Survey: States Vary Widely on Health Indicators

BY ALICIA AULT

A continued wide disparity in access to and quality of care across the United States argues strongly for a national health reform plan, according to executives at the Commonwealth Fund, who released a state-by-state survey of 38 health indicators.

According to the Commonwealth Fund survey, there is a fivefold difference in performance on the indicators between the highest-ranked states and the lowest. "The differences we see among the states translate to real lives and real dollars," Karen Davis, president of the Commonwealth Fund, said at a press conference. "In the richest country in the world, there is no justification for any state to be far below the best state for quality and access to health care."

Health reform legislation under consideration in Congress would go a long way toward improving access and coverage, and that would increase quality overall, Ms. Davis said.

This is the second time the nonprofit group has taken a microscopic look at issues of cost, quality, and access in each state and the District of Columbia. Since the first report card in 2007, the number of uninsured adults has risen—and this survey was done on the eve of the recession, so the "worst is yet to come," according to Cathy Schoen, senior vice president of the Commonwealth Fund.

Coverage for children, however, has remained steady or improved, thanks to the federally supported Children's Health Insurance Program (CHIP), Ms. Schoen said.

States in the top quartile have been top performers in previous scorecards and have higher rates of insured adults and children, better access to primary care, and lower mortality from preventable diseases, among other indicators. The top quartile comprises Connecticut, Hawaii, Iowa, Maine, Massachusetts, Minnesota, Nebraska, New Hampshire, North Dakota, Rhode Island, South Dakota, Vermont, and Wisconsin.

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Ten of the 13 states in the lowest quartile—Alabama, Arkansas, Florida, Kentucky, Louisiana, Mississippi, Oklahoma, Nevada, Tennessee, and Texas—also ranked at the bottom on the previous 2007 report. Illinois, New Mexico, and North Carolina dropped into the lowest quartile since the last survey, while California, Georgia, and West Virginia moved up out of the last quartile in this most recent report. The lower-performing states had rates of uninsured adults and children that were double those in the top quartile.

The uninsured and those with low incomes tended to have poorer access to care and to receive a lower quality of care, Ms. Schoen said.

The report also reflected some bright spots: The quality of hospital care for heart attack, heart failure, pneumonia, and the prevention of surgical complications improved dramatically for all states, as did the quality of nursing home care. The Commonwealth Fund attributed the improvements to the increasing national efforts to measure and benchmark performance, including Medicare's Hospital Compare and Nursing Home Compare Web sites.

Conversely, data on ambulatory care quality are sorely lacking, Ms. Schoen said. From what can be gleaned, states' performance on preventive care stayed the same or declined. And poor coordination of care is resulting in continued high—and increasing—rates of hospital readmissions, according to the scorecard.

Ms. Davis touted the patient-centered medical home as a way to improve performance in preventive care, ambulatory care, and hospital readmissions. She said that 31 states are sponsoring medical home projects, and that the Commonwealth Fund is supporting efforts in Colorado, Idaho, Massachusetts, Oregon, and Pennsylvania to help safety net clinics become medical homes.

According to Ms. Davis and her colleagues, if the lower-performing states were helped to reach the levels of the higher-performing states, 29 million more people would be insured; 78,000 fewer adults and children would die prematurely each year from preventable conditions; 9 million more adults aged 50 years and older would receive recommended preventive care; and almost 800,000 more children would receive key vaccinations.

The organization also said that the nation could realize $5 billion in savings a year by avoiding preventable admissions and readmissions. ■

Cost Concerns Need Not Limit Drug Options

BY DENISE NAPOLI

As debate continues over whether to enact a public health plan in the United States, researchers from Canada and Australia assert that "the use of cost effectiveness in coverage decisions need not be an undue barrier to drug funding" by a national plan.

That goes "even for expensive medications, when there is robust evidence of effectiveness, at least in some patient subgroup," Fiona M. Clement, Ph.D., of the University of Calgary (Alta.) and her colleagues reported.

'The use of cost effectiveness in coverage decisions need not be an undue barrier to drug funding' by a national plan.

Comparative effectiveness and cost-effectiveness research need not result in only either-or decisions, according to Dr. Clement and her colleagues. "Medications can be reimbursed in specific subgroups where they are felt to be cost effective or can be listed with a higher co-payment if choice and access to therapy are valued highly."

Currently, the Food and Drug Administration does not take cost-effectiveness into consideration when approving medications, nor does Medicare when making coverage decisions.

The investigators looked at a total of 602 decisions by governmental agencies tasked with determining whether new drugs should be listed in public formularies in their respective countries: the National Institute for Health and Clinical Excellence (NICE) in the United Kingdom, the Pharmaceutical Benefits Advisory Committee (PBAC) in Australia, and the Common Drug Review (CDR) in Canada.

The investigators made case studies of three high-cost drugs which were considered by all three agencies: ranibizumab (marketed as Lucentis in the United States); insulin glargine (Lantus), and teriparatide (Forteo).

Ranibizumab, which clinical studies showed to be highly effective for wet age-related macular degeneration, was approved by all three agencies, despite a high cost per monthly injection.

In the case of insulin glargine, which is three times more expensive than the already approved intermediate-acting insulin NPH, "although each of the committees agreed that insulin glargine offered small incremental benefits over insulin NPH, all felt that unrestricted use at the price submitted was not cost-effective," the authors wrote. Nevertheless, out of the three agencies studied, only Canada's CDR denied coverage of the drug. Australia's PBAC negotiated an unrestricted benefit for Lantus in that country at a "confidential," cheaper price after five resubmissions by the maker. And in the United Kingdom, the drug was still recommended for all type 1 diabetes patients, as well as for a subset of type 2 patients without restriction.

When it came to teriparatide, "each of the committees agreed that [the drug] had been shown to reduce the incidence of vertebral and nonvertebral fractures in comparison with placebo, but felt that bisphosphonates would have been a more appropriate comparator within randomized trials," wrote the authors. While the CDR and PBAC denied coverage, NICE "felt that the use of this agent might be cost-effective in a small subgroup of patients with severe osteoporosis for whom bisphosphonates had failed, and listed it for this small subset of patients."

The investigators concluded that "perhaps the main lesson from the experience of the three countries is that systematic, durable, and widely accepted decisions can be made using comparative effectiveness and cost effectiveness, although it is evident that other information beyond these two criteria can be incorporated into decision-making. Given that the number of expensive, targeted pharmaceuticals for cancer and other chronic conditions is increasing, pharmaceutical reimbursement will continue to be a key challenge to formularies in all countries."

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