Interested Party Testimony on House Bill 49
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Good morning Chairman Romanchuk, Ranking Member Sykes and members of the committee.

My name is Reem Aly and I am the Vice President for Healthcare System and Innovation policy at the Health Policy Institute of Ohio (HPIO), a nonpartisan, nonprofit organization.

2017 *HPIO Health Value Dashboard*

HPIO recently released the ***2017 Health Value Dashboard*** which builds upon the inaugural *Dashboard* released in December 2014. With input from many different sectors and stakeholders, HPIO developed the *Dashboard* as a tool to track Ohio's progress towards health value – a composite measure of population health outcomes and healthcare spending.

We know that improving health and addressing healthcare spending growth are concerns shared by policymakers and others. We believe that compiling public data in one place is an important starting place for us to understand whether health outcomes and healthcare spending are improving in Ohio and how our state compares to others. We also believe that the *Dashboard* is a useful tool for prioritizing our challenges to guide action for improvement.

Where does Ohio rank?

In the 2017 *Dashboard*, Ohio ranks 43rd on population health and 31st on healthcare spending out of 50 states and the District of Columbia. Our health value rank is a composite measure of our population health and healthcare spending ranks, equally weighted and relative to other states and D.C.

On health value, Ohio ranks 46th landing in the bottom quartile. Ohioans are living less healthy lives and are spending more on healthcare than people in most other states.

Why does Ohio rank poorly?

The answer is complicated. The *Health Value Dashboard* shows us that Ohio performs well on access to care but poorly on population health. This indicates that access to health care is necessary, in fact it is critical if you are sick, injured or have a chronic condition, but good performance on access to care alone is not sufficient to improving our overall health.

In addition, the *Dashboard* indicates that Ohio continues to perform poorly on the other factors that impact health value. Research estimates that of the modifiable factors that influence our overall health outcomes, 80 percent is attributed to non-clinical factors (including our social and economic environment, physical environment and health behaviors) and only 20 percent is attributed to clinical care (access to care and healthcare system performance).[1] Ohio is not doing well in many of those areas.

Where do other states rank?

As you can see in the state rankings maps in the *Dashboard* (pg. 8) there is wide geographic variation on health value rank. This tells us that health value does not depend solely on the geographic or demographic characteristics of a state. States with both poorer and older populations than Ohio (Florida and New Mexico), or larger and more diverse populations (California, Florida and Texas) have a higher health value rank, performing better on both population health outcomes and healthcare spending.

The correlation between percent of a state's population aged 65 and older and health value rank is relatively weak (r=.25). The correlations between children living in poverty and adults living in poverty are even weaker (r=.12 and r=.15). This tells us that the percent of a state's population over age 65 and the poverty level of a state are not driving health value rank.

What are Ohio's greatest challenges and strengths?

In the *Dashboard*, we also highlight Ohio's greatest challenges – metrics where Ohio is in the bottom quartile and metrics were Ohio is worsening. These metrics include infant mortality, cardiovascular disease mortality, smoking and drug overdose deaths.

The *Dashboard* also highlights Ohio's strengths. These are metrics where we are in the top quartile or where we are improving. Ohio has strong performance on several access to care metrics, as well as youth marijuana use and heart failure readmissions.

Is Ohio moving in the right direction?

Another feature of the *Dashboard* is highlighting trend over time. Ohio, like most other states, is moving in the right direction with more metrics that have improved rather than worsened. Specifically, Ohio improved on access to care, healthcare system, social and economic environment and physical environment. However, Ohio saw a net worsening on population health and public health and prevention metrics. To put this into greater context, Ohio was one of only eight states that did not have net improvement on the population health domain.

How does the *Dashboard* address equity?

The *Dashboard* also examines both health disparities and inequities across a set of metrics by race and ethnicity, income level, education level and disability status.

What we found is that Ohioans who are black or have a low income are more likely to experience larger disparities and inequities across metrics than other population groups. For some metrics, the *Dashboard* provides estimates of how many Ohioans would have a better outcome if their prevalence or exposure rate were that of the group with the best outcome.

We found that nearly 127,000 children in Ohio would not be exposed to second-hand smoke, for example, if the disparity between low-income and moderate-to-high income Ohioans was eliminated. If the racial and ethnic disparity was eliminated, more than 130,000 black children in Ohio would not be living in poverty. In order to improve our health value rank we must address the disparities and inequities across Ohio's population.

In closing, Ohio's ranking of 46 on health value means that Ohioans are living less healthy lives and are spending more on health care than people in most other states. Ohio performs well on access to care but poorly on the other factors that impact our overall health. Access is a strength we should build on, but we need to also improve our performance on the other factors that shape health value, including a focus on eliminating health disparities and inequities.

Thank you Chairman Romanchuk for the opportunity to share this information with the committee. I would be happy to take questions after my colleague's presentation.

[1] Booske, Bridget C. et. al. *County Health Rankings Working Paper: Different Perspectives for Assigning Weights to Determinants of Health*. University of Wisconsin Public Health Institute, 2010.