Health

Utah Citizens' Counsel Health Committee

Article 4. All Utahns have the right to comprehensive, quality health care at reasonable cost, and responsible societal efforts to help them achieve and maintain optimal well-being, with appropriate initiatives that encourage and facilitate healthy living and the prevention of disease, disability, and injury.

Introduction

Last year this report (1) continued to seek the expansion of Medicaid for full access to health care and (2) gave new attention to Social Determinants of Health (SDoH, i.e., determinants beyond medical care). These priorities remain this year, along with new opportunities. To improve health and better manage its costs, we urge: (A) expanding Medicaid by passing ballot Proposition 3 in November and (B) improving understanding and use of SDoH, such as air pollution (environmental health report), domestic violence (personal security report), and preschool programs (education report).

The Situation

Overall Measures: (Utah ranks high, while recent improvements and comparisons among states and nations suggest room for further improvements)[1]

The latest health rankings show Utah well within the highest-ranking states in the nation: moving from 8th to 4th in one ranking and maintaining its ranking of 5th in another. Utah is favored by demographics, lifestyles, education, relative income equality, and by the quality and efficiency of its medical care. Further improvements that can make Utah a substantially better place to live and to do business are within our reach.

Access (coming closer to universal access, but slipping in rank)

Failure to expand Medicaid left Utah behind other states and lowered its ranking in respect to the availability and equality of health care. Voter passage of Utah's Proposition 3 to expand Medicaid will add Utah to the 33 states filling the primary hole in insurance coverage.

Cost (now the major issue)

Utah health care costs, per person or per procedure, are among the lowest in the nation. Utah can, however, gain better health and economic advantage by understanding why this is the case. To some extent, the lower costs reflect the relative efficiency and effectiveness of medical care; they also reflect SDoH in the state, such as the low poverty rate. There is room for improvement in both areas.

Quality (arguably a primary means to control cost)

Higher expenditures presumably buy higher quality. In health, this presumption is often wrong. Better health can reduce expenditures. Improving the SDoH presents win-win opportunities.

Opportunities

A. Expand Medicaid

Access continues to be a challenging concern for Utah, with its uninsured rate significantly increasing in 2017.[2] Access can be improved by expanding Medicaid to the adult population under 138% of the federal poverty level (FPL).[3] The UCC once again calls for Utah to move forward with this opportunity.[4] In prior reports the UCC addressed the many positive outcomes Utah is likely to experience by implementing a Medicaid expansion.[5] Recent research continues to verify the benefits realized by states that have already adopted this Medicaid option. Among the positive impacts are: financial benefits to the state,[6] increased adult coverage (without sacrificing coverage for traditional Medicaid enrolled populations), better access to care, better utilization of services, affordability of care, financial security among low-income populations, and improved financial support of rural hospitals.[7] Recent reports also include better employment opportunities, with enrollees in Ohio, for example, reporting that Medicaid enrollment made it easier to seek or maintain employment.[8]

There are now three different Medicaid expansion proposals that would go beyond the recently implemented, though limited, expansion.[9]

1. *Medicaid expansion to 100% of the Federal Poverty Level (FPL) under HB 472. The* Governor has submitted to Centers for Medicare & Medicaid Services (CMS) a demonstration application in alignment with the 2018 House Bill 472 "Medicaid Expansion Revisions." This proposal will expand Medicaid to most adults under 100% of FPL, utilizing the enhanced 90% federal match authorized under the ACA. (Most Utah Medicaid programs receive a federal match rate of approximately 70%.) It also has a community engagement/work requirement[10] that complicates the determination of eligibility. It has the authority to limit enrollment based on the program budget.[11] It is funded utilizing an increase in the Utah hospital assessment.[12]
2. *Enhancement Waiver Program--HB 325.* If CMS fails to approve the HB 472 application, then under HB 325, DOH can add inpatient and outpatient hospital services and specialty physician services to the existing Primary Care Network (PCN) demonstration.[13]
3. *Ballot initiative, Utah Decides Healthcare Act of 2018*. If passed in November, this will provide for a full-benefit adult expansion to 138% FPL utilizing 90% federal matching dollars. It will prohibit reductions in current eligibility standards, benefit levels, and provider reimbursement. It has no enrollment caps and is funded through a 0.15 percentage point state sales tax increase.[14]

Although all 3 approaches have inherent flaws, UCC believes Utah as a whole, and its low-income population in particular, will be far better off under the ballot initiative. Our reasons include:

- It will draw in more federal dollars than the other approaches, allowing the state to take full advantage of the positive financial impacts of the enhanced federal matching dollars.

- It provides a better benefit package to the low-income adult population than do the other approaches and is less costly to that population, which struggles to meet basic living costs in today's economy.
- It is administratively simpler for all system participants, providing the opportunity to eliminate multiple current benefit packages. There would be no need for the PCN program with its limited benefit package, and with the expansion being funded with new revenue, there may be no need to continue with the modest benefit reductions like fewer covered hospital services, speech and audiology services, and some therapy visits that are currently applied to low income parents.[15]
- There is no work requirement under this approach.[16] (Most new recipients already work.)
- The next best option, expansion to 100% FPL under HB472, is unlikely to receive the necessary federal waiver.[17]
- Proposed time limits and work requirements under alternative options dampen access for new populations that critically need coverage, and set a problematic precedent for Utah's Medicaid program, even as recent reports find that coverage is already helping these populations in their employment, their health care, and their health status.[18]

B. Address Social Determinants of Health (SDoH) to improve health and manage costs.

Improving the social determinants of health (SDoH) can upgrade health and help manage costs.[19] A common definition of SDoH is that provided by the World Health Organization:

> The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.[20]

The concept embraces essentially all aspects of society. Definitions can vary, differentiating or consolidating determinants as situations change.[21]

Utah has many opportunities to address SDoH to improve health and lower the costs of health care. These include SDoH in which we are in a relatively good position (e.g., healthy lifestyles) and those in which we are in a relatively poor position (e.g., urban air pollution). Both types of opportunities show up in other committee reports in this year's report. Table 4 in the endnotes illustrates possible connections with recommendations made in other sections of this assessment.[22] Identifying these connections can increase support for their recommendations by identifying health benefits related to them. If this support leads to implementation of the recommendations, that in turn improves health.

For example, a primary concern of the education report is the need for better preschool programs to prepare students for kindergarten. High-quality programs are needed to successfully address young children's academic, emotional, and social development, which research has shown decreases later problems such as drug abuse, incarceration, and dropping out of school.[23]

Our assessment last year suggested two connections, as examples of the way the reports are linked. The first is the recommendation in the environmental health report to encourage shifting

from carbon-fueled energy generation to renewable energy in order to reduce CO_2 emissions that are primary determinants of global warming. Although CO_2 emissions in themselves are not direct health hazards, reducing them by reducing combustion of carbon-based fuels immediately affects the ground-level pollutants of noxious gases and fine particles that constitute major environmental health hazards. Thus, the recommendations to increase the use of renewable energy sources have large direct benefits for promoting health and reducing health care costs. A second connection last year concerned the personal security recommendation for more government research on the dangers of guns and proper regulation of the purchase and storage of guns. Some encouraging efforts are now emerging for reducing domestic violence and suicides.

Next year's report will further these two connections, with special attention to the roles of public health programs and to increasing data resources. Additional attention will go to 1) the long-term connections of preschool preparation and health and (2) more immediate connections between clinical health care and the concerns of public health programs.[24]

In Utah, there are new initiatives to identify and address opportunities to improve health through addressing SDoH. One is a collaborative pilot effort led by Intermountain hospitals and SelectHealth in Ogden and St. George. The effort seeks to improve health by focusing on non-medical factors such as housing instability, utility needs, food insecurity, interpersonal violence, and transportation.[25] Another is a recent symposium about SDoH held at the Kem Gardner Policy Institute.[26] These and other efforts provide enthusiasm and guidance for using SDoH to connect health with other concerns and recommendations in this year's UCC assessment.

Commendations

- **The successful voter initiative, which places on the November ballot an expansion of Medicaid** to the full extent of the provisions of the Affordable Care Act.
- Various, though still generally independent, **efforts by hospitals with other health care providers (1) to make better and better coordinated use of clinical information systems, (2) to engage patients in the understanding and treatment of medical problems, through clinical information systems, and (3) to pursue improved health through SDoH**.
- **The Utah Department of Health's progress, with local health departments and HealthInsight,** in developing and analyzing better measures of medical care.

Recommendations

- **Citizens should vote yes on Proposition 3** to expand Medicaid.
- **Utah should improve its use of Social Determinants of Health** to increase health and reduce its costs.

Endnotes for Article 4 (Health)

[1] The following measures update the overall statistics in our 2017 report. They come from two national reports.
The first report, "America's Health Rankings" "builds upon the World Health Organization's definition of health: "Health is a state of complete physical, mental, and social" well-being.
"America's Health Rankings, 2017" *United Health Foundation*, accessed June 2018, had not been updated for 2018. https://www.americashealthrankings.org/learn/reports/2017-annual-report, 152. The summative ranking places Utah fourth for 2017, climbing from eighth in 2016.
The report uses four "determinants" of health and a summative category of "outcome" of the determinants. The table shows Utah's ranking and examples of measures used for each category.

Determinant Category	Number of Measures	Utah's Rank	Example Measures (determinants and outcomes)	Utah's Rank
Behaviors	6	1	High School Graduation	26
Community and Environment	8	9	Air Pollution	30
Policy	8	35	Public Health Funding	30
Clinical Care	5	15	Preventable Hospitalizations	2
Outcomes	8	2	Diabetes	2

The report offers specific commentaries:
"Strengths: • Low prevalence of smoking • Low percentage of children in poverty • Low cancer death rate.
"Challenges: • Lower number of primary care physicians • High incidence of pertussis • High drug death rate
"Highlights: • In the past five years, drug deaths increased 24% from 18.4 to 22.9 deaths per 100,000 population • In the past five years, smoking decreased 25% from 11.8% to 8.8% of adults • In the past seven years, cancer deaths increased 10% from 1374 to 1505 deaths per 100,000 population • In the past four years, preventable hospitalizations decreased 25% from 37.2 to 27.9 discharges per 1,000 Medicare enrollees • In the past four years, cardiovascular deaths increased 11% from 208.0 to 231.8 deaths per 100,000 population"
In partial updates for 2018, "The state ranks second for senior health and sixth for the health of women and children."
The second referenced national report, "Scorecard on State Health System Performance," measures the professionals, hospitals, insurers, and others directly providing health care. "Commonwealth Fund Scorecard on State Health System Performance, 2017," *Commonwealth Fund,* accessed June, 2018, http://www.commonwealthfund.org/interactives/2017/mar/state-scorecard/#chapter1
These are the categories and Utah's rankings.
www.commonwealthfund.org/~/media/Files/2018%20State%20Scorecard/Utah.pdf498.260857248.1528581184-821125935.1528581184:

Dimension Category	Number of Indicators	Utah's 2018 Rank	Example Indicators	Utah's 2018 Rank
Access and affordability	6	32	Adults 19-64 uninsured	28
Prevention and treatment	16	21	Hospital 30 Day Mortality	35
Avoidable hospital use and cost	13	2	Potentially avoidable E.D. visits	2
Healthy lives	10	1	Deaths amenable to health care	5
Disparity	19	3	Low income uninsured, ages 19-64	31

Compared with the rankings a year ago, Utah maintained its overall ranking of 5. Utah fell from 26th to 32nd in access and affordability (largely a reflection of greater progress made by other states that expanded Medicaid under the Affordable care Act) and from 14 to 21 in prevention and treatment. Utah improved from 8 to 3 in disparity and maintained its rankings of 2 in avoidable hospital use and cost, and 1 in healthy life styles.
An international comparison is provided by Wikipedia's summary of international data showing that in quality the U.S. ranks "26 among the 34 OECD member countries, (even though) it has the highest costs by far. All OECD countries have achieved universal (or almost universal) health coverage, except the U.S. and Mexico.", "Health care," *Wikipedia*, accessed September 6, 2018, https://en.wikipedia.org/wiki/Health_care.
For the rankings last year see: Utah Citizens' Counsel, "Standing Up For Utah's Needs, 2017 Report," 17 (with endnotes 20-21) www.utahcitizenscounsel.org.
[2] Dan Witters, "Uninsured Rate Rises in 17 States in 2017," *Gallup*, accessed July 21, 2018, https://news.gallup.com/poll/233597/uninsured-rate-rises-states-2017.aspx. After passage of the ACA, states using it to expand Medicaid eligibility achieved major decreases in the percentage of their populations without insurance.

States not expanding Medicaid also had a decrease in their uninsured percentage, but at an average decrease of a far smaller amount. Their decrease is attributed to an improving economy, the ACA's expansion of the individual market, and the individual coverage mandate. In 2017 the national uninsured rate increased slightly, by 1.3 percentage points. But Utah's rate increased by 2.1 percentage points, adding to the gap between Utah and states that expanded Medicaid eligibility. Utah's uninsured rate now ranks 31st in the nation.

Utah rates of uninsurance

Without health insurance 2013	Without health insurance 2016	Without health insurance 2017	Change in uninsured 2017 vs 2016
15.6%	9.7%	11.8%	+ 2.1%

"Health Insurance Coverage in the United States: 2017," *United States Census Bureau,* September 2018, accessed September 14, 2018, https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf.

[3] This expansion directly authorized in the Affordable Care Act (ACA) is to 133% of the FPL. The ACA Medicaid Expansion, however, permits the use of Modified Adjusted Gross Income (MAGI) in calculating qualifying income. In certain cases this will allow for up to a 5% disregard of some income, which can create an effective rate of 138% of FPL rather than the statutory 133%.

[4] While UCC applauds Utah for increasing the Medicaid income eligibility limit for parent's eligibility to 60% of poverty ("Utah Medicaid State Plan," *Utah Department of Health Medicaid website*, accessed July 21, 2018, https://health.utah.gov/stplan/spa/S25.pdf), the failure to expand Medicaid more broadly has been an unfortunate missed opportunity to improve low-income Utah residents' access to care and reduce their financial burdens as well as to better support the state's economy and health care providers. The minimal expansion initiative that passed in 2016 was approved by CMS in late 2017, allowing Utah to provide full Medicaid benefits to a very limited number of adults without dependent children, was also a step in the right direction.(CMS website, accessed July 21, 2018, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ut/ut-primary-care-network-ca.pdf. This demonstration amendment provides coverage to adults ages 19-64 with incomes at zero percent of the federal poverty level (FPL) who are chronically homeless or involved in the criminal justice system, and in need of substance use or mental health treatment; or only in need of substance use or mental health treatment.) However, while this expansion helps address some important public policy needs, it is an incomplete and expensive approach, using traditional, rather than enhanced, federal financial support. As discussed in our report last year, the proposal fails to address unfairness in our public health care policies for the uninsured and fails to fully capitalize on the fact that Medicaid expansion improves cost management and total population health. ("Health," in "Standing Up for Utah's Needs, 2016 Report," 22, *Utah Citizens' Counsel,* accessed August 10, 2017, http://www.utahcitizenscounsel.org/). In prior year reports, UCC has pointed to the literature indicating the financial benefits related to expansion utilizing the enhanced 90% federal funding provided under the ACA. We pointed out that the research results generally show positive economic benefits to the states in spite of higher than estimated enrollment. State experiences differ because states differ in program and implementation. Last year's report also pointed to a discussion by Sven Wilson of the potential multiplier effects. He concludes, while "highly skeptical of (large) multipliers (commonly used, in) a full cost-benefit framework where the *direct* benefits of spending on health insurance is [sic]so high, these *indirect* benefits are hardly needed to tip the balance in favor of Medicaid expansion." Sven E. Wilson, "Economic Perspectives on Utah Medicaid Reform under the ACA," 28-9, accessed December 2016," https://medicaid.utah.gov/Documents/pdfs/MedExpansionOption/EconomicPerspectives.pdf, 28-9. Newer studies also support this outcome.

[5] All prior reports can be accessed at http://www.utahcitizenscounsel.org/.

[6] James A. Richardson, Jared J. Llorens, and Roy L. Heidelberg, "Medicaid Expansion and the Louisiana Economy," *LSU Public Administration Institute*, accessed July 21, 2018, http://gov.louisiana.gov/assets/MedicaidExpansion/MedicaidExpansionStudy.pdf. This report has a summary of prior work done for other states in the area of financial benefits. Two of its conclusions are that for Louisiana expansion, "The estimated state tax receipts generated by the infusion of federal dollars exceeded the state dollars budgeted for the Medicaid expansion program by over $50 million and this does not include any net budgetary savings from moving participants from one Medicaid program to Medicaid expansion with the higher FMAP" and "The economic impact associated with the Medicaid expansion program is spread across the state and will be sustained as long as Medicaid expansion is sustained."

[7] Richard C. Lindrooth, Marcelo C. Perraillon, Rose Y. Hardy, and Gregory J. Tung, "Understanding The Relationship Between Medicaid Expansions and Hospital Closures," *Health Affairs*, accessed July 24, 2018, https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0976.

[8] Robin Rudowitz and Larisa Antonisse, "Implications of the ACA Medicaid Expansion: A Look at the Data and Evidence," *Kaiser Family Foundation,* accessed July 21, 2018, https://www.kff.org/medicaid/issue-brief/implications-of-the-aca-medicaid-expansion-a-look-at-the-data-and-evidence/?utm_campaign=KFF-2018-May-Medicaid-Expansion-Costs-Benefits&utm_source=hs_email&utm_medium=email&utm_content=62972269&_hsenc=p2ANqtz-97YeMS9yhi_Htox9qBVzu207j4OxKgSl--F_XehEmsmws7uHj1pZvwF3AgUOsnImPccv-8f_M3t8pzVfAS-V09PAlUBYMRjDpsjfN1Bfjvuy3Dpig&_hsmi=62972269. This has a review of the more current research literature on the impacts of Medicaid expansion. Additionally, see "The Effects Of Medicaid Expansion Under The ACA: A Systematic Review," *Health Affairs*, accessed July21, 2018, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.1491. "After analyzing seventy-seven published studies, we found that expansion was associated with increases in coverage, service use, quality of care, and Medicaid spending. Furthermore, very few studies reported that Medicaid expansion was associated with negative consequences, such as increased wait times for appointments—and those studies tended to use study designs not suited for determining cause and effect."

[9] For a detailed side-by-side comparison of the three approaches, see Laura Summers, "Utah's Expanding Medicaid Coverage: Three Scenarios," *Kem C. Gardner Policy Institute*, accessed October 13, 2018, http://gardner.utah.edu/wp-content/uploads/Medicaid-Expansion-Brief-Final.pdf.

[10] "Utah's 1115 Demonstration Application," *CMS website*, accessed July 21, 2018, https://medicaid.utah.gov/Documents/files/Utah%201115%20PCN%20Waiver-Adult%20Expansion%20Amendment-21Jun18.pdf. Individuals who do not meet an exemption and are required to participate in a work requirement will be referred for participation on the first of the month following approval of the Demonstration program. This will be month one of the three-month participation period (this is the same as SNAP). Individuals will be required to complete participation requirements within the three-month period. Once they have met the work requirement, they will be eligible for the remainder of their eligibility period. Eligibility periods are 12 months. The individual must complete participation requirements every 12 months to continue to receive Medicaid.

[11] "Utah's 1115 Demonstration Application." "The Utah demonstration proposal has several different components, including:

- Adult Expansion to adults ages 19-64 who have household income up to 95 percent of the federal poverty level (FPL) using the modified adjusted gross income (MAGI) methodology, which includes a five percent of FPL income disregard.
- Community Engagement–Requires non-exempt individuals eligible under the demonstration to participate in a work requirement.
- Employer Sponsored Insurance (ESI) – Provides premium reimbursement and wrap-around Medicaid coverage to demonstration-eligible individuals who have access to ESI.
- The ability to limit enrollment based on the available state funding.

[12] There are two major components of this demonstration that CMS may not approve. First, Utah is requesting that the federal government pay the 90% federal financing even though the expansion request goes only to 100% of poverty. CMS has already declined to approve two prior requests for this expansion approach, one from Arkansas, the other from Massachusetts. Both these states would reduce their income limit for expansion adults from 133% FPL to 100% FPL. Some Utah legislators have argued that Utah has a different approach in that the other two states were proposing to reduce an existing income limit, thereby terminating coverage while Utah would be expanding coverage, offing more people Medicaid. However, it is not clear how CMS could make this type of distinction under the terms of 1115 demonstration authority. The second issue is capping adult expansion enrollment based on the available state funding. While the adult expansion population is an optional overage group under original Medicaid, it is not clear that CMS has the legal authority or desire to grant this type of waiver of optional groups' entitlement status under 1115 statute. If CMS were to approve such a waiver, it would not be surprising to see litigation on the issue.

[13] The authority for the PCN program comes from section 1115 of the Social Security Act, which gives the Secretary of the Department of Health and Human Services the authority to waive specific provisions of the Medicaid program law and regulations. This demonstration example will still continue to have significant limitations in its benefit

package, such as providing only 4 prescriptions a month. The current reductions in adult traditional Medicaid benefits and the demonstration enrollees benefit package will also continue.

[14] An effort by a consortium of interest groups led by the Utah Health Policy Project organized the *Ballot Initiative, Utah Decides Healthcare Act of 2018,* which succeeded with the petition drive and now campaigns for November votes to enact the initiative. This was highlighted in the *New York Times* by Robert Pear, "Medicaid Expansion Finds Grass-Roots Support in Conservative Utah," September 9, 2018, accessed September 13, 2018, https://www.nytimes.com/2018/09/09/us/politics/utah-medicaid-expansion.html.

[15] "Utah Medicaid Provider Manual, Non-Traditional Medicaid Plan," accessed October 13, 2018, https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/Archives/Non-Traditional%20Medicaid%20(NTM)%20(Archived%20April%202018)/Archive/2016/NTM-manual4-16.pdf.

[16] UCC believes that work requirements are counter-productive. Most Medicaid recipients are already working. Those that are not are typically either unable to work due to a disability that is preventing them from working even though they are not receiving disability benefits, are retired, are students, or are caring for household members. Those that are working often have more limited education and are in jobs/occupations that are low wage, volatile in nature, have higher unemployment rates, and have had stagnant wages over the past 15 years. Although the Utah requirement is not as onerous as many that are being proposed across the country, it is not clear how this requirement benefits the beneficiaries while it does add extra paperwork burden to many that must meet the requirement as well as many who will be exempt. For more information regarding the characteristics of those who are in the newly eligible population, see:

- "Most Workers in Low-Wage Labor Market Work Substantial Hours, in Volatile Jobs," *The Center for Budget and Policy Priorities*, accessed July 29, 2018, https://www.cbpp.org/research/poverty-and-inequality/most-workers-in-low-wage-labor-market-work-substantial-hours-in?utm_source=CBPP+Email+Updates&utm_campaign=42adc42d06-EMAIL_CAMPAIGN_2018_07_27_08_45&utm_medium=email&utm_term=0_ee3f6da374-42adc42d06-43400417
- Norman J. Waitzman, "Who would be newly eligible for coverage under the Healthy Utah Plan, or Full Medicaid Expansion? A Demographic and Labor Market Profile," 2014 presentation to Utah Legislature's [was this a legislative task force?]Health Reform Task Force, accessed July 29, 2018, https://le.utah.gov/interim/2014/pdf/00003826.pdf.

[17] Although there are problems with this approach as described in above endnotes, UCC believes this is preferred to the enhanced PCN waiver with its reduced benefit package along with its capped enrollment and proposed work requirement.

[18] "Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly," *Ohio Department of Medicaid*, accessed July 30, 2017, http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf; Drew Altman, "No, Medicaid Isn't Broken," *Axios*, accessed July 30, 2018, https://www.axios.com/no-medicaid-isnt-broken-2404950733.html.

[19] "Research demonstrates that improving population health and achieving health equity will require broad approaches that address social, economic, and environmental factors that influence health." From "Beyond Health Care: The role of Social Determinants in Promoting Health and Health Equity," *Kaiser Family Foundation*, accessed September 9, 2018, https://www.kff.org/search/?s=Social+determinants+of+health.

[20] "Social determinants of health," *World Health Organization*, accessed September 8, 2018, http://www.who.int/social_determinants/sdh_definition/en/.

[21] Common variations illustrate the purposeful openness of the concept, explain its meaning and use. See, e.g., the quote below from *U.S. Centers for Disease Control (CDC)*, accessed September 9, 2018, https://www.cdc.gov/socialdeterminants/.

"Conditions in the places where people live, learn, work, and play affect a wide range of health risks and outcomes. These conditions are known as social determinants of health (SDOH). We know that poverty limits access to healthy foods and safe neighborhoods and that more education is a predictor of better health. We also know that differences in health are striking in communities with poor SDOH such as unstable housing, low income, unsafe neighborhoods, or substandard education. By applying what we know about SDOH, we can not only improve individual and population health but also advance health equity." See other language below from "An Opportunity to Address Societal Determinants of Health," *Healthy People 2020*, accessed September 8, 2018 https://www.healthypeople.gov/2010/hp2020/advisory/societaldeterminantshealth.htm.

"We know that taking care of ourselves by eating well and staying active, not smoking, getting the recommended immunizations and screening tests, and seeing a doctor when we are sick all influence our health″ but "there is growing recognition that *social and economic factors shape individuals' ability to engage in healthy behaviors.* For example, children born to parents who have not completed high school are more likely to live in an environment that poses barriers to health such as lack of safety, exposed garbage, and substandard housing. They also are less likely to have sidewalks, parks or playgrounds, recreation centers, or a library. Social norms and attitudes, such as discrimination, racism and distrust of government; exposure to crime, violence and social disorder; residential segregation, language and literacy challenges; and socioeconomic problems such as concentrated poverty; all affect health. Further evidence shows that *stress* negatively affects health across the lifespan, and that environmental factors may have multi-generational impacts."

"Addressing social determinants of health is not only important for improving overall health, but also for reducing the disparities, and hence the inequality, influenced by social and economic disparities. Resources that enhance quality of life have a significant influence on population health outcomes. Examples of these resources include safe and affordable housing, access to quality education, public safety, and availability of healthy foods, local emergency and health services, and environments free of life-threatening toxins."

Healthy People 2020 is highlighting the breadth of concerns by emphasizing the goal of "creating social and physical environments that promote good health for all." This broad emphasis is also in the work of the World Health Organization and that of other U.S. health initiatives such as the National Partnership for Action to End Health Disparities, the National Prevention and Health Promotion Strategy, and such professional and institutional organizations as those of land use planners, public health officers, and health insurers. Some initiatives seek to increase the focus on health in non-health sectors, while others focus on having the health care system address broader social and environmental factors that influence health. The Utah Citizens' Counsel has the broader concern, with the health and equity impacts of both social and physical situations and programs.

[22] Examples of possible relationships of SDoH to Utah Citizen Counsel's committee reports.

Examples of SDoH

Chapter topic particular concern	**Examples of related SDoH**	**How SDoH can be improved**	**How health then is improved**
Equal Rights **Equal in law, dignity and opportunity**	**Economic opportunities; income disparities; and employment**	**Equal opportunity for women, children, low income, and minorities**	**Life expectancy and infant mortality by race and income**
Environmental Health **Air & water pollution and global warming**	**CO_2 emissions; DEQ measures of pollution; water availability**	**Shifting to renewable resources and economic incentives**	**Reduced burdens of chronic disease**
Public Education **Investment in preschool education**	**Kindergarten readiness**	**High quality preschool, e.g. for those of limited English or income**	**Improved physical and mental health of children and mothers**
Health **Health promotion programs**	**Healthy life styles (diets, exercise, habits, immunizations, etc.)**	**Coordinating public health and insurers' programs**	**Disease prevention**
Personal Security **Domestic and gun violence**	**Status of women; pervasive level of gun violence**	**Education re gender equality, base gun laws on scientific data**	**Reduced premature deaths and physical and emotional trauma**
Social Support **Family needs, focus on young children**	**Toxic stress in housing; healthy family life; Income status**	**Quality housing and its environment; income v. costs of living**	**Incidence and costs of environmental and income-related disease**
Participatory Governance **Equal representation**	**Trust in election processes and government officials**	**Citizens' trust in gov't fairness, transparency, and accountability**	**Citizen commitment to community progress in the public's health**

[24] "Standing Up For Utah's Needs, 2017 Report, Health Chapter and recommendations," *Utah Citizens' Counsel*, *www.utahcitizenscounsel.org*.
[25] "New Alliance Seeks to Promote Health and Prevent Illness by Addressing Social Determinants of Health in Ogden, St. George," *Intermountain News Release*, June 27, 2018.
[26] "Data Points, Social Determinants of Health," *Kem Gardner Policy Institute, University of Utah*, August 2018.