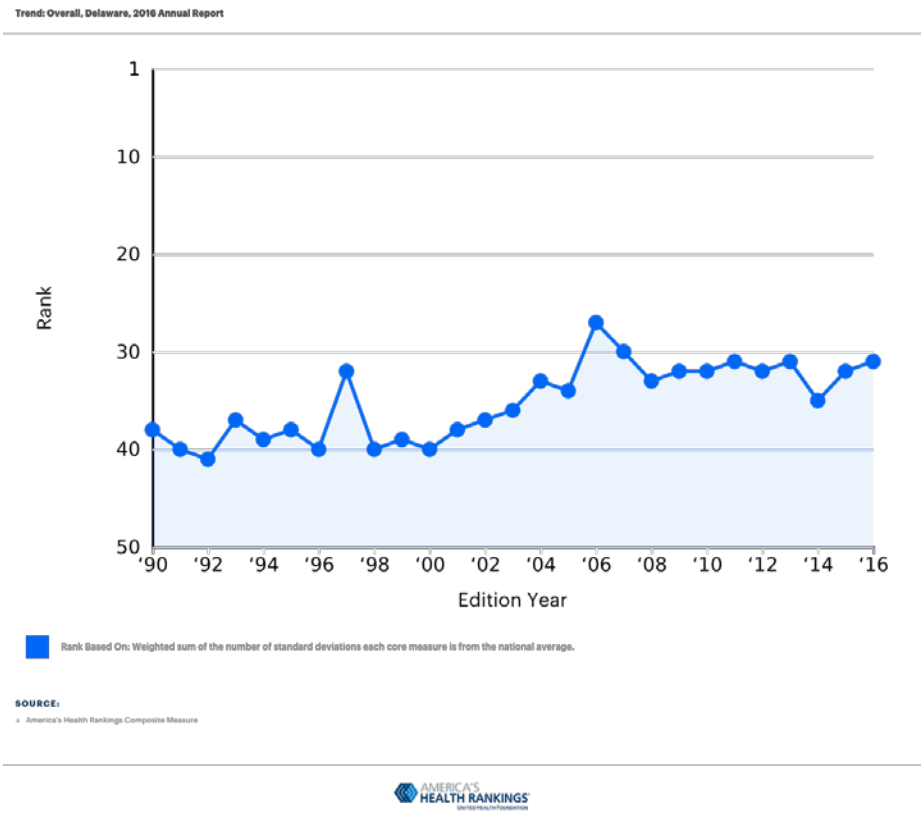
Commentary on the
Report to the Delaware General Assembly on Establishing a Health Care Benchmark
Timothy E. Gibbs, MPH

Introduction

The Report to the General Assembly on Establishing a Healthcare Benchmark contains a positive response to a situation that seems untamable. However, as with the Affordable Care Act (ACA), there are underlying factors and indicators that need further consideration and development. Additionally, the short turn-around time for public discourse and comment on this important matter is concerning: an answer to an issue this significant deserved a longer public comment period. As it currently stands, this document does not represent the best solution to increase the overall health of Delaware, nor improve the First State's financial position.

Delaware's Overall Health

The American Public Health Association (APHA) has collaborated with United Health Foundation and the Partnership for Prevention to produce the America's Health Ranking report: a state-by-state analysis of health and the factors affecting it. The report gives Delaware's overall health ranking for the last 10 years, but it is more instructive to view the trends from the report's inception in 1990.



In spite of the HIV/AIDS epidemic, a growing aging population, a dramatic increase in metabolic syndrome (cardiovascular disease, diabetes, and obesity), and the opioid epidemic, Delaware's health has trended upward: it has gone up in rank from a historic low of 41st in 1992 to 31st in 2016.

The overall health in every state is better than it was in 1990: the discovery of HIV combination therapy, the advancement of telemedicine, robotic surgical techniques, the introduction of the human papilloma virus (HPV) vaccine and other important medical breakthroughs have all occurred in the last two decades. However, these advances come at a cost in research and treatment expenses – and in advances in overall longevity that may open other doors for later, expensive healthcare expenses.

This Report to the Delaware General Assembly on Establishing a Health Care Benchmark seem to herald a shift responsibility and control from stakeholders to the State after considerable work was done by the Delaware Center for Health Innovation (DCHI) and other interested parties to self-regulate costs and improve quality and value metrics. DCHI spearheaded this work since 2014 (a scant three years ago) and was making excellent progress in its stated goals. Moving forward with renewed urgency and alacrity *in conjunction with* benchmarking would have yielded better results. Now, there is a sense that the clock has been reset, and there is new external entity: one that does not benefit from the insider perspective of Delaware stakeholders.

One of the ways Delaware healthcare institution have responded to increased healthcare costs over the years is by the founding of Accountable Care Organizations (ACOs). The use of ACOs is a voluntary initiative and Delaware healthcare institutions statewide are using them to independently control costs, increase value and quality of care, and support a stressed health workforce.

Limitations of the Benchmark

1) A benchmark is a standard or point of reference against which things may be compared or assessed. With this understanding, we must further define "healthcare costs." The term can have wide and varied meanings, and consideration needs to be given to understanding our healthcare costs based on the real income of the persons receiving care. For example: should the consumption and cost of care by a wealthy retiree in Lewes or Centreville be considered on par with a single parent family living in Southbridge? Similarly, does the lifetime of care an individual with development disability may receive be validly compared to that received by a healthy person on a cost basis?

2) Additionally, we must ask ourselves what exactly is being benchmarked? Is the healthcare benchmark tracking the total cost of care (TCOC)? Is it looking at the value of care, or the quality of care? Is the benchmark determining a point of reference for consumer driven consumption of care, or the real cost of care and its delivery? Is the reference value the real cost of care, delivery, and a profit margin?

3) Furthermore, using a single benchmark, or even a blended composite, obscures both successes and areas for improvement. In order to get a true picture of healthcare spending, the benchmark would need to be segmented by populations served and/or nature of the underlying condition. One way to break this down could be to include the following subcategories:

- Early childhood care
- Children in poverty
- Developmental disabilities care

- Transitional care
- Chronic disease care
- Long term care
- End of life care

Or by illness/condition:

- Metabolic Syndrome (cardiovascular disease, diabetes, obesity)
- Cancer
- Vaccine Preventable Infectious Disease
- Other infectious diseases
- Substance use/drug related (e.g. drugs, alcohol, and smoking)
- Preventable hospital re-admissions
- Disability
- Terminal diagnosis

4) The benchmark report mentions "public health funding dollars per person." The increase or decrease of public health funds within a given year does not imply the failure or success of a public health intervention within that same time interval. The suspicion that tobacco use adversely affected health was first publicized in the 1950s, but support of an anti-tobacco public health campaign came slowly. Public health interventions can take a generation to manifest change, be it positive or negative.

Delaware's ability to access public health funding has made many innovated programs possible. The very act of generating and acquiring these funds increases public health dollars: what appears as a detractor is arguably a positive data point.

5) Chart 4 illustrates AHR's Delaware State Ranking on Select Measures. In order to render a more easily understood picture Delaware's healthcare costs, the public health funding data point should be removed, and the chart itself should be broken into at least three charts with clusters of similar data: health conditions, workforce data, and population characteristics.

6) To be sure, there are aspects of the Benchmarking Report that are laudable including the examples and sessions learned from other states section which provides some perspective on how other states are taking steps toward similar goals. It has generated a new conversation about healthcare costs between the public, Delaware stakeholders, and the state throughout its inception and presentation. Hopefully, the report will incorporate the comments and concerns of the public and various institutions within Delaware to solidify this new framework.

Conclusion and Recommendation

It is clear that the State of Delaware is invested in the care of its citizens. Maintaining a focus on science based public health measures is a key long-term strategy, as is embracing the knowledge that healthcare is an economic driver. To that end, Delaware's hospitals are investing in their communities through the use of ACOs, and are allies in Delaware's fight for quality healthcare at decreased costs.

Prevention and coordination of care are key areas for resource allocation, and a thoughtful review of the drivers of defensive medicine is essential. The social determinants of health, institutional racism, and

the unequal distribution of resources must be considered and addressed as a part of the larger solution our Population's health.

Delaware has prided itself on being a tax-free state. Our pride in that distinction may also be our downfall. It may come to pass that adding a tax is the simplest and best way to ensure the health of Delaware and her people. It may be that taxation is inappropriate at this time.

Intelligent, resilient organizations and jurisdictions understand when to surge forward, and know when to pause or go in a different direction. Minimally, the benchmarking process needs to pause. A house built cheaply will not weather a storm: it will need to be built again at additional cost. We deserve the time to get this right.