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HEALTH DIVIDES

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Healthcare Spending and Economic Well-Being in Colorado: One Doesn't Follow the Other

By Chris Stiffler
CFI Economist

By most measures, Colorado is one of the healthiest states in the country. The state consistently ranks among the least obese, with high levels of physical activity and low levels of diabetes and smoking.

But how does all this translate into economic well-being for Coloradans?

The standard proxy for economic vitality in a state is Gross Domestic Product (GDP), which sums up all the dollars that are spent in the state each year. While GDP is a useful broad-based measure, it does a poor job telling us about the *economic well-being* of the average Coloradan.

That's why in January 2014, the Colorado Fiscal Institute released Colorado's first Genuine Progress Indicator report. That study calculated a new, more comprehensive metric to measuring economic well-being in Colorado. It improved upon GDP by focusing on not just dollars spent in the economy, but on whether there were net economic positives for Coloradans during a given period. As a few other states have done, we applied the GPI

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Spotlight: Boulder County extending paid family leave

From Boulder County Health Services

Boulder County is taking a step that will ensure greater access to health care for parents and children, particularly working moms.

As of Jan. 1, 2016, Boulder County extended its paid leave policy for county employees for new birth or adoptive parents.

The new policy extends paid parental leave for county employees from one week to four weeks, which can be followed by available paid leave and/or utilized as part of Family Medical Leave Act (FMLA) leave for a maximum of 12 weeks off.

The county's parental leave extension follows growing recognition across the country about the importance of early childhood development and the impact that experiences at that age can have on the child's health and well-being

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Economic Well-Being

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model, which is increasingly gaining acceptance among economists internationally.

Let's talk first about the limitations of the longstanding Gross Domestic Product measurement.

GDP does not make any distinction between dollars spent that add to our economic well-being and dollars spent that do not; GPI corrects for that — so a dollar spent on vacation improves well-being but a dollar spent to fix a car damaged in a car crash does not in the GPI methodology. GDP also omits environmental externalities and ignores negative social conditions ranging from family breakdown to crime as well as positives like volunteerism, household labor and economic benefits from farms and forests; GPI corrects for those.

Our research showed that from 1960 to 2011, Colorado's GDP per capita had tripled, but its GPI per capita had only doubled. In other words, the economic well-being of Coloradans had trailed far behind the state's economic growth. This implies that the benefits from increased economic growth have been partially offset by costs associated with things like income inequality, natural resource depletion, "regrettable" expenditures and other breakdowns in social and economic well-being.

However, even CFI's examination did not scrutinize health care spending differently from a standard GDP perspective. That is, under GDP, all health care spending is seen as positive. So, if people get diabetes or high blood pressure as a result of obesity, spending on medication or treatment is seen as an economic positive, not as a negative. Similarly, if smoking causes one to develop COPD (Chronic Obstructive Pulmonary Disease), health care treatment for it is viewed as a positive under a typical GDP lens.

CFI is attempting to modify its GPI methodology to more thoughtfully measure how health care spending figures into economic well-being.

What is the Genuine Progress Report (GPI)?

GPI starts with a proxy for material welfare — the amount of goods and services Coloradans themselves buy each year — known as personal consumption. This is then adjusted for income inequality. GPI adds the monetary value of activities that add to economic well-being but are not counted in the standard GDP framework, such as volunteer labor. GPI then subtracts the monetary cost of the expenditures that we incur to protect the depletion of our natural and social capital like the dollars spent on auto accidents, mitigating crime and dealing with pollution.

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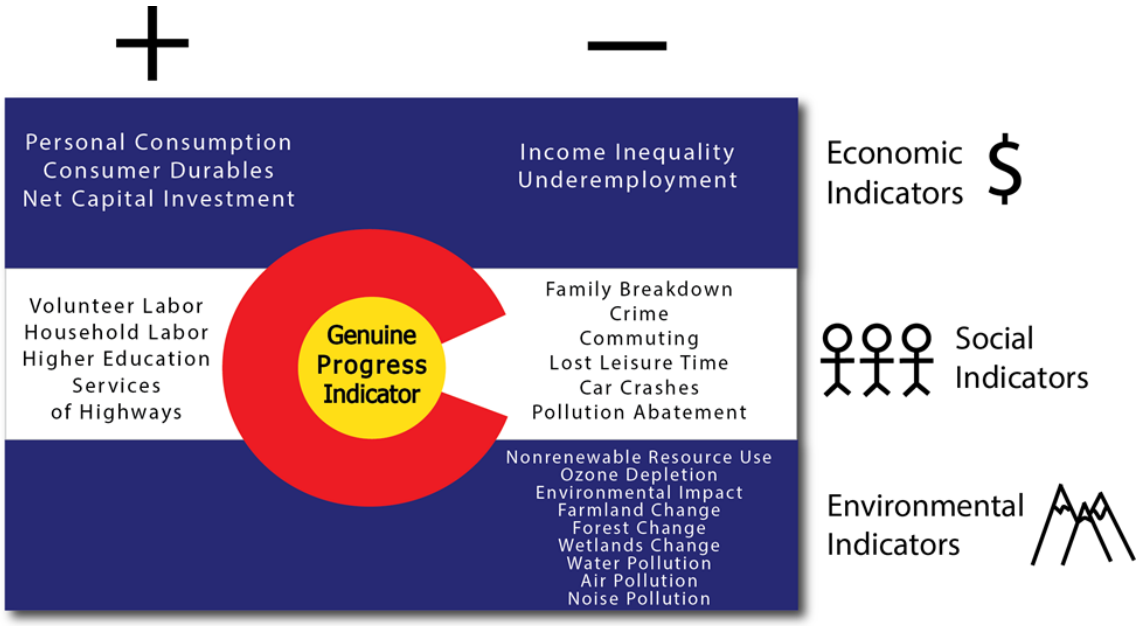

Access to care – viewpoint from a rural community

By Jen Fanning, Executive Director, Grand County Rural Health Network

Grand County is a picturesque mountain community. The views are amazing and residents and guests alike have numerous outdoor recreational opportunities. The county houses one of the closest ski resorts to the Denver Metro area, Winter Park Resort. In the summer, mountain bikes can be found on nearly all of our trails.

However, Grand County is also a vast, rural community spanning 1,800 square miles with just two main roads to get from one side of the county to the other. We also have to drive over a mountain pass in every direction in order to leave the county. Our population is about 14,000 people, making it difficult to sustain many services. But we are one of the fortunate rural communities — we have primary care, dental and mental health providers. We also have a critical access hospital and three emergency departments (only two are 24 hours, seven days a week). Many rural communities do not even have that.

Our rural healthcare providers are committed to our community and our way of life. They choose to live here. They choose to care for their neighbors, whom they often run into at the grocery store or a party or their kids' soccer game, where they get asked patient-related questions. They choose to make

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Twenty-four separate indicators are used to make up the GPI. Yet in the current GPI methodology, there is no indicator for health care. The current framework counts all healthcare expenditures by individuals as enhancing well-being. The current GPI suggests that some, if not all, health care expenditures should not be counted as positive, particularly those expenditures relating to increasing health care costs brought on by social, economic and environmental change.

Consider an example where someone decides to change from working 40 hours a week to working 60 hours. Because he works longer, he has less time to cook meals, so he eats more fast food and must take medicine for high blood pressure. In GDP terms, all those dollars are counted as positive even though the dollars spent on blood pressure medicine don't really add to economic well-being but are a requirement to mitigate the new lifestyle. The theory behind the GPI is to net out the dollars that add to economic well-being and those dollars that must be spent to mitigate the side effects of the way we live. The current GPI model, however, nets out the added cost of lost leisure time but doesn't net out the extra medical spending that arises because of the new way we live.

The Colorado Fiscal Institute is developing a method for a health care indicator to add to the GPI framework, the same framework that states around the county are adopting to help measure economic well-being.

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How we treat the expenditures on healthcare in the GPI

Our proposed healthcare indicator calculates all the dollars that would be saved if Colorado had a level of health

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Boulder County

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in the long run.

Paid parental leave has significant positive social and economic implications, including:

- Increased female labor force participation by making it easier for women to stay in the workforce after giving birth or adopting, which contributes to economic growth.
- Increased staff retention and reduced turnover, saving significant costs associated with replacing employees.
- Reduced reliance on public assistance.
- Improved health for parents and children, ultimately reducing health care costs.
- More potential for new moms to breastfeed successfully, if they choose, which ultimately improves the health of both mother and baby.
- Increased involvement by both parents.

Extended family leave programs have been proposed in 17 states and adopted in California, Rhode Island, New Jersey, Massachusetts and Connecticut. Similar policies have passed in King County, Wash.; Multnomah County, Ore.; and the City of Portland, Ore.

"We are pleased to be able to offer additional paid leave to our new or repeat parents as a way of letting our employees know how much they mean to us, and to help more families get a healthy start," said Boulder County Commissioner Cindy Domenico. "Additionally, when we looked at the long-term benefits of adding three weeks paid leave for new parents to our plan, it was pretty clear that the initial investment was worth the increased stability and continuity of county operations that result from a more generous family leave structure."

Boulder County Human Resources Manager Julia Yager was also a champion of the policy.

"This small investment in our employees and their families can make a lifetime of difference," Yager said. "And it helps us reach our human resource goals of keeping employees engaged and returning to work. It was just the right thing to do."

provide paid parental leave. Only 12 percent of people working in the private sector in the U.S. have access to paid family leave through their employers. While FMLA guarantees workers 12 weeks of unpaid leave to care for a newborn or sick relative, in reality, few can afford to go that long without pay.

POSITIVE EXPERIENCES IN THE EARLIEST YEARS ARE VITAL FOR HEALTHY BRAIN DEVELOPMENT. JUST LIKE BUILDING A HOUSE, FUTURE DEVELOPMENT DEPENDS ON A STRONG FOUNDATION. SUPPORTING PARENTS TO TAKE TIME AFTER THE BIRTH OF A CHILD OR AN ADOPTION IS AN IMPORTANT STEP TOWARDS HELPING CHILDREN GROW UP TO BE HEALTHY AND PRODUCTIVE, WHICH ULTIMATELY LEADS TO HEALTHY AND PROSPEROUS COMMUNITIES.

Positive experiences in the earliest years are vital for healthy brain development. Just like building a house, future development depends on a strong foundation. Supporting parents to take time after the birth of a child or an adoption is an important step towards helping children grow up to be healthy and productive, which ultimately leads to healthy and prosperous communities.

The United States remains the only advanced economy that does not

Learn more about the importance of early childhood experiences by watching the documentary series, Raising of America, on Rocky Mountain PBS beginning Jan. 7, 2016. The series explores how a strong start for all

kids leads not only to better individual outcomes (e.g. learning, earning,

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physical and mental health, etc.) but also to a healthier, safer, better educated, more prosperous, and more equitable society. In Congress, the federal FAMILY Act would create a national family and medical leave insurance program to provide workers with a portion of their wages for a limited period of time (up to 60 workdays, or 12 weeks in a year) to address their own serious health condition, including pregnancy or childbirth; to deal with the serious health condition of a parent, spouse, domestic partner or child; to care for a new child; and/or for specific military caregiving and leave purposes.

Benefits would amount to 66 percent of an individual's monthly wages (based on highest annual earnings from the prior three years), up to a capped monthly amount, and would be indexed to the national average wage index. If a person takes the maximum number of days, the benefits would range from a minimum benefit of $580 to a maximum of $4,000 per month in the program's first year.

In Colorado, HB15-1258 would have allowed workers up to 12 weeks of paid leave to care for a sick family member or themselves. That measure failed.

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that matched the healthiest level of any state in any point in the recent past, in this case using baselines from 1995-2012. The indicator looks at health risk factors (obesity, high blood pressure, inactivity, depression, high blood glucose, stress and tobacco use) and compares them to a baseline rate. Then it calculates the dollar value that is spent on every individual whose health maladies are above that established baseline. This method calculates spending that could be used to enhance economic well-being instead of simply mitigating the harmful health effects of the way we live, since today's society contributes social, economic, and environmental stressors that have negative health effects on Coloradans.

	Colorado Rate (2012)	Baseline Rate	Portion of Coloradans above Baseline	Marginal Health Spending per Risk Factor
Depression	6.4%	3.0%	3.4%	$ 2,184
Tobacco Use	16.0%	0.0%	16.0%	$ 587
Inactivity	41.5%	40.0%	1.5%	$ 606
Stress	16.8%	0.0%	16.8%	$ 413
High-Blood Pressure	23.9%	18.6%	5.3%	$ 1,378
Obesity	22.8%	10.1%	12.7%	$ 1,091
High-Blood Glucose (Diabetes)	7.0%	2.7%	4.3%	$ 1,653

For example, in 1996 the obesity rate in Colorado was 10.6 percent, and the

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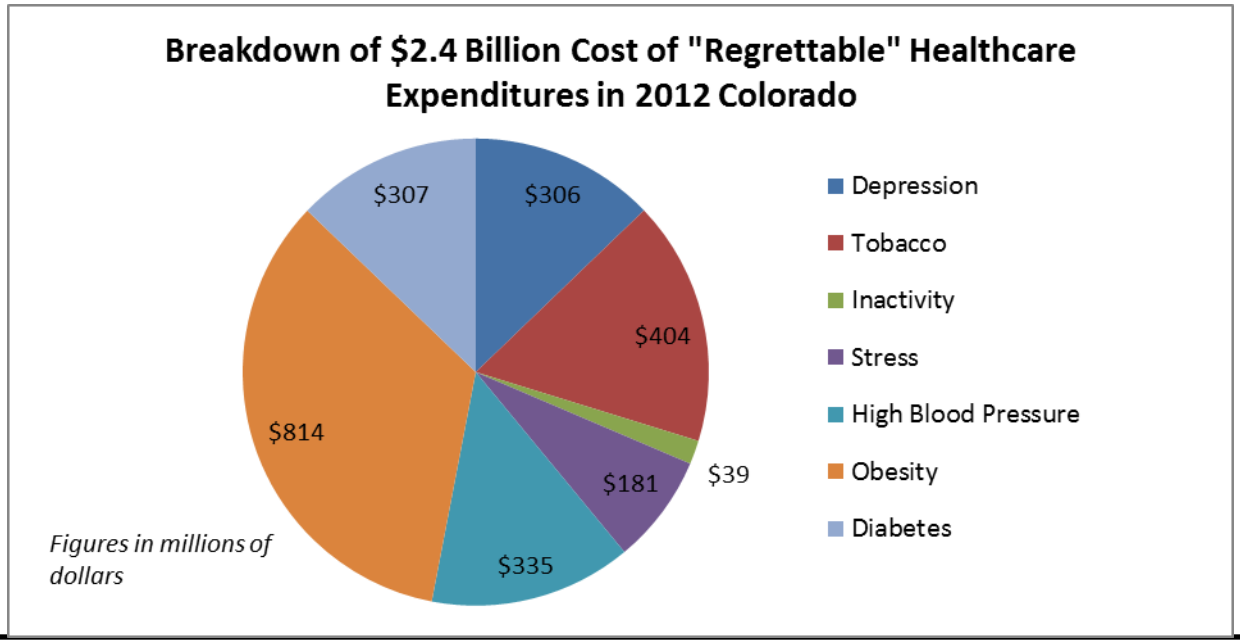

Equity in rural Colorado

By Tim Hoover
CFI Communications Director

For many people, rural life in Colorado may bring to mind images of fresh air, mountain vistas, vigorous hikes and days spent fly-fishing and eating farm-raised, wholesome foods. This Ralph Lauren-like vision of Americana presents a picture of healthy living — fit people living long lives, chopping wood and playing hard by clear blue streams.

Without question, this lifestyle certainly exists for some Coloradans who live well in rural, mountainous settings. But statistically speaking, this isn't the reality for most rural Coloradans, who experience a greater incidence of chronic illnesses and obesity, who have more limited access to health care and who have shorter lifespans than people in urban areas.

According to the nonprofit Colorado Rural Health Center, 73 percent of Colorado's 64 counties are rural, while 18 percent of the population lives in rural areas.

Here are a few sobering facts about rural counties, according to the organization:

• Median household income in rural counties is 26.5 percent less than in urban counties.

• Of families living in rural counties, 9.8 percent live below the federal poverty level, while only 8.9 percent of families in urban areas do.

• Meanwhile, 24.5 percent of kids in

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Access to Care

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less money than if they practiced in an urban area.

But that comes with its own challenges. According to the National Rural Health Association, Medicare payments to rural hospitals and providers are significantly less than to urban providers for the same services. This reality, coupled with low Medicaid reimbursements, unfortunately causes many private providers to only accept private insurance. This in turn affects some of our most vulnerable populations — the low-income, seniors and the disabled. Our neighbors with public insurance have to travel farther to access care. Grand County has no public transportation option, and these populations often do not have their own transportation or the means to pay for it. Further, our low-income population specifically often is the service workers at restaurants, grocery stores, and ski resorts that make our tourist economy function so well. They may work seasonally or full-time, year-round.

Grand County also suffers from a symptom familiar to many other rural and frontier communities: economies of scale. Our population is so small and spread out that many services do not pay for themselves in the way they do in urban or suburban areas with more people in a closer geographic area. This makes obtaining and retaining healthcare services in rural communities extremely difficult. For example, pregnant women in Grand County cannot deliver babies here and probably won't be able to until and unless our population more than doubles.

"OUR POPULATION IS SO SMALL AND SPREAD OUT THAT MANY SERVICES DO NOT PAY FOR THEMSELVES IN THE WAY THEY DO IN URBAN OR SUBURBAN AREAS WITH MORE PEOPLE IN A CLOSER GEOGRAPHIC AREA. THIS MAKES OBTAINING AND RETAINING HEALTHCARE SERVICES IN RURAL COMMUNITIES EXTREMELY DIFFICULT."

Another perfect example of this occurred in the first week of January this year. Within days of each other, Grand County's Hospice (a nonprofit) and Home Health (a government agency) announced they were suspending services or closing their doors. Both agencies cite economic or funding difficulties. Hospice serves 20-25 people per year and simply cannot keep an organization requiring special licensure alive with that number. Home Health serves 100-120 people per year with a consistent case load of around 14-16 people. Home Health also requires a special license, different from that of Hospice. Both agencies make home visits and care for our people in one of their most dire times in life. Providers travel upwards of 100 miles per day to care for the dying, home bound, medically fragile or disabled. And they must be on-call and available 24 hours a day, seven days a week, 365 days a year. Their loss is devastating in our community and leaves a gaping hole for our most vulnerable populations in accessing care.

So what is a rural community to do? Move forward as best as possible. Constantly look at opportunities to practice healthcare more efficiently. And deal with gaps in services as best as possible. Unfortunately, our community members, parents and children, neighbors, and employees sometimes bear the brunt of lack of services.

Rural Health Equity

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rural counties live in poverty, as compared to 15.8 percent for urban children.

- Deaths from coronary heart disease occur at a rate 14.4 percent higher in rural areas than in urban areas.

Access to care is certainly an enormous factor in health outcomes in rural areas, but so are social determinants like age, household income, race, gender and behavioral factors. According to the Disparities National Coordinating Center, an agency under the federal Centers for Medicare and Medicaid Services, only between 10 percent and 20 percent of health is explained by care received in doctors' offices and hospitals.

"Broader issues such as poverty, lack of transportation, occupational hazards, poor environmental conditions, lack of education and behavioral factors impact these outcomes to a greater extent," a recent report from the DNCC said.

According to the DNCC report, 87 percent of the difference in life expectancy between rural and urban populations comes from high death rates of individuals over 25 due to unintentional injuries, heart disease, Chronic Obstructive Pulmonary Disease (COPD), suicide and diabetes. In fact, COPD death rates are the highest for both men and women in rural counties, where smoking rates are higher and environmental hazards may be higher.

"Life expectancy for all U.S. population groups has increased by almost a decade during the latter half of the twentieth century, but a gap in longevity for rural populations has become apparent," the DNCC report said. "Until 1990, the urban-rural disparity was not as significant; however, the gap is now more than two years and widening.

"Life expectancy in rural populations has increased over the past four decades, but rate of change has not kept pace with urban rates. In fact, the life expectancy for both genders in rural and urban populations from 1984-1986 was the same. The life expectancy for rural males in 2009 was 74.1, which was almost the same for urban males 10 years earlier at 74.5. It is this lack of progress which is the most disturbing aspect of this data."

These troubling statistics on social determinants in rural America are coupled with a real lack of access and availability of health care.

The National Rural Health Association reports that only about 10 percent of physicians practice in rural areas, and rural residents are less likely to have employer-provided health care coverage for prescription drugs and less likely to be covered by Medicaid than residents in urban areas.

It's also harder for folks in rural areas to get to medical providers. The Colorado Rural Health Center says 14 percent of rural adults have low incomes and lack transportation compared to a state average of 8 percent.

According to the NRHA, about two-thirds of all automobile fatalities occur on rural roads, which are frequently less safe than those in urban areas. Response times to accidents are on average eight minutes longer.

Besides car accidents, rural residents are nearly twice as likely as their urban counterparts to die from gunshot wounds. Alcohol and tobacco use rates are higher, with rural eighth-graders twice as likely to smoke as those in urban areas.

Rates of teenage pregnancy are also higher, with the rate of births by teens 15-19 in rural areas 1.6 times higher than in urban areas.

And despite stereotypes of fresh, wholesome, nutritious food in the country, the report from the Disparities National Coordinating Center shows that while only 8.2 percent of urban residents live in "food deserts" — areas more than 10 miles from a grocery store — 23.3 percent of rural residents do.

In fact, the rate of obesity in rural areas is 28.6 percent compared to 25.8 percent in urban areas, the DNCC report said. These disparities are even more pronounced among minorities.

Clearly, the long litany of health disparities in rural areas dispel any notion that country living in and of itself makes one healthier. But what is even clearer is that access to care in and of itself does not tell the whole story of health disparities in rural areas.

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lowest rate it was in any state was 10.3 percent. The current rate of obesity in Colorado is now more than 20 percent. We calculate the added cost that we as a state spend on medical expenditures for all Coloradans suffering from obesity.

The biggest challenge to placing a dollar value on an individual health care risk is isolating that cost from other combined health risks. In other words, the effects of being obese need to be separated from the effects of also having another risk factor like high blood pressure. Fortunately, there was a landmark report in 1998 known as the "HERO study" that did just that. It was the first study to determine the association between health risks and costs that also controlled for demographic variables and for the concurrence of multiple health risks in a given person so various risk factors could be evaluated individually. The study was replicated later using enhanced methods and contemporaneous data as the HERO

study and was published in Health Affairs in 2012.

Using this methodology, Colorado could spend $2.4 billion a year less on health care expenditures if Colorado's rate of obesity, depression, high blood pressure matched the historic low rate of each health risk.

The largest amount of "regrettable" healthcare spending comes from obesity, as Colorado's obesity rate has doubled since 1995, which is also a trend we've seen nationwide. If Colorado's obesity rate were 10.1 percent instead of 22.8 percent, Colorado as a whole would spend $814 million less on health care expenditures.

Because Colorado is such an active and exercise-oriented state, health care costs as a result of inactivity are relatively low.

What our initial look indicates is that Coloradans' economic well-being is enhanced by low obesity rates and active lifestyles but that the state's economic well-being could be even higher if obesity rates were at historic low levels.

The full GPI report and latest update can be found at www.coloradofiscal.org

The Colorado Fiscal Institute provides credible, independent and accessible information and analysis of fiscal and economic issues facing Colorado. Our aim is to inform and influence policy debates and contribute to sound decisions that improve the economic well-being of individuals, communities and the state as a whole.

Our offices are located at 1905 Sherman St., Suite 225, Denver, CO, 80203. Please consider making a donation by mail or online at coloradofiscal.org

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