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"Ranking Health Care in the States: What Matters?"

By John R. Graham

- In the past two years, a number of organizations have ranked states according to various health measurements.
- PRI's *Index of Health Ownership* is unique in that it counts government intrusion as a drawback to good health care, whereas other measurements always count it as a benefit.
- Claims that "access" to health care – often caused by greater government intrusion – leads to higher quality health care rest on shaky ground.
- Much more research is needed to understand the appropriate role of state governments in controlling citizens' use of health services.

State-Based Health Reforms Demand State-Based Performance Measurements

These days more action on health reform appears to be happening in the states than at the federal level, and we heartily approve for at least two reasons. First, because none of us knows exactly what the "right" answer is for health reform, it makes sense to allow each state to experiment with policies it thinks will work. Reforms that work will jump across state lines, as appropriate, and reforms that do not will cause limited harm.

Second, because each state is unique, it makes sense that state governments remain free to make different choices. Surely Alaska and Rhode Island have different health needs, and it would be absurd to expect the federal government to have the knowledge required to regulate and finance according to local conditions. Of course, for citizens to understand the consequences of health legislation and regulation, they need indicators that they can use to hold policymakers to account, and these indicators must identify differences between the states. So it is gratifying to see a number of organizations produce "report cards" that measure health care in all 50 states. Some of the reports cover very narrow ground.

Most "Report Cards" Call For More Government Intrusion

Public Citizen, which never met a government intrusion into health care that it didn't like, recently published a ranking of state Medicaid programs that gives higher scores to states that make more people dependent on government by enrolling more of them in Medicaid and spending more money on the program. The National Association of Community Health Centers, a lobbying group that seeks more taxpayer funding for its members, published a ranking that determines the proportion of a state's residents it estimates are "medically disenfranchised," and therefore in need of community health centers.[2]

The American College of Emergency Physicians produced a *National Report Card on the State of Emergency Medicine,* which assigned letter grades in a number of areas. Interestingly, it includes measurements generally not considered part of the health-care system. For example, the College gives higher scores to states with lower traffic fatalities, or strongly enforced seat-belt laws, and mandatory helmet use for motorcyclists. While we might consider such measures "preventive emergency care" (notwithstanding their threats to individual choice), if we were considering how well a state's hospitals deliver emergency services, these are factors for which we would control, not that we would include in our estimate.

While each of the above reports has just one axe to grind, four organizations have recently completed projects that look more at health care overall, from state to state: The Agency for Health Care Research & Quality (AHRQ), UnitedHealth Care Foundation, the Commonwealth Fund, and PRI.

AHRQ, an agency of the U.S. Department of Health & Human Services, assesses states on more than 80 quality indicators, and does not assign an overall rank, but

divides the states into quintiles.[3] For many years, the United Health Foundation and partners have published *America's Health Rankings*, which scores every state, and the Commonwealth Fund has just produced a very similar publication.[4] Indeed, their rankings "overlap" by 85 percent when compared through their correlation coefficient, a statistic used to compare two series.[5]

Because these publications have such similar results, this article focuses on the Commonwealth Fund's report, and contrasts it with PRI's *U.S. Index of Health Ownership.*

Good Health Rankings Do Not Predict Good Health Outcomes

The Commonwealth Fund's report covers 32 indicators that fall into four categories: access, quality, potentially avoidable use of hospitals and costs of care, and "healthy lives," which refers to the health status of the population.[6] The four indicators of "access" are related to insurance and availability of doctors. The fourteen "quality" indicators include measurements such as the share of adult diabetics who received preventive care and the share of adults over 50 years old who received recommended screening and preventive care. In other words, indicators of "quality" largely control for whether you are sick or healthy, and measure what treatment you receive appropriate to your condition.

The next category is "potentially avoidable use of hospitals and costs of care," which includes nine indicators such as the share of children admitted to hospital for asthma (which should have been managed), and Medicare hospital admissions for conditions that could have been treated in an ambulatory care setting. Finally, the five "healthy lives" indicators include the share of deaths attributable to health care, child mortality, and breast-cancer deaths. These are largely, but not entirely, attributable to the health care you receive.

The Commonwealth Fund authors provide an elegant progression by categorizing their indicators in this way. Common sense dictates that good access leads to good quality of care, which leads to reduced inappropriate use of costly hospital care, which leads to "healthy lives." Right? Not quite.

The Commonwealth Fund report demonstrates that there is a relationship between access and quality, but after that the connection pretty much falls apart.[7] Table 1 shows a correlation matrix between the four categories of indicators in the Commonwealth Fund report that shows how all four categories interact.

Table 1: Correlation matrix for four Commonwealth Fund Aiming Higher categories and PRI *U.S. Index of Health Ownership*

	Access	Quality	Avoidable Use of Hospitals & Costs of Care	"Healthy Lives"	PRI *U.S. of Index Health Ownership*
Access	1.00	.084	0.08	0.16	(0.13)
Quality		1.00	0.10	0.11	(0.05)
Avoidable Use of Hospitals & Costs of Care			1.00	0.80	0.20
"Healthy Lives"				1.00	0.08
PRI *U.S. Index of Health Ownership*					1.00

Source: Author's calculations from Commonwealth Fund *Aiming Higher* and PRI *U.S. Index of Health Ownership.*

Clearly, "access" and "quality" overlap very well: 84 percent. However, the connection between either access or quality and avoidable hospital admissions is miniscule: both at eight or 10 percent. Nor do they seem to have much to do with "healthy lives." Although there is a healthy overlap between avoidable hospitalizations and healthy lives, this does not seem to "loop back" to access or quality. Indeed, to the degree that "healthy lives" are a function of liv ing healthy, not the use of health services, these relationships indicate that staying out of the hospital unnecessarily is largely a result of things unconnected with health-care delivery.

Does this mean that all our fretting about health "system" performance is for nothing? By no means! However, it does demonstrate that "No indicators are currently available across states that measure the quality of life amenable to health care, rates of chronic disease under control, or the ability to participate in work or community life as a result of timely, appropriate care for potentially disabling conditions."[8]

Where Does PRI's *U.S. Index of Health Ownership* Fit?

The *U.S. Index of Health Ownership* does not solve this mystery. Indeed, Table 1 shows that the overlap between PRI's *Index* and the Commonwealth Fund's rankings, as well as its component categories, is neither convincingly positive nor negative. Nevertheless, it can perhaps help us understand how states fall where they do in the Commonwealth Fund's ranking.

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Hawaii for example, was the first state to mandate, years ago, that employers provide health benefits to full-time workers. According to the Commonwealth Fund report, it ranks first in access to care – counting both private and government health benefits.[9] Does this mean that an employer mandate is necessary to improve access to health insurance? Not at all: according to PRI's *Index*, Hawaii has quite a light burden of regulation of private health insurance and few coverage mandates (such as alcoholism, chiropractic and so on). Massachusetts, on the other hand, which suffers from greatly over-regulated private health insurance, finds a mandate to have health insurance much more difficult to achieve.[10]

The Commonwealth Fund authors also praise Rhode Island for having implemented incentives to motivate Medicaid managed care plans to reach quality targets, which take that state to the top of the Commonwealth Fund's rankings on quality of care. In PRI's *Index,* Rhode Island ranks first in our calculation of Medicaid waivers granted, an indicator of innovation in government health care programs.

Both advocates of greater individual health ownership and of more state government intrusion have much more work to connect the dots between what they value in health care and actual health outcomes. Nevertheless, the recent spate of reports comparing states will serve as a starting point for those who want to hold states accountable for the reforms they commit to undertake. Competition between organizations producing these rankings, like competition in health care, will lead to better outcomes.

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Endnotes

1. Annette B. Ramírez de Arellano & Sidney M. Wolfe, *Unsettling Scores: A Ranking of State Medicaid Programs* (Washington DC: Public Citizen Press, April 2007).
2. National Association of Community Health Centers & The Robert Graham Center, *Access Denied: A Look At America's Medically Disenfranchised* (Washington, DC: National Association of Community Health Centers, March 2007).
3. Agency for Health Research & Quality, *2006 State Snapshots* (Rockville, MD: Agency for Health Research & Quality, 2007).
4. United Health Foundation, *America's Health Rankings* (Minnetonka, MN: United Health Foundation, December 5, 2006; and Joel C. Cantor, *et al., Aiming Higher: Results from a State Scorecard on Health System Performance* (New York, NY: Commonwealth Fund, June 13, 2007).
5. For example, if series A comprises 1,2,3,4,5 and series B comprises 1,2,3,4,5 then the correlation coefficient is 1. If series B comprises 5,4,3,2,1 then the correlation coefficient is -1.
6. There is a fifth category, "equity," but this is cross-cutting.
7. Joel C. Cantor, *et al., Aiming Higher: Results from a State Scorecard on Health System Performance* (New York, NY: Commonwealth Fund, June 13, 2007), p. 11. Cantor, *et al.*, report the R-squared between access and quality. R-squared is a measurement of goodness of fit that is a result of a linear regression. However, the authors do not report any other results of executing a linear regression on these two variables, the most important of which is the beta, the parameter described by the co-efficient of the independent variable.
8. Joel C. Cantor, *et al., Aiming Higher: Results from a State Scorecard on Health System Performance* (New York, NY: Commonwealth Fund, June 13, 2007), p. 38.
9. Joel C. Cantor, *et al., Aiming Higher: Results from a State Scorecard on Health System Performance* (New York, NY: Commonwealth Fund, June 13, 2007), p. 11.
10. Sally C. Pipes, "At one year, Mass. health plan falls short," *Boston Globe,* May 15, 2007.