STRATEGIC HEALTH CARE

DR. STEVEN WOOLF ANWSERS THE QUESTION: HOW HEALTHY ARE AMERICANS

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P R O C E E D I N G S

MR. OOSTRA: Hello, my name is Randy Oostra, President and CEO ProMedica. I'm pleased to welcome you to this eight-part series of healthcare reform discussions with nationally recognized health policy experts. These interviews will discuss Medicare policy including healthcare pricing, long-term care, and the social determinants of health.

This series is part of an ongoing two-year effort by more than a dozen hospital CEOs from around the U.S. to urge Congress to take up significant healthcare policy reform legislation largely by calling for the creation of a national commission on healthcare reform. It is our intent that these policy reforms discussed during these interviews demonstrate our desire for substantive national reform. Moreover that these interviews help to further inform congressional members and committee staff as they work to craft legislation to improve healthcare delivery and financing during the next Congress.

Our motivation is straightforward. Well before the onset of the COVID-19 pandemic, we were

adamant that race, age, and/or economic circumstances should not be defined as preexisting conditions, nor do we accept the premise that Americans should be resigned to live shorter lives in poor health. We invite you to listen to or to read the transcripts of all eight interviews. If you'd like to provide comment, you can do so via the contact information noted at the conclusion of these interviews.

MR. INTROCASO: Welcome to this first interview in a series of eight interviews concerning national healthcare policy reform. My name is David Introcaso and I'll be conducting these interviews. It's appropriate to begin this series with a discussion of health status. Comparatively how healthy are Americans? With me to discuss this topic is Virginia Commonwealth Professor of Population Health, Dr. Steven Woolf. Dr. Woolf, welcome.

DR. WOOLF: It's a pleasure to be here.

MR. INTROCASO: In 2012 Dr. Woolf chaired an Institute of Medicine expert panel to examine our country's comparative health status. The expert panel's findings were published in 2013 under the title "U.S.

Health in International Perspective, Shorter Lives, Poorer Health". Dr. Woolf's complete bio is posted with this interview's audio file and transcript.

Dr. Woolf, let me begin by asking, what does the current pandemic's mortality rate tell us about our underlying health status relative to comparable countries?

DR. WOOLF: Well, on its face, it's pretty well known that the COVID-19 mortality rate in the United States is extremely high. Our case numbers have exceeded that of any other country and our mortality rate per hundred thousand persons is well above most developed countries. But I think of COVID as a current fresh example of a very old problem, and really the pandemic has exposed a lot of longstanding problems in the United States in its ability to protect the health of its population and deal with deep-seated inequities.

So for example, the much higher mortality rate of COVID-9 among African Americans and Hispanic Americans is just a new manifestation of a longstanding problem that has been responsible for health inequities for many years in the United States.

MR. INTROCASO: Okay, thank you. Since I mentioned Shorter Lives, Poorer Health, let's go to the report and your more recent related research findings relative to U.S. life expectancy compared to other rich countries. Per the title of the report, why do live shorter lives; can you explain?

DR. WOOLF: Well, I think many Americans operate with a misconception that the United States has the best healthcare system in the world and the best health in the world, but neither is actually true. We were commissioned back in 2012 as you said by the National Research Council and Institute of Medicine with funding from NIH to examine the health of Americans relative to other countries.

By that time, there had already been a growing literature about what we call the U.S. health disadvantage and our expert committee which was multidisciplinary spent a lot of time digging though the data in trying to get a sense of the scope of the problem, and we were really shocked, and in our report, Shorter Lives, Poorer Health, documented on outcome after outcome that Americans are sicker than people in

other peer countries and live shorter lives.

The life expectancy in the United States is the lowest among industrialized countries and it has been this way for quite some time actually.

MR. INTROCASO: Okay, thank you. Let's go to the specifics and drill down here. Over what time period has U.S. life expectancy lost pace with other countries? I mean, this isn't an overnight phenomenon.

DR. WOOLF: Well, that's a very good point because obviously we're dealing in a glaring way right now with our health disadvantage relative to other countries, but this is really not new. We actually started to go into a decline in the 1980s and our report documented this pretty extensively. It used to be that U.S. life expectancy was higher than peer nations. We actually did have among the best health status in the world when I was a young man, but in the 1980s we started to see a fall off.

If you look at graphs of life expectancy for us in the OECD countries, you'll see that the pace of increase in life expectancy that all modern countries had experienced for a century continued in the other

peer nations in the 1980s, but our rate of increase started falling off. By 1998 we crossed the line, and the U.S. life expectancy fell below that of the peer countries, and as of 2010 we had basically plateaued, and for the past few years our life expectancy has been declining, all the while, life expectancy in the other countries has continued, and this was all going on obviously before COVID.

We can talk more about what the pandemic is going to do to these numbers, but even before that occurred, we were in a pretty perilous situation despite the fact that we spend far more on healthcare than any of those peer nations. So we're spending more on healthcare, but we're living shorter lives and we're sicker than the peer nations that are spending less.

MR. INTROCASO: Okay, let's go to what explains what disease conditions and what subpopulations are counting moreover for this fact. So the declining life expectancy can be attributed to, again, what primary disease conditions or behaviors and to what populations?

DR. WOOLF: Well, let me get your audience up

to date because that report came out in 2013. Around 2015, the news media began covering research initially done by the Princeton Economist Anne Case and Angus Deaton showing what appeared to be an increase in death rates in middle-aged white Americans. Subsequent research showed that this was an increase in mortality that was occurring across the working age population from age 25 to 64.

In other words, when we try to unpack this decline in life expectancy, what seems to be driving it is the poorer health of working-age adults. Mortality rates for children, infants, young children, teenagers has been declining, in other words going in the right direction, and mortality rates for older Americans has also been declining. It's this middle group between age 25 and 64 where we've seen an alarming increase in death rates.

Initially this was reported by Case and Deaton in the white population, but subsequent research, including studies that our group has done, showed that it actually has set in with all racial and ethnic groups. So you asked, you know, what diseases are

driving this. Well, the one that's most famous is drug overdoses. The opioid epidemic has had a huge impact on mortality rates really since the 1990s when Oxycontin first came out.

So it's a major contributor, and also there's been an increase in death rates from alcohol-related causes and suicides. That combination, drugs, alcohol, and suicides led Case and Deaton to coin the term, "deaths of despair," because they saw that as a connecting theme between those three causes of death, but actually our research, when you dig into the data, has shown more than 30 causes of death that have all increased for this working-age population, so it includes not only the so-called deaths of despair but also chronic diseases like hypertensive heart disease, obesity, diabetes.

Diseases with very different disease processes what, you know, we in medicine would call the pathophysiology is very different across all these conditions, but what's in common is that the same age group is experiencing this alarming increase in mortality.

And circling back to what we were talking about earlier, this is not happening in other countries. We don't see an increase in mortality in this age group in any other peer nation on the scale that's happening in America.

MR. INTROCASO: Yes, and I'll just reference for you a more recent research. You had a special communication in JAMA last January, January 26, 2019, and per your point, you noted in that the greatest increase in decline was in the middle or among young and middle-age adult's, 25 to 64 as you stated.

Interestingly you stated further that greater still was between the age 25 to 34. That increase in mortality was 6 percent between 2010 and 2017, to further your point, and relative to disease conditions, you do note in that same publication that a mortality increase for upwards of 35 causes of death, so again it's not just the understanding that these are these types of deaths of despair.

Let me ask you if you could break this down a bit further relative to men and women and then by geography because there are some interesting aspects

relative who is being affected and where, moreover.

DR. WOOLF: Right. Well, as a general rule, men die at higher rates than women, so mortality rates for any of these conditions tend to be higher among men than women, but if you think in terms of relative increase, what we find is that there is something alarming happening among American women. The relative increase in mortality for women over these years has been higher than for men for many of these causes of death.

In our 2013 report, Shorter Lives, Poorer Health, we actually compared the probability of men and women surviving to age 50, and when you looked across the various countries, there was a range for most peer nations, but the U.S. was nowhere in the normal range. The probability of a woman surviving to age 50 was far lower in the United States than in any of these peer countries. So already then in our 2013 report, we were raising questions about what's going on with the health of American women. Subsequent studies have continued to show a phenomenon of a women's health disadvantage in the United States.

You mentioned geography and that's actually very important. In our recent studies where we've looked at these national trends in the United States, the decline in life expectancy, the increase in death rates for the working-age population, we were very interested in whether this is a general pattern that's occurring evenly across all 50 states or whether it's concentrated in certain areas.

So we have analyzed the data for all 50 states and for the District Of Columbia, and what we found is that there are particular regions of the country that are driving this trend, most notably the Rust Belt, the industrial Midwest, where a large proportion of the excess deaths that are being caused by this mortality trend have occurred.

In fact, in our recent analysis that was published last year in JAMA, the study that you mentioned earlier, we found that if you calculated how many excess deaths have occurred since 2010 due to this recent mortality increase, fully a third of those occurred in four states in the Ohio Valley, so four Ohio Valley states accounted for one-third of the excess

deaths.

Those areas and the Appalachian area, together, accounted for half of the excess deaths. So there are other regions of the country like California, the Pacific states, and so forth that have been hit much less harshly by this trend. But the geographic clustering of this in certain areas provides important clues about what may be at the root of this.

These are places that have been hard hit by the economy, and when we think about the history that we discussed earlier, that this decline in U.S. health began in the 1980s, we have to put on our thinking cap and think about what was happening in the country in the 70s and 80s that might have set off this decline, and why in particular it would be particularly bad in the Rust Belt states, and it doesn't take too much creativity to begin understanding what's behind that when you think about the collapse of the manufacturing sector and mining industries and so forth in the region that I'm talking about; we begin to see an explanation for this health trend.

MR. INTROCASO: And to further that point,

again in your JAMA piece of last year, you noted that deaths from mental and nervous system disorders were second only to deaths from drug overdoses. Also, too, in that research publication, I found it interesting that you concluded, and I'm quoting here, "If the slow rate of increases in life expectancy persists, it will take the U.S. more than a century to reach the average life expectancy of other high-end countries that had achieved in 2016," so very interesting.

We do have to -- I should ask you, we do know that, as you suggested, there seems to be a correlation between a socioeconomic status particularly in these Rust Belt states, particularly amongst, since Case, Deaton noted, men without a college diploma, and of course as we noted at the start, you did identify COVID's disproportionate effect disease has on minority communities in this country.

But let me ask you this: This health disadvantage that you've stated, Americans have a longstanding pattern of poor health, but this health disadvantage is more pronounced again amongst socially-economically disadvantaged, but also, too, are wealthier

Americans compromised as well?

DR. WOOLF: Well, that's actually a question we confronted head-on back with our 2013 report. We were aware of the criticism of comparisons between the United States and other countries. You know, people will say, "Well, this isn't Norway, it's not Sweden, it's not Japan. The United States is a very large country with a big population. It's very diverse and we know that, you know, people of low income and people of color have higher rates of disease, and maybe the poor standing of the United States is explained by those at-risk populations that are in effect dragging down our numbers and that the rest of America is doing just fine."

Unfortunately, that actually doesn't hold up to scrutiny. When you look at the data you find that, while it's true of course, that people of color and low-income households are doing worse in terms of health, even rich Americans are dying earlier than rich people in other countries. We sliced and diced this multiple ways by income, by education, by smokers and non-smokers, by people with health insurance and not health

insurance, and across all those comparisons, we found a consistent pattern that health in the United States was worse.

So while, you know, being rich or highly educated is a protective factor in the United States in making your health better than it is for other Americans, even the most fortunate in our society, except for perhaps the very, very rich, are doing worse than their counterparts in other countries.

MR. INTROCASO: Okay. And per your research, you did cite per the data with the exception of cancer and cerebral vascular disease, Americans still across the board have higher mortality for most of the other major causes including as you know circulatory disorders, diabetes, infectious diseases, mental and behavioral disorders, diseases of respiratory, nervous, genital, urinary, and muscular skeletal systems, so all those play into this.

Let's now go to the big question, and you did touch upon this, and that is -- and feel free to expand about your comment about socioeconomic status in the Ohio Valley states, but what largely explains our

experiencing poor health and shorter lives?

DR. WOOLF: Well, you know, when you go through that list of diseases you just mentioned there's an obvious takeaway there especially for people who understand, again, the pathophysiology of those diseases. Those are all very different conditions. It would be convenient if we could say, "Well, you know, it's obesity that explains the U.S. health disadvantage," or "It's the fact that, you know, we have more guns," or "It's the fact that we have an opioid epidemic," but when you see the long list of conditions for which Americans have poor health, it's very difficult to try to wrap that around a single cause.

Even this death of despair argument is really not satisfying because that wouldn't explain the increase in deaths from hypertensive heart disease and diabetes and many other conditions, nor would it explain this concentration of the problem in the industrial Midwest or Appalachia. It was, you know, clear to us in our 2013 report, and it has been clear to researchers since then, that there is something systemic going on that's causing this disadvantage.

The way I think of it is that there is a systemic problem that's expressing itself in different ways. It's affecting our health in multiple different ways. To some extent, it's responsible for people turning to drugs, like opioids and alcohol, but it's also leading to gaps in healthcare and the inability of people to manage chronic diseases, and this is a much more logical explanation for the geographic clustering of this in the population groups that seem to be most deeply affected.

MR. INTROCASO: In your IOM report, you do use this phrase, "the antecedence of good health," and you said the antecedents of good health are lacking, and you just touched upon healthcare coverage, so you say, antecedents are lacking in sufficient healthcare quality, the prevalence of health-related behaviors,care ishighly fragmented, limited public health, limited primary care, and enlarged uninsured populations, so that certainly sums up the systemic nature.

You also wrote in a more recent British medical journal that systemic causes for U.S. health disadvantage involve not only deficiencies in

healthcare, prevalence of risky behaviors, but also socioeconomic inequalities, unhealthy environmental conditions, and detrimental public policy, so it's all of the above.

DR. WOOLF: Well, I'd really like to underscore that point because it's certainly something that framed our thinking in that 2013 report, but I think it really becomes very clear when we think about what's going on right now with the pandemic. So in our 2013 report when we saw this terrible health status of the U.S. relative to other countries, that one of our charges was to explain why, what's responsible for this.

And we thought very systematically about what are the different things that affect our health, and we have this misconception in the U.S. that healthcare is what drives our health, but research shows that it only explains about 10 to 20 percent of health outcomes. So what are the other factors that affect our health? You mentioned one, healthy behaviors, you know, whether you smoke, whether you overeat, whether you use drugs, so healthcare health behaviors, but social and economic factors are huge.

So factors like education, income, housing, transportation are all known to be major drivers of health. So that's the third; the fourth is our physical and social environment. That refers not only to the air and water quality that we live in, but also the built environment, whether we live in places where you can exercise, whether there's green space, and the social environment, are we victims of segregation and discrimination, structural racism, or social traumas related to crime and other conditions.

And what's the fifth one? The fifth one affects all of the other four, and that' public policies. So healthcare, health behaviors, physical and social environment, social and economic conditions are all driven by the choices we make as a country, as states, and at community levels, and those are all potential drivers of our health disadvantage. In our 2013 report, we went through all five of those buckets in search of an explanation for the U.S. health disadvantage, and we found the U.S. coming up lacking in all five of those areas.

So for example, you mentioned the issues with

our healthcare system. You know, famously we don't have universal healthcare like the peer nations, but there's other problems with our healthcare system relative to other countries, but also in those other buckets, health behaviors. Americans consume more calories than people in other countries, social and economic factors. We have higher child poverty rates. Our education system has not kept pace with many of the peer countries, and frankly some developing countries.

The social and physical environment, the way we design our cities and, you know, access to healthy forms of transportation and so forth are lacking in the U.S. But importantly, our public policies, the way we go about making decisions in this country has flaws compared to the other countries. I'm not saying that we need to switch over to a different model of governance, but there are aspects of what we do and the way we approach policy in this country that put us at a disadvantage, and COVID is a very poignant example of that.

It sort of puts on display the problems we have in our country, not only in mounting a national

response to a public health crisis, but also how choices made by the 50 states, the fragmentation that we have due to our federal model, leads to very different health outcomes at the state level. It's part of the reason why we've seen a widening gap, even before COVID, in the health of Americans depending on which state they're in. State policies affect our health, and now we've seen that in a huge way with COVID.

MR. INTROCASO: All right I should note since your mention of child poverty in your IOM report, not only do you note it, but you also note children in the U.S. are less likely comparatively to improve their socioeconomic position as they age. Let's go -- my last question of course is, and we touched upon this, and that is, we do know, as suggested. that a health status or this health disadvantage has socioeconomic effects. You recently published a piece in JAMA concerning excess deaths over the first few months of the COVID pandemic.

CDC keeps track of those numbers as well and they're substantial of course, but accompanying your piece was a piece by Cutler and Summers at Harvard that estimated the cost, and again this October JAMA

Viewpoint piece, they estimated the lost GDP output in health reduction added an unbelievable amount of $16 trillion, so what's at stake here, is my question reframed for you, socioeconomically for this country as our shorter lives, poorer health reality continues and has existed as you suggested at the top for quite a long while now?

DR. WOOLF: Well, if you bear with me, let's rewind the tape and go back to November of last year when our JAMA study came out. We had no idea a pandemic was coming, but in that review of the literature up to that point, what scared us, and we tried to emphasize this in the paper, is that this decline in U.S health relative to other countries had huge economic implications, not only because in general it is potentially destabilizing to the country for Americans to be sicker, but the concentration in the working-age population has huge implications for employers.

So our concern was that, you know, having a workforce that is sicker and dying early has potentially huge economic implications for the American competitiveness, even national security issues, and that

was all before COVID came along. Honestly when the pandemic began, I thought about this in terms of what affect this was going to have on the U.S. health disadvantage, and I naively thought that it would be a wash, that we would take a hit, but so would the other countries, it's a global pandemic overall, and that that would basically even out.

What I didn't realize is how badly we would handle the pandemic, and studies now, you know, with the benefit of seeing what's actually occurred, that is the huge death toll in the United States, and our failure to bend the curve as effectively as other countries did, modeling studies are now predicting that the U.S. will take a much bigger hit in life expectancy than other countries.

A recent study just came out showing that's it going to set us back by over a decade, whereas the decline in other countries I think is going to be much more modest, and in some of them no decline at all because of how they handled it. So the widening gap in the health of Americans that we've been tracking all these years is only going to widen further with this.

So, you know, the implications to our economy are huge. So, you know, David Cutler's analysis gives you a sense of the scale of it, but we've been actually paying an economic price for this for some time.

MR. INTROCASO: Right. And so you would say, you noted at the top, U.S. life expectancy stopped increasing in '10, '11 and it actually has been decreasing since '14, so I'm assuming you would suggest or believe that life expectancy will continue to decrease this year and at least for the near term?

DR. WOOLF: Yes, people who were following the news in January may have seen an update from the CDC that had a glimmer of good news that after three consecutive years of declining life expectancy there had been a slight increase in U.S. life expectancy in the most recent year of analysis. That was a short-lived period of optimism because then along came COVID, and, yes, it's quite likely that now we're going to take a huge hit with U.S. life expectancy, and the modeling studies I referred to that said we were going to be set back by over a decade were based on COVID data through September. It's now November and all signs

indicate we're spinning out of control. So it's a very alarming situation in terms of the health of Americans. As a physician that's obviously what I'm most concerned about, but for policymakers who are concerned about the U.S. economy, the warning lights really need attention.

MR. INTROCASO: Okay, Dr. Woolf, that covers what I wanted to discuss during this. I will say relative to COVID, we already have the highest chronic disease burden amongst comparable countries, so that doesn't seem to be going to improve or decrease any time soon. So with that, Dr. Woolf, again thank you for this overview. I'm very appreciative.

DR. WOOLF: It's been a pleasure.

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