might have risks associated with specific health problems
- One state may have higher infant mortality rates than another

Nevada and Utah



National Cancer Institute.
Public Domain.

Discussion

- Would you use “need” in your statement of the problem?
- If so, which of these measures of need is most compelling?

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Section C

Access to Care

Access

- The level of service which the health care system actually offers to an individual
- Example—number of physicians per capita

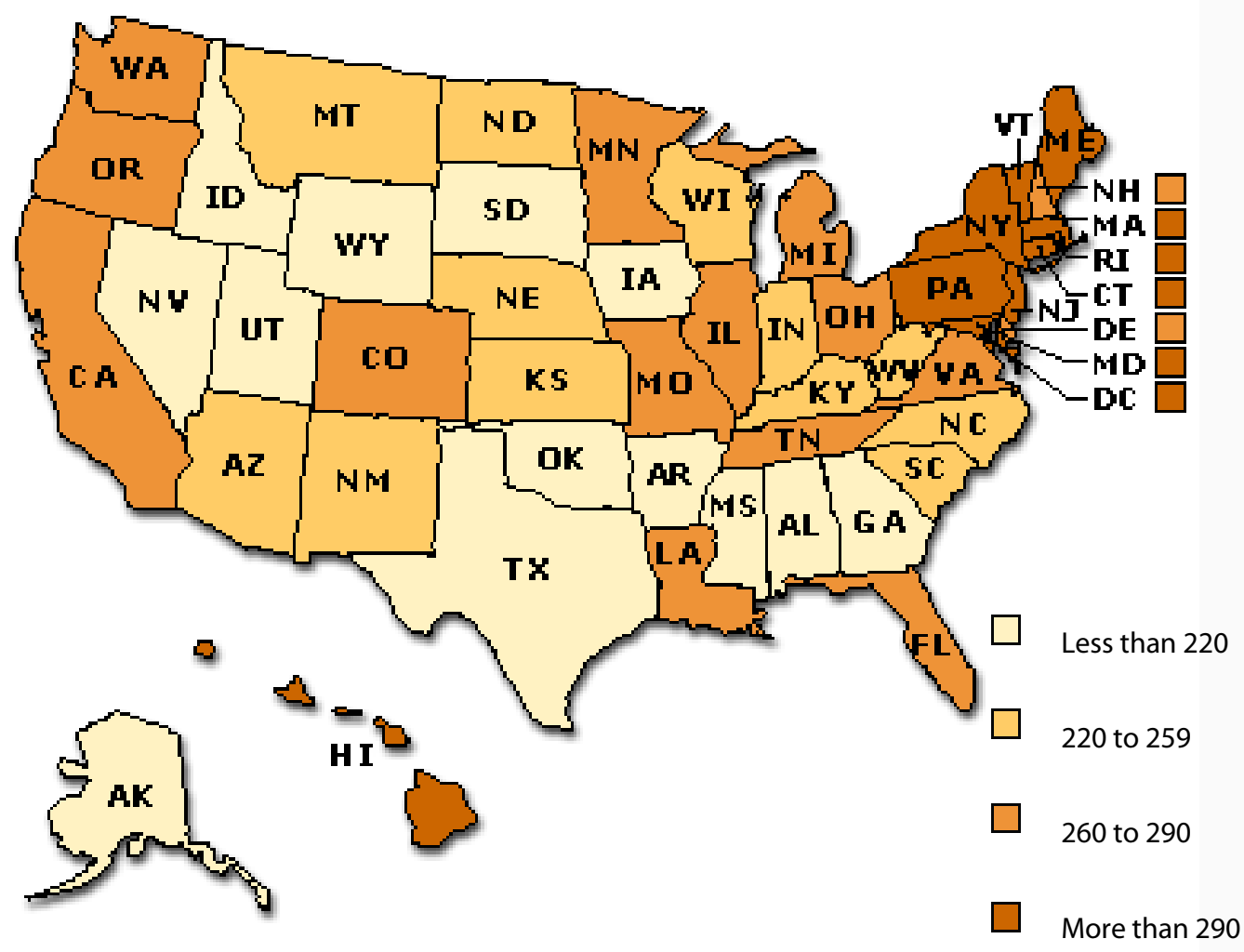
What Influences Access?

- Availability of services
- Quality of services
- Cost of services
- Information about services

Availability of Services

- The number of service providers . . .
  - By region
  - By state
  - Within states
  - By country
  - Within country
  - On an Indian reservation

Geographic Distribution of Non-Federal Physicians, 2003



Source: American Medical Association, 2004

Appropriate Level of Access

- Does Massachusetts have too much or does Idaho have too little access to physician services?
  - How would you know?
  - Is the median correct?

Quality of Services

- Quality may differ despite patients having identical needs
- What is an acceptable level of quality to say that you have access to care
- How do you measure quality?
  - Clinical
  - Perceived

Comparison of Nursing Home Quality in Baltimore

About the Nursing Home	Quality Measures	Total Number of Health Deficiencies	Nursing Staff Hours per Resident per Day	CNA Hours per Resident per Day
CHARLESTOWN CARE CENTER 709 MAIDEN CHOICE LANE CATONSVILLE, MD 21228 (410) 247-9700 **Mapping / Directions**	Information for 15 of the 15 quality measures is available	4 Deficiencies	1 hour 1 minute	2 hours 47 minutes
			Total Number of Residents: 218	
GLEN MEADOWS RETIREMENT COM. 11630 GLEN ARM ROAD GLEN ARM, MD 21057 (410) 592-5310 **Mapping / Directions**	Information for 0 of the 15 quality measures is available	0 Deficiencies	1 hour 44 minutes	2 hours 8 minutes
			Total Number of Residents: 28	
LOCH RAVEN CENTER 8720 EMERGE ROAD BALTIMORE, MD 21234 (410) 668-1961 **Mapping / Directions**	Information for 14 of the 15 quality measures is available	7 Deficiencies	1 hour 16 minutes	2 hours 11 minutes
			Total Number of Residents: 105	
RIDGEWAY MANOR NURSING 5743 EDMONDSON AVENUE CATONSVILLE, MD 21228 (410) 747 5250 **Mapping / Directions**	Information for 14 of the 15 quality measures is available	2 Deficiencies	1 hour 5 minutes	2 hours 15 minutes
			Total Number of Residents: 59	

Source: www.medicare.gov

Cost

- People may be unable to afford all the care that is available in the community
- Cost may prevent them from seeking care

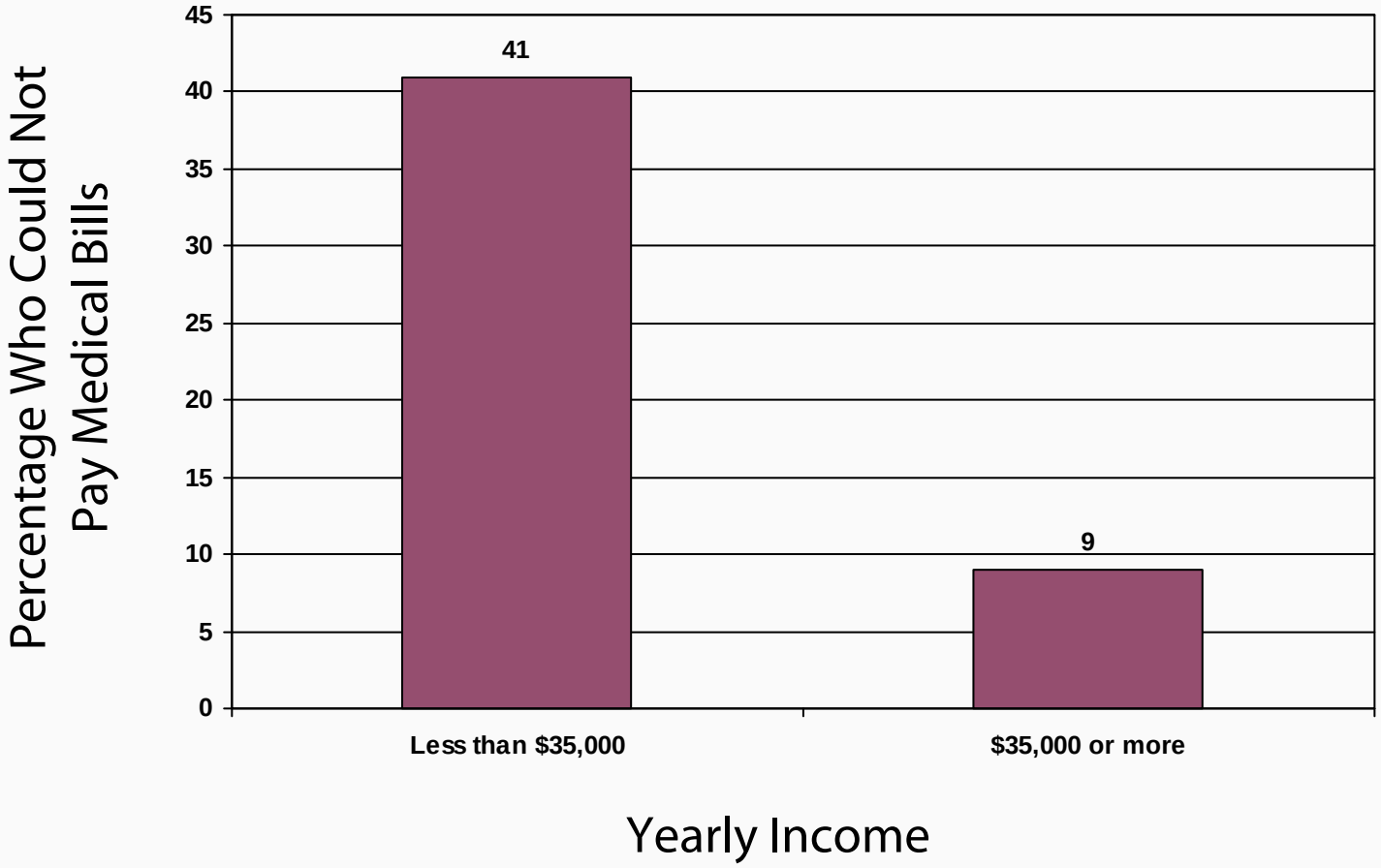
Alternative Cost Measures

- Total direct medical expenditures
- Out-of-pocket direct medical expenditures
- Out-of-pocket direct medical expenditures as a percent of income
- Indirect costs
  - Transportation
  - Time from work

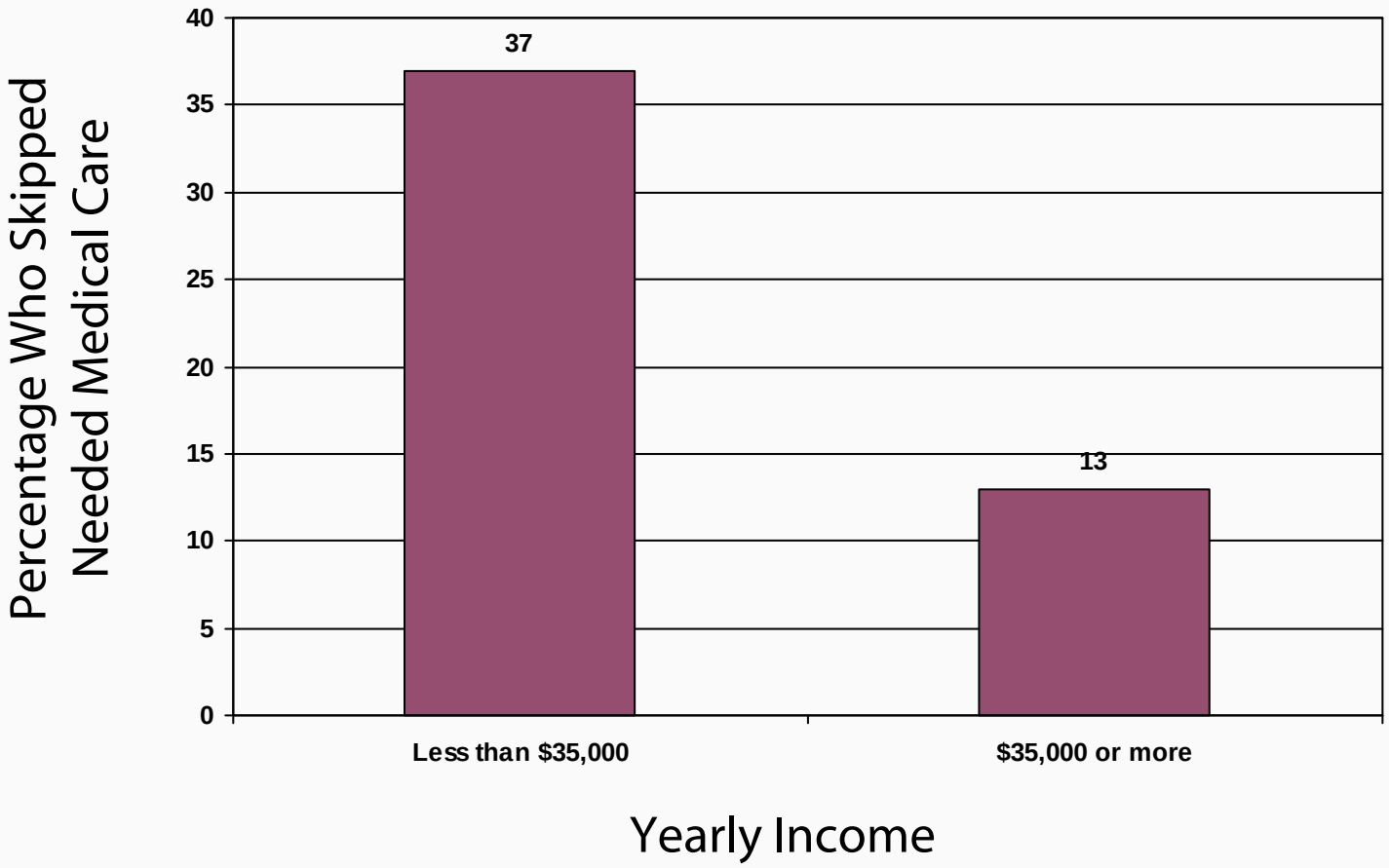
Cost

- Choosing the correct cost measure is critical
- Cost from whose perspective?

Percentage of Adults Who Could Not Pay Medical Bills in the Past Year, by Income



Percentage of Adults Who Skipped Needed Medical Care in the Past Year, by Income



Information

- Awareness of the availability of a service
- Clarity of the benefit of health services
  - Medical necessity criterion

Questions

- How do you know if the benefit is a covered service?
- How do you know if you are entitled?
- Whose responsibility is it to tell you that you are entitled to care?

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Section D

Other Measures of Need

Utilization = Observable Access

- Examples
  - How many doctor/clinic visits do you get?
  - How many people were immunized?
  - Percentage immunized
  - Percentage living in dwellings without lead paint
  - Percentage with MD visit
  - Number of physician visits per capita

Equality

- Similar inputs to all people
- Everyone has the same number of MD visits
  - But do they have the same “need”?

Equity

- The absence of systematic and potentially remediable **differences** in one or more aspects of health across population groups is defined socially, economically, demographically, or geographically
- But how do we determine who should get more?

Equity

- Should we provide additional inputs to disadvantaged groups?
- Who are disadvantaged groups?
  - Native Americans
  - Poor
  - Men

Equality vs. Equity

- Which should be the policy objective?

Disparities

- Racial or ethnic differences in the quality of health care that are not due to access related factors or clinical needs, preferences, or appropriateness of intervention
- Opposite of equity

Using the Various Terms

- Almost half of all Americas have at least one chronic condition
- 25% of Americans have multiple chronic conditions
- For this population, how would you measure the following?
  - Need
  - Access
  - Utilization
  - Equality
  - Equity
  - Disparities

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Section E

Application: The Uninsured

Application of the Eightfold Path

- Cover the uninsured

1. Define the Problem

- Forty-five million uninsured
- Uninsured → poor health → higher spending
- **Uninsured have poorer health and shortened lives**

2. Assemble Some Evidence

- What information will convince the public, providers, and policymakers that universal health insurance coverage is necessary?
  - Percent of adults with no doctor visits in the past year, by insurance status
  - Site of usual source of care for adults, by insurance status
  - Use of services, by insurance status
  - Differences in use of preventive services, by insurance status
  - Stage of cancer at time of diagnosis, by insurance status
  - Risk of mortality, by insurance status

3. Construct the Alternatives

- Major public program expansion and new tax credit
- Employer mandate, premium subsidy, and individual mandate
- Individual mandate and tax credit
- Single payer

4. Select the Criterion

- Universal
- Continuous
- Affordable to individuals
- Affordable to society
- Enhance health

5. Project the Outcomes

	Status quo	Public program expansion	Employer mandate	Individual mandate	Single payer
Universality	0	+	+	+	+ +
Continuity	0	+	+	+	+ +
Affordability to individuals	0	+	–	– –	+ +
Affordability to society	0	–	–	0	– –
Enhances health	0	+	+	+	+ +

5. Project the Outcomes

	Status quo	Public program expansion	Employer mandate	Individual mandate	Single payer
Universality	0	+	+	+	+ +
Continuity	0	+	+	+	+ +
Affordability to individuals	0	+	–	– –	+ +
Affordability to society	0	–	–	0	– –
Enhances health	0	+	+	+	+ +

Bush Plan

- Workers who establish health savings accounts (HSAs) would be allowed to deduct premium payments
- Refundable tax credits up to $1,000 for individuals and $3,000 for families to buy health insurance
- Association health plans will allow small businesses to jointly negotiate with health care providers, allowing them to offer health insurance to their employees more affordably
- Expanded community health centers to offer medical care to uninsured and underinsured Americans

Kerry Plan

- Tax credits
  - 25% tax credit for workers 55–64 below 300% of poverty
  - 75% tax credit for people out of work and below 300% of poverty
  - Up to 50% tax credit for small businesses that cover low- and moderate-income workers
- Federal government pays for children enrolled in Medicaid, and requires states to expand eligibility for children to 300% of poverty, for families to 200% of poverty, and for adults to 100% of poverty
- Drug reimportation, expanding disease management efforts, subsidizing malpractice insurance
- Federal reinsurance

6. Contrast the Trade-offs

	Bush plan	Kerry plan
Universality	0	+ +
Continuity	+	+
Affordability to individuals	–	–
Affordability to society	–	– –
Enhance health	+	+ +


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BUSH
CHENEY

8. Tell Your Story

Notes Available