Analysis of healthcare in california

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Introduction

In recent years, United States healthcare expenditure focused on expanding health care coverage and increasing access to medical services. For example, the state of California has been grappling with the burden of cardio-metabolic diseases such as diabetes and obesity. Though billions of dollars are spent annually to treat these lifestyle diseases, the prevalence of both obesity and diabetes is still on the rise (Meng, Pickett, Babey, Davis, & Goldstein, 2014; Mirzadehgan, Harrison, & DiSogra, 2004).

While access to basic health services is critical to maintaining health status, it is important to also acknowledge and capitalize on the roles of social, economic and/or environmental determinants contexts within which people live as they hold tremendous potential to positively influence health status. The objective of this Issues Summary is to address the current status of health care spending in California and demonstrate how an emphasis on the underlying social, economic, and environmental determinants of health may reduce financial hardship for the state while managing its most problematic chronic diseases more effectively in the long term.

Background

History

Although health care spending in California is high, quality of care for individuals is low. Quality of care remains low because approximately 20% of California's population is uninsured, and the majority of these individuals avoids seeing a doctor until emergency care is required (Helfand, 2011; " Emergency as normal", 2002). This reliance on emergency care, which should act as a safety net and not a patient's primary source of health care, leads to steep health care costs.

Healthcare spending in California has come under scrutiny since the passing of the Patient Protection and Affordable Care Act (ACA) in 2010. In that year's general elections alone, two health care spending measures were approved for the ballot. Proposition 45 would force health insurance companies to be more transparent about rate hikes and increase accountability through mandated review of requested rate changes. The other, Proposition 46, was meant to increase accountability from healthcare providers. The measure specifically required random drug testing for doctors and that those found to be impaired would face disciplinary action from the California Medical Board. Proposition 46 also proposed an increased cap on pain and suffering damages from medical negligence lawsuits. These propositions encourage increased vigilance from doctors with the aim of ultimately improving the quality of the services administered. However popular, neither of these propositions capitalized on the potential for decreasing direct healthcare expenditures while increasing quality of care.

With the increased financial cost of cardio-metabolic disease, Californians have recognized the strain that chronic disease such as diabetes and obesity-related illnesses put on the state's health care system, as evidenced by recent policies such as Senate Bill 1000, which outlines the potential consequences of soda consumption and subsequently reduce its demand (" Warning Labels on Sugary Drinks"). Providing health education and more affordable preventative care services to vulnerable populations can significantly reduce the burden of chronic disease and its related healthcare costs.

Current Status

In 2011, nearly one-third of hospitalizations among Californians age 35 and older were related to diabetes; interestingly, only 8. 4% of California adults had diabetes (Meng et al., 2014). According to the California Health Interview Survey (CHIS) in 2009, 22. 7% of California adults were obese based on their body mass index (Cook et al., 2013). Obesity is strongly associated with the incidence of chronic diseases, including coronary heart disease, type 2 diabetes and hypertension (Cook et al., 2013).

The rising prevalence of obesity and diabetes in the United States is of particular concern among low income and minority populations (Melius, 2013). Researchers have shown that income is negatively associated with adolescent obesity: youth from low-income families were more likely to be obese than their higher income counterparts (Babey, Hastert, Wolstein, & Diamant, 2010). This inverse correlation suggests that a successful intervention against obesity and its related diseases should address the

conditions that drive differential behaviour and nutritional patterns in people of various socioeconomic strata (Melius, 2013). One such intervention is the proposed “ soda tax” that will be on the ballot in Berkeley and San Francisco in this November’s general election. Evidence suggests that when prices of sugary drinks increase, “ consumers, including low-income consumers, [make] more nutritious purchases” (Varney, 2014). The “ soda tax” is estimated to “ prevent 240, 000 cases of diabetes per year” according to Dr. Bibbins-Domingo, a professor of medicine at UCSF, who co-authored a study on the tax (Cook, 2014). In addition, the tax revenue generated by this measure may be utilized for programs focused on childhood nutrition (Cook, 2014). While taxes on unhealthy foods may be highly controversial, California may consider adopting other strategies that target nutritional choices and low-income populations throughout the state.

Differential factors in the physical environment are also an issue. For instance, low income diets and neighbourhoods are characterized by low intake of vegetables and high consumption of fast food due to the lack of supermarkets in low-income neighborhoods (Melius, 2013). Additionally, access to public parks and other sites of recreation encourage increased physical activity, which can influence the development of obesity and diabetes (Melius, 2013). However, public parks are more likely to be absent or in a state of disrepair in low-income neighborhoods, due to limited funding or resources. Zoning regulations and incentives programs can be effective ways to produce changes in the physical environment. Finally, home environments that do not encourage healthy eating habits from an early age or encourage regular physical activity contribute to the development of

obesity-related conditions (Meng et al., 2014). However, healthy eating habits and a healthy, active lifestyle is a learned behavior, which requires adequate health education, particularly early in life.

Diabetes and obesity, and their comorbid conditions are expected to continue to increase in prevalence. It is absolutely essential to address the underlying factors contributing to obesity-related illnesses. With the current state of health care expenditures for acute care of largely preventable conditions, it is imperative that California consider measures that will maximize health status within the confines of a tight state health care budget (Meng et al., 2014; Helfand, 2011). These measures must include increasing access to preventative care or early intervention in the care of chronic disease.

Recommendations

Pandemic obesity and diabetes in the state of California and across the nation is a call to action to develop prevention strategies, rather than solely focusing and relying on providing primary health care. Both lack of physical activity and poor diet (high carbohydrate, high fat, and low fiber intake) increase the risk of developing obesity and diabetes. As such, our proposed policies are 1) establishing amicable environments encouraging physical activities 2) promoting healthy and nutritious dietary intake at a young age and 3) providing access to affordable preventive health care. The proposed policies intend to modify underlying causal determinants of disease and therefore improve the health of the general population and reduce health care related costs.

Recent surveys and research on California's population have shown that diabetes and obesity will continue to be of significant concern for the health status of the state's population in coming years. While creating an environment where people can exercise and engage in regular physical activity and ensuring access to affordable health care are important steps to take in order to manage these diseases, we recommend prioritizing social policies aimed at improving nutrition and lifestyle choices. Californians are receptive towards policies that address social determinants of health, including early childhood nutrition, and these policies can have a tremendous impact on health outcomes in the long term at a lower cost than would be required of policies that simply increase health care services.

Two policies recently approved in California that address social determinants of health are Senate Bill 402 and Assembly Bill 290. Senate Bill 402 was enacted in 2013 and requires that all hospitals with a prenatal unit adopt an infant-feeding policy that is equivalent to " Ten Steps to Successful Breastfeeding" (De León, Pavley, 2013). It was adopted to manage obesity in California by addressing early life nutrition, supported by evidence that " early infant-feeding practices can affect later growth and development, particularly with regard to obesity" (De León, Pavley, 2013). Assembly Bill 290 also aims to prevent obesity by ensuring that child care centers have an employee with " at least one hour of childhood nutrition training" as part of an already required health and safety training (California Senate, 2013). The bill targets child care centers because child care participation is at an all-time high, so they are a great space to reach a large number of youth at an age when " lifelong nutrition habits are formed" (California Senate, 2013).

These policies have great potential to stem obesity and its associated chronic diseases and reduce healthcare costs in the future.

In order to achieve our goals to positively influence health status in California, we recommend enlisting public health practitioners more frequently in the policy making process. With their background in health, social and economic determinants, and fluency in interpreting data from academically-driven research, public health practitioners are an untapped resource for policymakers. In fostering this collaboration between public health providers and our state policymakers, we will effectively bridge the data gap and provide the opportunity to maximize health status, while minimizing health care expenditures. The collaboration would promote active assessment of the impact of policy change, which can increase recognition of social determinants of health and of inter-sectoral responsibility for health (Oxford, 2013).

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