OCL Health Disparities Study
Steering Committee Meeting
September 28, 2007
Meeting Minutes

Present: Sandra Barrett, Betty DeFazio, Liz Crockett, and Mary Jensen.

The meeting was called to order at 8:45 a.m. Guests for this meeting were Tom Dennison, Ph.D., Professor of Practice, Advisor, Health Services Management and Policy (HSMP) Program, Maxwell School of Citizenship and Public Affairs, Syracuse University, and David Sutkowy, commissioner of the Department of Social Services for Onondaga County. Betty began the meeting recapping the study committee's activities to date.

Tom started out by saying that healthcare system is one small piece of the problem and that outcomes are not a relevant measure. The numbers of people who do not use the healthcare system because it doesn't meet their needs are not accounted for in the healthcare system, i.e. those who use complementary medicine, which insurances don't tend to cover.

When we look at health outcomes, we know that we under or over treat… there is not good management of chronic disease, which comes down to a financial issue. Chronic disease prevention is three tiered: a primary prevention would be, for example, to lose weight; a secondary prevention would be prescribing drugs to manage disease; the tertiary prevention level is to prevent further deterioration or advancement of the condition, such as rehabilitation.

Betty commented that issues in financing create health disparities, and poverty plays a role, but is not the only barrier to healthcare.

Tom described the situation in post-World War II: The British convened to discuss how to create a healthy and productive society in England after the war. The Lord Beveridge report stated that the way to achieve such a state is that education, housing and healthcare must be accessible to all citizens. At the end of the war, Britain created nationalized healthcare, removing financial inequities. According to Tom, poverty, poor nutrition and poor housing are the biggest factors leading to poor health outcomes.

The U.S. ranks 27 or 28 among the international community for healthcare systems. Others do much better because of nationalized coverage and managed care, which plays a big role in outcomes. The U.S., at the end of WWII, put much money toward the healthcare system; in the 30s and 40s, there had been no funds to invest. During the 60s, Medicare was created and spending continued. From the 70s on, investment in the healthcare system has been slow and utilization decreased.

Betty stated that education is an important element. Tom concurred, citing the U.S. dropout rate of 50%. Betty asked what might be the link between education and healthcare. Tom said that those more educated learn life skills, earn more money, can take advantage of opportunities and are better able to move out of the cycle of poverty.

Liz commented that she thinks even universal health insurance will not eliminate disparities.

Tom brought up the work of the Commission for a Healthy CNY. Due to funding, they are no longer functioning. They had received a grant to collect data on health status. From data collected, it was deemed obesity was a major health issue and they heal a teaching day on the topic.

David Sutkowy joined the meeting, and agreed with Tom that the bottom line in health inequalities is poverty. One of the biggest impacts could be the shift from high-tech specialties (where the money is for physicians) to primary care practices, where care could be better managed. There has been a huge drop in the number of residents opting into primary care, which weakens the system's ability to provide care at a basic level.

Sandra asked, "What can we do locally?"

David responded by stating that he does not believe that anyone is doing anything deliberate to deny access. There is a major initiative now to enroll people who may be eligible for Medicare and Medicaid. He does not believe, however, that the state's estimate of un-enrolled is accurate for Onondaga County (he feels it is too high). He also said his department assess whether they are truly reaching all the populations. Possibly not, due to issues of language, race, ethnicity and location, for example. He mentioned the Verizon Translator Program that is used to reach people who speak languages (150-200 languages) for which the department has no translator. He also mentioned videoconferencing to reach those with physical disabilities. He says there is an affirmative dedication to reaching out to ensure that all have access.

The question was asked that if one is uninsured, does the system provide services differentially. David responded with an example of statistics collected by the Dallas Mavericks concerning calls by black and white referees. White refs had a higher number of calls on Black players, while Black refs had a higher number of calls on White players. David said this shows that statistics can help uncover inequities and keep us honest.

David stated that in this regard, moving into managed care and being issued cards that do not identify someone as the Medicaid recipient help level the playing field. Although he does not have statistics to prove this, he observes that access has improved locally and that there is better access to care now than nine or ten years ago.

Sandra asked about the role of the community health center: is there a difference between going to a clinic versus to a private practice? Tom responded, saying that federally qualified health centers are re-imbursed at higher rates for Medicare; that they can secure

grants for complementary staff, such as social workers; that they can mount programs targeted toward the populations they serve; and that they use "wave schedules," which is a different pattern of utilization of services.

Betty commented that only one local practice provides chemotherapy services to Medicaid patients, and wonders why. David offered that some reasons could be the inordinate amount of paperwork that needs to be completed, low-show rates for Medicaid patients (although due to legitimate reasons), and the fact the physicians are not re-imbursed at an acceptable rate.

In leading the meeting toward its conclusion, Betty asked Tom and David what one thing would help our community the most. David responded that lack of data is unbelievable, and that we could do a much better job if we could review data and then gear services and programs based on actual statistics. Tom agreed, saying that we don't have enough data so we can prioritize initiatives. He feels one tangible action item would be to tackle the problem of obesity, as it is the foundation for many chronic diseases. Tom added that we cannot just blame the healthcare system, for that lets everyone off the hook. David concurred, saying that we need to solve the problem, not just put band-aids on the symptoms, adding that we need to challenge ourselves and to break some of the rules we've imposed on ourselves.

The meeting was adjourned at 10:00 a.m.

The next committee meeting is scheduled for October 12 at 8:30 a.m. at University College.