

COMMENTS ON POPULIS

1. Without Universal Coverage, Health Care Use Data Do Not Provide Population Health

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WHILE DEEP STRUCTURAL DIFFERENCES ARE readily apparent between the approach of a Canadian province like Manitoba to delivery of health care to its residents and that of a state like Minnesota, both nevertheless address similar public policy questions. Health care in Manitoba, as in all the Canadian provinces, is funded by a single payer, the government, which provides universal coverage. Minnesota, like the other states, has no organized system of health care and does not provide universal coverage, although its percentage of people without health care is the second lowest in the United States. However, in accomplishing this feat, Minnesota, like other government entities—both federal and local—currently pays for about 40 percent of the health care bill (\$5.6 billion in 1993).¹

In reimbursing this considerable share of health care costs, Minnesota is often expected to address issues similar to those faced by Manitoba as the purchaser of all health care within its borders and thus to answer

¹Health economics program, issue brief 75-03, Minnesota Department of Health.

questions like the following: What levels of health exist in different regions? What is the availability of physicians in underserved regions, both rural and urban? What level of health care resources is appropriate to each region? To what degree can financial cuts be made without jeopardizing populations that are "at risk"?

One big difference between Manitoba and Minnesota lies in the information that each has available for analyzing these issues. Manitoba's POPULIS, a built-in administrative data system that was generated from health care bills, provides the province with population health information, and it does so in an extremely cost-effective way. Just beginning to collect similar information on those who have health care coverage or can provide it for themselves in our disorganized multipayer system would require a significant expenditure of funds. Should even this degree of documentation be accomplished, there are still the difficult issues of the uninsured and the underinsured. Collecting the available data on health care does not provide population-based health information that is equivalent to Manitoba's because these two problematic groups are at best handled differently, and may in fact be largely ignored.

The states vary greatly in their ability to collect and analyze health care data. I know of no state that has collected sufficient data to match Manitoba's system. To use an example from Minnesota: in 1993 and 1994, after the passage in 1992 of our first major health care reform legislation, anecdotal evidence surfaced about an exodus of rural physicians from Minnesota as a direct result of the reform legislation. In order to determine what was actually going on, the Joint Legislative Commission on Health Care Access contracted with the Institute for Health Service Research in the School of Public Health at the University of Minnesota to survey Minnesota's rural physicians. To discover which physicians were practicing in rural Minnesota, the institute had to contact every rural hospital and ascertain which physicians were practicing at each facility. Its outreach efforts established a baseline to monitor future changes in this population, but determination of actual flight from rural areas would require this procedure to be repeated and the results of the two surveys compared.

In fact, prior to the passage of the 1992 health care reform legislation, the state of Minnesota did not have the authority to collect data on the provision of any health care except regarding the people whose costs it reimbursed. Our only other available data were supplied by the yearly publication, *Hospital Charges by Diagnosis Related Group*, compiled by

the Council of Hospital Corporations, which represents the hospitals in the Minneapolis–St. Paul metropolitan area. Although this publication was supposed to encourage competition by informing consumers about the fiscal charges imposed by area hospitals for the most commonly used procedures, because the information was collected by the hospitals themselves, its presentation could be “massaged” to keep each hospital happy.

In 1992, as part of the major health care reform legislation passed that year, Minnesota authorized the Department of Health to collect data on all aspects of health care. The state thereby committed itself to controlling the rate of growth of health care costs, to providing increased access to affordable health care for the working poor, to reforming its small business health insurance market, and to maintaining or improving the quality of the health care in Minnesota. To determine the mechanism we would use to control the growth of health care costs, we created a commission made up of representatives from all constituents of the provider community, as well as consumers. We also instituted programs to encourage physicians and nurses to practice in rural areas and worked out an agreement with the medical school of the University of Minnesota to increase the number of primary care physicians it produced and to cut back on the numbers graduating in specialist areas.

At the beginning of 1993, the Health Care Commission recommended that Minnesota adopt a managed competition approach to controlling health care costs. This approach was adopted as part of a legislative package that also introduced the concept of the Minnesota Data Institute, a public–private partnership to facilitate and coordinate health care data systems and to make other required data available once it was collected. The Data Institute will gather and analyze data for report cards on health care systems, comparing them on the basis of client satisfaction and a variety of outcome measures. Should the institute encounter unresolvable problems, the authority to collect health care data will remain with the Department of Health.

The Department of Health is also directly responsible for monitoring health care costs and their rate of increase to determine whether the health plans and various providers are abiding by the legally imposed maximum rates. The collection of these data by the Department of Health and the Data Institute is being phased in over a number of years. We believe that by accessing data either already being collected or currently available in compatible data systems, rather than inaugurating a totally new effort, we can succeed in building the system cost-effectively.

By instituting this new system, we will have access to a great deal of information for making public health care policy; furthermore, in areas like condition-specific data and patient satisfaction, we will have additional, significant information for arriving at policy decisions. Manitoba could add this kind of data to its system as well if it wished to do so. However, there is still a crucial difference between the two data systems: Minnesota will be able to provide information on competing health care systems and on individuals who have health coverage, but not on those who have none; its information on the uninsured will be incomplete at best. In effect, Minnesota will not have a population health information system like Manitoba's until it provides universal coverage.

I am compelled also to observe that without the unique circumstance of our significant health care reform legislation, which passed into law despite opposition from the Minnesota Medical Society, the Council of Hospital Corporations, and the Minnesota Hospital Association, we probably would not have the publicly controlled health data system that is such an important tool in our continuing efforts to formulate public policy.

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