

## **ALTARUM POLICY ROUNDTABLE**

### **Measuring Human Development in America**

**With Sarah Burd-Sharps and Kristen Lewis  
Co-directors of the American Human  
Development Project  
and co-authors of  
Measure of America: American Human  
Development Report 2008-2009**

**and**

**Sherry Glied, Ph.D., Chair of the Department  
of Health Policy and Management,  
Mailman School of Public Health,  
Columbia University**

Washington, DC  
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**ROUNDTABLE REPORT**

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## Measuring Human Development in America

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# Altarum Policy Roundtable

## Measuring Human Development in America

### I. Roundtable Purpose and Overview

Development—in national, aggregate form—has traditionally been measured not in terms of human health or well-being but in terms of economic attainment, with a nation’s Gross Domestic Product (GDP) as the prevailing statistic. But just how accurate is that indicator? What does *human* development really mean? Does economic prosperity equate with overall well-being? Is there a better, more comprehensive metric?

Working at the World Bank, Pakistani economist Dr. Mahbub ul Haq noticed that in comparing the national development of Vietnam with that of Pakistan—at a time when both nations had a per capita GDP of around \$2,000—the Vietnamese were living about eight years longer. In addition, Vietnam had a far higher overall level of literacy at 93% compared to that of Pakistan at 40%. This finding, demonstrating that GDP failed to account for, or failed to reflect, the very different ways in which per capita income was being invested in people, and thus producing different outcomes, set Dr. Mahbub ul Haq on a path to a new approach.

Dr. Mahbub ul Haq teamed up with Indian economist, and Nobel Laureate, Dr. Amartya Sen, to help define human development as the *attainment of opportunities to reach an improved state of well-being*. In 1990, the two economists and others produced the first Human Development Report for the United Nations Development Programme. The report, now published yearly, uses their innovative Human Development Index (HDI) as a key measure of a population’s well-being.

The composite HDI *is an easy-to-understand numerical measure, made up of what most people believe are the very basic ingredients of human well-being: **health, education** and **income***. The HDI is currently used as an official government statistic by many nations and forms the backbone of their national efforts to improve the well-being of their populations.

At Altarum Institute, we have been working to develop indices that would help us better understand and measure our nation’s health status. We have asked ourselves: could the U.S. make use of something like an HDI specifically designed to capture the conditions in our nation? What insights could such an index provide our people, our policy makers and in particular those involved in health systems policy? If such an index were used, what research priorities and systems advances could its findings suggest?

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On July 16, 2008, the American Human Development Project (AHDP) published, *Measure of America: American Human Development Report 2008-2009*. The Project is a nonpartisan, nonprofit initiative, unaffiliated with the U.N., and established to introduce the HDI to the U.S. The project's mission is to stimulate fact-based public debate about human development issues in the U. S. Co-founders Sarah Burd-Sharps and Kristen Lewis formed the project in 2006 with funding from Oxfam America, Conrad N. Hilton Foundation, The Rockefeller Foundation, and the Social Science Research Council, with additional funding from the Annenberg Foundation. The 2008 report is their first. They plan to update it biennially.

On October 23, 2008, Altarum Institute hosted Sarah Burd-Sharps and Kristen Lewis and Sherry Glied, Ph.D., Chair of the Department of Health Policy and Management, Mailman School of Public Health, Columbia University, in a roundtable discussion about the American Human Development Index (AHDI) and Report.

The roundtable format had three components: a two-part presentation of the AHDI and Report split between Ms. Burd-Sharps and Ms. Lewis; a follow-up policy implications commentary by Dr. Glied; and a question and answer period with meeting participants from around the country.

Prior to the roundtable, participants were encouraged to review background material available on the American Human Development Project's website:  
<http://measureofamerica.org>.

Invited meeting participants from around the country were able to watch via video teleconference and listen via teleconference. Participants included health researchers and policy analysts, U.S. government officials, and Altarum Institute clients, partners and senior staff. A list of attendees can be found in Appendix B and the speakers' brief biographies appear in Appendix C.

The following is a report of the roundtable proceedings.

Jeff Moore, Altarum Institute's Senior Vice President for Development and Public Affairs welcomed the speakers and invited guests, and prefaced the roundtable by stating:

*"The Measure of America Report caught my eye because as an institute of systems researchers we like data, like to measure things, like to evaluate. And for some time we have been looking at this question of indices, measures we might know to exist or think about creating that would help us better understand health status in the U.S. So, we encourage you to talk to us about the methodology, about the research, about the measures and the product that is your report. I also encourage you to talk to us about what you see as the emerging research agenda in the health care space that comes out of your work. How do we begin to think about the research agenda in health care that ultimately turns the dial on this metric?"*

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## II. The Measure of America Presentations: Key Observations

*Kristen Lewis* set the stage for the two presentations that would follow by addressing three issues: what is human development? What measures did her project use to produce the AHDI? And what does the AHDI reveal?

### Human Development

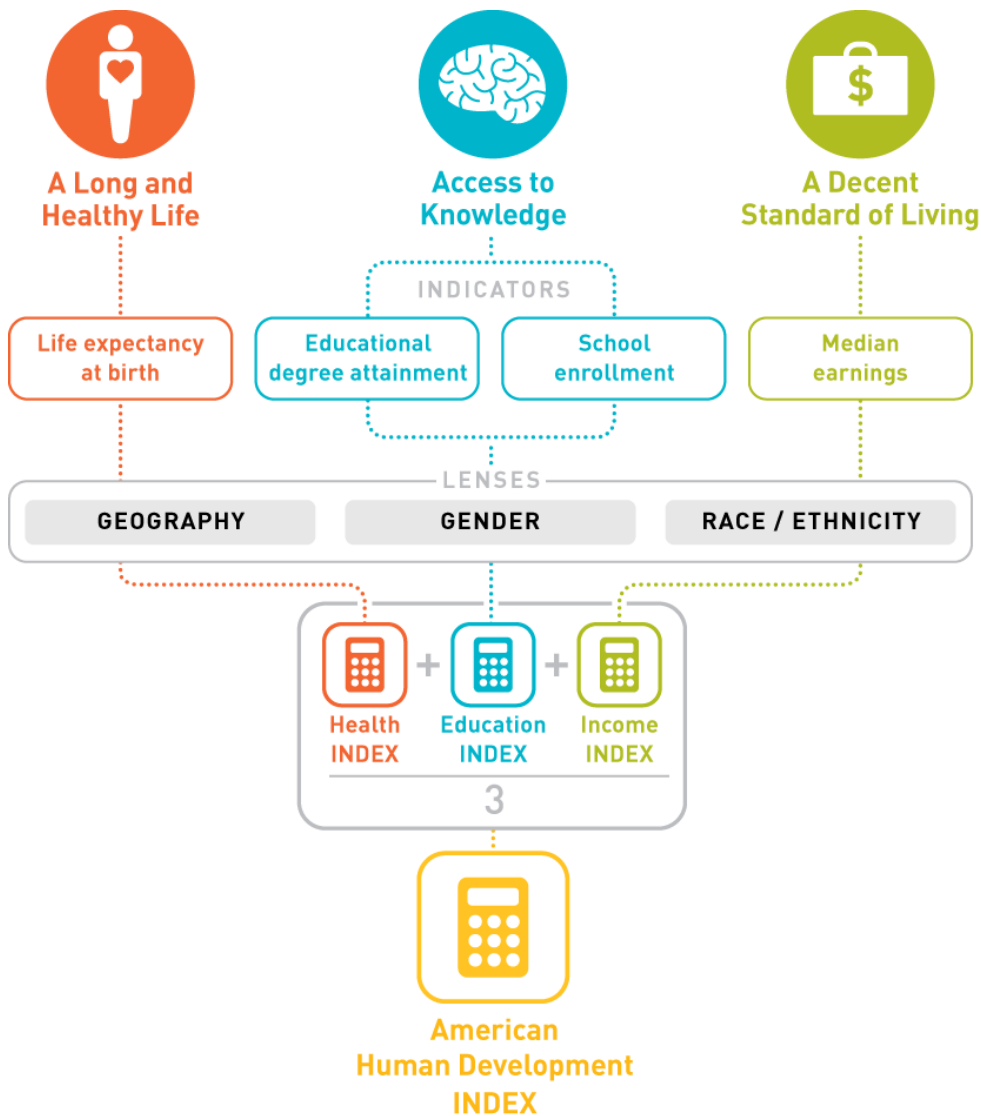
Lewis defined human development as “the process of enlarging people’s freedoms and opportunities and improving their well-being.” She said that “actual human development occurs when opportunities and choices are expanded, not only when GDP grows.”

### Measures

The American Human Development Index (AHDI) uses data from the American Community Survey, U.S. Census Bureau, 2005, to measure the same three categories as the U.N.’s Human Development Index (HDI). “We then take them together and divide by three to get our AHDI, which is a measure from zero to ten, zero being low, ten being high.”

But, the AHDI tweaks the HDI measures to better capture the U.S. picture. In the AHDI, **health** is measured by life expectancy at birth; **knowledge** is measured by a combination of educational degree attainment among those 25 years of age and older and school enrollment among those in the range from three to 24 years of age; and **standard of living** is measured by using median earnings. Lewis acknowledged that the index does not include environmental issues or political participation, community safety, and many things that are typically important to people's abilities to seek opportunities and to develop into the person that they want to become.

See figure 1 on the following page.



## Findings

The AHDP did a historical U.S. index for every decade from 1960 to 2000 and then again in 2005 and found steady overall progress. In 1960, the U.S. overall AHDI score was 1.23, but by 2005 it was 5.05—a nearly fourfold increase. Life expectancy alone rose from 69.7 years to 77.9 years over the same 45 year span and the U.S. economy grew exponentially. In terms of high school diplomas, people are graduating from high school at twice the rate they were in 1960 and in terms of bachelor's degrees and professional degrees about four times as much.

But Lewis stressed two trends that cast that progress in a different light: first, other countries have progressed more quickly than the U.S. over the past quarter century. In 1980, the U.S. was ranked number two in human development, behind Switzerland and ahead of such countries as Iceland, Norway, Australia, Canada, Ireland, Sweden, the

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Netherlands, Japan, Finland and France. By 2005, the U.S. score had steadily decreased and was twelfth on the list, behind all of the mentioned countries.

Lewis underscored the second trend as indicative of the sources of that decrease. The index shows us an average, “the country as a whole, but lots of people are being left behind and not all are being left behind in the same way. For some groups, health is a real challenge where for others education is the critical issue.” In overall terms, our median earnings have decreased over the past decade and the discrepancies in AHDI scores between and within U.S. states and within individual indicators are telling. These discrepancies, and their root causes, have largely gone unaddressed, and are individually and collectively contributing to the lower scores.

The AHDI figures show that the top ranked state (Connecticut at 6.37) scored almost twice what the lowest state (Mississippi at 3.58) scored. Mississippi’s current AHDI is what the country’s was nearly a generation ago. In 2005, the top U.S. state in “life expectancy at birth” was Hawaii at 81.7 years, while the lowest was Washington, D.C. at 73.8 years—a difference of almost 8 years. As a country, our average national life expectancy at birth was last at 73 years in 1980, a generation ago.

The 2005 median earnings in California’s 20<sup>th</sup> Congressional District (CD) were \$16,767 while the median earnings of New York’s 14<sup>th</sup> CD were \$51,139—a 67% difference. Within California, 95% of adults 25 years old and older in the 30<sup>th</sup> CD had at least a high school diploma; while in the state’s 20<sup>th</sup> CD only 52.6% had at least a high school diploma—a 42.4% disparity.

Lewis concluded by saying:

The disparities are also clear between racial and ethnic groups. Asian Americans have the highest overall human development scores in the country, followed by Whites, then Latinos, then Native Americans and African-Americans are last in this index, which is largely because of health scores. And if we just aggregate by race, gender and ethnicity altogether Asian men are at the top and African-American men are at the bottom on this well-being score. African-American men are living shorter lives today than the average American lived in 1960. Asian Americans again are at the top in terms of health, followed by Latinos, Whites, Native Americans, and finally African Americans.

*Sarah Burd-Sharps* couched her presentation in terms of two major issues: What does the health component of the AHDI reveal? And what will it take to boost the overall AHDI score?

### **AHDI: Health**

Burd-Sharps began by asking “given U.S. advances and resources why is it that we routinely talk about a health care system in crisis?” She pointed to five focus issues: **accountability, rationing, prevention, protecting the next generation and un-**

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**insurance.** She stressed that these were “not the only five issues, but critical issues, some of which are being discussed and others of which aren't on the table at all, but that are really a big part of why our health care system is in crisis.”

### Accountability

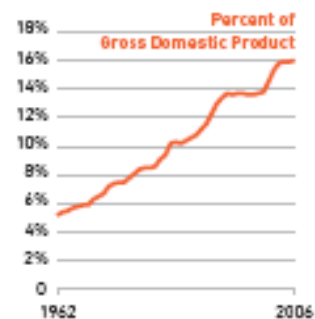
When the project began doing research on the health component of the report the authors started by looking for the country's targets—what the U.S. has set as national health goals. They found the benchmarks in the U.S. Department of Health and Human Services' Healthy People 2010, a continuation of the efforts of Healthy People 2000. The initiative establishes 467 specific national health objectives and two big goals—to increase lifespan and to eliminate health disparities. So using the two big goals as measures and looking at the life expectancy findings of the AHDI at 2005, the half-way mark from 2000 to 2010, the study clearly documents a tremendous national failure to reach the stated goal of eliminating disparities. The question then becomes, who is accountable for this?

The authors then used the national health statistics data to obtain the leading causes of death for the country as a whole and for the five major ethnic groups. They found a number of continuing disparities. For example, homicide rate is the 15<sup>th</sup> most common cause of death for the country as a whole, yet it is the number six cause of death among African-Americans and number seven among Latinos. Another glaring disparity is in the number of new AIDS cases between 1990 and 2004. Among Whites new AIDS cases halved in this time frame, whereas among African-Americans and Native Americans it went up. So, the authors argued, the U.S. has failed to reduce disparities on widely agreed targets. But who is responsible for setting and attaining those targets? Where is the accountability?

### Rationing

Using a table at the presentation, Burd-Sharps pointed to expenditures on health as a percentage of GDP since 1962, when it was about 5% compared to today when it is above 16%. “To get a handle on expenditures, we are going to have to ask: who gets treated, who doesn't, and who decides? Our system today is mostly set up to serve those who can pay, and the elderly through Medicare. What if we rationed health care by a different measure--who is affected the most? How do we balance individual and public health, how do we prioritize the types of universally needed services and those that are specialized procedures? If you look at our peer countries, the way they prioritize their health care spending is on certain medical systems. We may have to do the same.”

**National Health Expenditures as a Percentage of GDP**



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## Prevention

The bulk of U.S. health care resources go to medical treatment and medical research, yet the progress which the AHDR has identified in its historical trend data came from public health investment. It came from wearing seat belts and helmets, from requiring cigarette warnings and imposing cleaner water and air standards. Burd-Sharps then offered two case studies.

Minnesota has the second highest lifespan of any state in the country and in terms of public health spending they spend 50% above the national average. It is interesting to note that in recent public health issues such as identifying tainted foods, it is often Minnesota that found it first. They have a strong and very effective public health machine there. They also invest heavily in recreational infrastructure, particularly walking paths for the aging, so that people can get physical activity. When you look at scales of physical activity, they are near the top. They also have one of the lowest rates of un-insurance.

My second case study is about the issue of obesity. As I am sure you all are and many people are aware, it is a growing epidemic—extremely serious for us as a society. Now, from a simple perspective we can say they need to change what they eat and they need to get more exercise. Most people know that is the answer, but it doesn't seem to be helping the situation. So how can we as a society invest in an enabling environment that helps people adopt healthy behaviors? If you live in an area where there is plenty of walking and biking paths and recreational facilities, it is less of a challenge to get exercise.

The U.S. Census Bureau does this excellent study called *A Child's Day*, and the most recent one showed that 48% of urban Latino parents don't let their kids play outside in their neighborhoods because of fear of danger for their children on the streets. So one says, "yes, it would be great if we all got more exercise, but some of us live in a context where it is not always safe for kids to get exercise." I think it is really important to look more broadly at other issues that impact addressing our obesity epidemic.

## Protecting the Next Generation

All Western European countries have a lower infant mortality rate than the U.S. If the U.S. had that number-one ranking, over 21,000 babies would have lived to celebrate their first birthday instead of dying prematurely.

To use a recent UNICEF report card on child health and well-being measures. The U.S. is at the very bottom in terms of child poverty compared to our peer nations. In terms of physical activity we are number three, but then in terms of overweight, in the category Young People age 13 to 15 who report being overweight, the U.S. is off the charts. In teenage fertility per 1,000 women the U.S. has the highest rate 46 per 1,000. In terms of accidental deaths the U.S. was worse than all countries but New Zealand.

The U.S. record, despite decades of focusing on infant mortality is poor. In fact, there has been a recent rise in infant mortality rates in the Southeastern states. Despite our tremendous prosperity, we are not caring enough for our most vulnerable population.

## Un-insurance

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President Truman said, at his state of the union address in 1949: *In a nation as rich at ours, it is a shocking fact that tens of millions lack adequate medical care. We must have without further delay a system of prepaid medical insurance to enable every American to afford good health care.* It is sobering to realize that 60 years later the nation is still talking about this issue and millions in the country are still without health insurance.

**AHDI: How do we boost the overall AHDI scores?**

The AHDR identified eight major issues that need to be addressed in order for the U.S. to raise its AHDI score.

**In terms of health:** we need to **promote prevention** and **make health care affordable** for all.

**In terms of education:** focus on **modernizing the educational system** to address the needs of a global economy and **invest in at-risk kids**, the earlier the better.

**In terms of income:** implement **family friendly workplace policies**, to better balance work responsibilities with home responsibilities and **help people build assets** so they can invest in the next generation.

**In overall terms:** **attend to the most vulnerable**, implementing a concerted and sustained effort to bring back the Gulf States and to find ways of ensuring that the burden of care for particularly vulnerable populations does not fall on their immediate families.

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### III. Policy Implications of Health Findings Presentation: Key Observations

*Sherry Glied, Ph.D.*, followed up on the Lewis and Burd-Sharps presentations by summarizing the salient AHDI health component issues relevant to the top five policy formulation issues: Accountability, Rationing, Prevention, Protecting the Next Generation and Un-insurance. She said:

As we have known for some time, U.S. health systems are pretty weak by international standards. But I think what is interesting about the new perspective the AHDR brings us is that it shows us the tremendous variability of development within the U.S., across geographic regions and across populations. Within that context, I want to have us think about **policy that is data driven**—how we can use our data and exploit it to really make policy address the problems that we have. Also, we need to understand that **health care**, perhaps even more than education or income, **is truly a local phenomenon**. People's health outcomes depend on a local environment, local patterns of behavior, and local availability of food; and it depends as we are increasingly coming to know on the local provider system, the local public health system. So whittling down to small areas, Congressional districts and states, is a really important tool, particularly in the health field because if we are going to make progress it is going to be by improving health at the patient / provider, patient / public health department and community levels as we move forward. So within this context of variability and a data driven focus on local health issues, I want to talk to the five issues Sarah raised in terms of thinking about U.S. health and health care systems going forward.

**Accountability.** In the U.S., current incentives and rewards result in the provision of a lot of health care to a few people. We are now moving to a focus on pay-for-performance, and on adverse events in hospitals rather than thinking about the health care system as a whole. Our focus should be on the outcomes we want out of the system and whether we can reward their occurrence. And the first step is measurement—we need frequent, detailed assessments of populations and outcomes. We need to come up with standardized ways of thinking about things so everyone is focused to get the same outcome. Then we move to standards and work with communities and providers to ensure these are attainable. Then, finally, as the standards are met, we need to reward that kind of accountability.

**Rationing.** The reality is that we don't have any evidence either within the U.S. or across other countries that higher costs produce better outcomes in the health care system. There is a lot of evidence we are wasting money in the sense of spending money we are not getting anything for—we are not getting what we pay for. We are spending lots of money in places where the health outcomes are pretty lousy, instead of investing in things that are working. We think about rationing – but we should think about moving the U.S. to look more like Minnesota or like Boston. Dr. Glied then said:

There is a study that compares three of the hospitals honored on the U.S. News & World Report's best medical centers in America, UCLA, Massachusetts General Hospital, and the Mayo Clinic. What you see is twice as much spending in the UCLA center than the Mayo Clinic and the worst quality scores at UCLA. So if we follow the Mayo Clinic's example we can cut costs and raise quality and not have waiting lists or any of the other things that scare us about other people's health care systems.

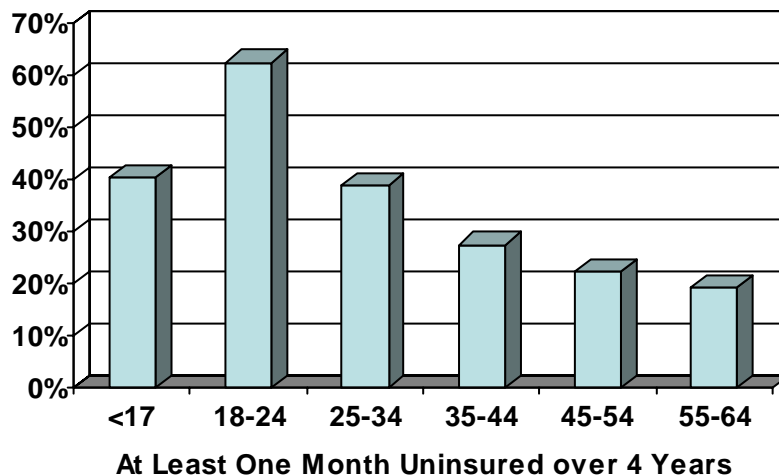
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**Prevention.** We looked at what the leading causes of death are in the U. S., but we can go further and break those down into the causes of the causes of death, and if you do you find they are actually tobacco-related or hypertension-related or cholesterol-related or obesity-related or accident-related and these are causes, measures where we can intervene. We have interventions that work in each one of these areas and I think there are ways we can make them better. For example, Dr. Glied said:

In New York City, the Commissioner of Health has been a very aggressive user of data and has been very interested in trying to reduce smoking related deaths in the city by passing regulations like no smoking in workplaces, but also by using mapping techniques like the AHDR does to try and find the areas where people are not stopping smoking and getting into those areas and trying to make interventions that are targeted at populations. Another way to think about it is using micro-data to try to design things better. Prevention involves looking at where the causes of ill health stem from.

**Protecting the next generation.** It is important to help kids as kids, before they come to adulthood, to address issues early. We do this in part by understanding long-term trends in mortality rates for different age groups in the U.S. Understanding the causes of death in these populations helps in preventing accidents and vaccinating for preventable illnesses. Also, we need improvements in the health insurance coverage of kids, particularly in getting to those children who are eligible for coverage but not enrolled. We also need to help get family interventions for at-risk families. These are all on the policy table, but they need to be taken up if we are really going to make progress.

**Un-insurance.** Showing a slide, Dr. Glied pointed out: “This is a four-year picture of how many people are uninsured and what you can see is that if you take the high risk age groups, people 45 and over, about 20% of that population has a spell of un-insurance over four years. It seems to me absolutely ludicrous to imagine we can fix the other problems in our system, in any systematic way, when 20% of the people in the system are falling out of the system, for at least a month every four years.”



Source: SIPP, Census Bureau 2003

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In closing Dr. Glied reiterated the fact that the AHDR mentions there are at least 25 known effective models to get universal coverage in use in other nations around the globe—“we need to come up with one that can work in the U.S. too.”

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## IV. Questions and Answers

**Question:** What is really striking to me is that the downward movement in the HDI for the U.S. is very rapid and started sometime between 1990 and 1995. To see these statistics without something dramatic happening is rare, so I am looking for a little bit more of the why and particularly demographically if there is anything that you looked into. I am wondering about immigration and the effect of immigration during that period, particularly when you talk about education and income. What are your thoughts on this?

**Answer:** Just to clarify, first of all, this information is not from our index. The data is taken from the Global Human Development Report, which publishes an index every year, and an every five-year trend of the index. The second thing is it is a photo finish at the top. The differences are very small. I think the reason that we brought this out is because it is not going up from two to three to four to one to whatever. It is really a big drop over time. Now in terms of why the drop, in terms of health, what I can say is that we have not made the kind of progress that our peer nations have and in terms of income as well.

**Question:** What else goes into this U.S. index besides life expectancy?

**Answer:** That's it.

**Question:** How much do you break down the costs of health care as a statistic when you have high pharmaceutical costs? Do you go into those kinds of costs as well?

**Answer:** No, just preventative versus actual care is the division we made.

**Question:** Could you elaborate that point a little bit and make a distinction between prevention and actual care, how great is the line and how do you define that?

**Answer:** We draw this on secondary sources that the lion's share of gains have come from public health and the lion's share of expenses go to medical treatments and that is not the best way for us to be spending all of our money. We should spend more in the area of prevention.

**Comment:** I think your point is well-taken, but a lot of the medical expenses now are being considered secondary prevention.

**Question:** I had a question based on the comparison between our shorter lives to virtually every Western European country. We have a much more diverse population here. I didn't see any African or South American countries ranked above us yet a large portion of our population is of African or South American descent. Has there been any effort to compare, for example, how Asian American men and women in the U.S. compare to, those in Japan, for example? If you take a large population of Japanese Americans, do

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they do better here or have they done better historically in Japan? The same might be said for the Hispanic population.

**Answer:** Yes. There is a fair amount of literature on some of those groups so that we know Japanese Americans do worse than Japanese in Japan and Hispanics do about the same when they first get here and worse in the second generation. So the data doesn't suggest that people do better by moving here. To add to that, there is literature which shows that, in fact, Latinos are arriving in this country with a higher life expectancy than most citizens and five years later after assimilating to our many things, including junk food and lack of exercise and being subjected to high levels of un-insurance, because often they are doing jobs where their employer doesn't offer them benefits, their life expectancy goes in the other direction.

**Question:** In your income or earnings category you use people 16 and over. I wondered why you chose to go down to 16 years?

**Answer:** That was a census category. That is how we were able to collect the information, and we know the earnings figures can seem low to lots of people but they encompass full and part-time workers. And if we aggregate by gender, and you are looking at a woman's earnings and say she is working part-time and is married to a hedge fund manager, obviously her material standard of well-being is higher than her earnings alone would suggest, but we felt that that was an okay risk to take, because we wanted to aggregate this by gender.

**Question:** I have a question for professor Glied. Your chart that is comparing academic medical center costs, Medicare costs, it is one thing to show that disparity. Do you have some thoughts on a mechanism by which that disparity would be diminished?

**Answer:** That is the \$50,000 per person question, right? Well, we do know that the disparity is correlated with certain characteristics of the health care system, including the number of hospital beds, the size of ICU's and other capacity measures, and we also know that our payment system doesn't do a whole lot to reduce the disparities over time, so I think that both of those avenues are directions in which we might go.

**Question:** Have you looked at migration patterns to see if, first of all, this information is available to people? Or they intuit this information from somewhere, and that is sufficient to draw them to better states, like Minnesota, or even to draw them to given counties?

**Answer:** Migration is a huge issue around New York City, Washington, D.C., L.A. and San Francisco—markets and metropolitan areas that are attracting a very educated work force and they are getting paid a lot of money. It is also particularly clear when you look at the Washington, D.C. example. You have the lowest life expectancy in D.C. and then you have the highest educational index and the highest income. This is because there are two populations in a sense. One is coming here to work and brings a high degree of educational attainment and then ends up going elsewhere to die at a very late age. Meanwhile the people who are being born and staying in D.C. are a different population,

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with much lower life expectancy. So we try to flag it when there are big anomalies but it is difficult to do because we are working with census data which gives you who is there at the moment the census form is being filled out, it doesn't account for migration.

**Question:** How does one make the Mississippi Delta more like Minnesota or New York? What are the levers that have to begin moving some of these things?

**Answer:** One thing we had suggested in our recommendations for moving the scores up was something like a Marshall plan, also known as the European Recovery Program, which rebuilt Europe after the devastation of World War II. We were thinking of this in terms of a concerted effort to rebuild institutions that can deliver health services and quality education and so forth. There has not been a lot of investment by the country as a whole in these most needy areas, and we have the resources, certainly.

We did some focus groups around this issue; we went about two years ago, a year after Katrina. What really struck us was that it was the church and other who were actually helping people, not professional builders. They were wearing identifying T-shirts and doing their level best to help, but they often have no expertise, and so they were building houses not knowing how to pour concrete. We have the national resources to act, but it didn't come and it ends up being the good will of citizens that makes brings about any relief.

**Question:** How do you see this index being used?

**Answer:** Our goal is to put out a report every two years, and in addition we are working with different groups to create things like state guides or community guides where communities and states can do themselves their own segregated index. We are working with charities and with the United Way about how they might adapt our index to progress against goals that they have set. For example, Catholic Charities have a poverty and health campaign and we have worked with them to consider what indicators they can use to check their progress. So we are working with groups about adapting this methodology, and still using the same framework. They are excited about this human development framework and found it a good way to articulate to their membership what it is that they are trying to do, and the objective they are trying to move toward.

**Question:** Are you aware of any efforts to combine all of these international data sets on these various indexes and the characteristics of the demographics of the countries and the time trends? It just strikes me that there would be an opportunity to pull together a lot of data across all of these different countries, the regions within the countries, and to do something very sophisticated in a multivariate analysis to try and pick out the various components of what is driving these indexes.

**Answer:** There is an international agency within the UN family that is responsible for each indicator, each critical socioeconomic indicator. So if you go to the UNDP web site and look up the HDR, you can look at the indicator tables for the most recent report and

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you can see the most current indicators on key areas. Taking it to the next level of doing some analysis of trends overtime is a great idea. Very interesting.

**Question:** My question is that there is a huge disparity between homicide rates across different demographics and in some communities in the U.S. trauma is essentially an epidemic disease and I think it is pretty safe to say any epidemic is going to have a huge impact on all three of the factors considered in the HDI, so has there been any analysis on how trauma prevention programs have affected HDI in communities?

**Answer:** I didn't come across anything in that area, but it is an interesting issue to look at. One thing that is very clear is that we have the highest homicide rate, five times that of any of our peer countries.

**Question:** I think one of the things that go along [with] people living longer lives is that the end of life care could be more expensive, and I was wondering, if anyone has been able to come up with a way of dealing with these end of life care issues or if that is not really something that is affecting this index?

**Answer:** There is not a lot of correlation and not all countries collect good data on end of life care. But, everybody spends a lot of money at the end of life.

**Question:** When we talk about Japan or France, these countries are a lot smaller than the U.S. Do you all look at size—I mean not just population wise? We are a lot bigger than Japan. Does this come into the mechanics?

**Answer:** No. In a sense when we do something per 100,000, yes, it does, but in terms of the complexities of a larger nation of a multiethnic, diverse nation no.

**Question:** If you look at the U.N. development indices, is there anything that concerns you about whether or not these measures are sometimes politicized? What does the history show, for instance with the U.N. reports?

**Answer:** I think what is great about this index is that represents things that pretty much everybody cares about, and the indicators shows relatively whether progress is being made. Data reliability is another issue, but it is very hard for people to quibble with the goal of making people's life spans longer. It is very hard for people to object to the fact that kids need to graduate from high school, and it is very hard to object to the fact that families need to earn enough to put food on the table. People connect to it right away. So as indicators, they are relatively balanced and can help to facilitate a reasoned debate on these issues. So that is what the HDI has going for it.

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## **V. Appendices**

### **Appendix A. Altarum Institute – An Introduction**

#### **Who we are**

Altarum Institute is a nonprofit health systems research and consulting organization serving government and private-sector clients. We provide objective research and tailored consulting services that help our clients understand and solve the complex systems problems that impact health and health care. Our model combines the analytical rigor of a research institution with the business acumen of a traditional consultancy to deliver comprehensive, systems-based solutions.

#### **Our systems approach**

As systems researchers, we begin with the understanding that there is no single health care “system.” Health and health care depend on a complex fabric of systems that are constantly interacting and shaping human health. Our Systems Change Model helps us see the broader environment in which these systems operate and in which problems arise. This methodology identifies critical systems interactions and keeps us focused on the root causes that can lead a system to fail. With this approach, we help clients visualize the whole picture – ensuring a more comprehensive and sustainable solution to a problem.

#### **What we do for clients**

Altarum Institute is widely recognized for providing its clients with research and solutions that are technically robust, pragmatic, and carefully aligned with the cultural norms of the populations being served. Our technical service offerings are grouped into the following four categories:

- Health Research and Analysis
- Health Program Development and Evaluation
- Health Care Operations and Finance
- Health Promotion and Knowledge Transfer

#### **Our staff and our values**

With a history dating back more than 60 years, Altarum Institute offers unparalleled knowledge and practical expertise. Our more than 250 employees represent the best in health care policy, research, business and clinical process improvement, technical assistance, and program evaluation. Our values – intellectual excellence, diversity in perspective, impeccable business ethics, and a commitment to client success – are evident in the work we do every day.

For more information, please visit us at [www.altarum.org](http://www.altarum.org).

## Appendix B. Roundtable Attendee List

Name	Affiliation
Fredric Abramson	AlphaGenics, Inc.
Halima Ahmadi	Altarum Institute
Ricky Allen	Altarum Institute
Roger Anderson	Altarum Institute
Linda Bilheimer	National Center for Health Statistics
Terri Boyd	Altarum Institute
Gabe Cano	Altarum Institute
Christina Ciucci	Altarum Institute
Stanley Chin	Altarum Institute
Larry Cobler	Altarum Institute
Beth Costello	Altarum Institute
Rodrigo Daly	BIO Ventures for Global Health
Jen Decker	Altarum Institute
Harold DeWeese	Altarum Institute
Dolores Dunn	House Veterans' Affairs Committee
Natasha Efrat	Altarum Institute
Sherri Farias	Altarum Institute
Isha Fleming	Altarum Institute
June Gertig	Altarum Institute
Laurie Graig	Altarum Institute
Glen Greenlee	Altarum Institute
Russell Herrold	Altarum Institute
Sally Holthouse	Altarum Institute
Alex Hughes	Altarum Institute
Paul Hughes-Cromwick	Altarum Institute
Mary Joscelyn	Altarum Institute
Richard Klein	National Center for Health Statistics
Ed Kobrinski	Altarum Institute
Domingo Lara	Altarum Institute
Danielle Larsen	Altarum Institute
Joan Lawrence	Altarum Institute
Jim Lee	Altarum Institute
Sarah Lifsey	Altarum Institute
Erin Lyons	Altarum Institute
Victoria Madrey	Altarum Institute
Sheryl Mathis	Altarum Institute

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Mary McCall	
Karen Metschler	Altarum Institute
Jeff Moore	Altarum Institute
Gretchen Noonan	Altarum Institute
Jonathan Orr	Altarum Institute
Ray Paris	Altarum Institute
Mark Perry	Altarum Institute
Sam Perryman	Altarum Institute
Lt. Makeva Rhoden	U.S. Public Health Service
Bob Riccio	Altarum Institute
Liz Ritter	Altarum Institute
Kristen Robinson	Altarum Institute
Charles Roehrig	Altarum Institute
Kara Rudolph	Altarum Institute
Kelly Sanders	Altarum Institute
Maria Sardegna	Altarum Institute
Devon Seibert	Altarum Institute
Linc Smith	Altarum Institute
Ritu Tuteja	National Center for Health Statistics
Rachel Witsamen	Altarum Institute
Tom Wilkinson	Altarum Institute
Dennis Zaenger	Altarum Institute

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## Appendix C. Speaker Biographies

### *Sarah Burd-Sharps*

Sarah Burd-Sharps is Co-Director of an independent, non-partisan project to produce a first-ever *American Human Development Report*. Prior to this position, Sarah worked for the United Nations starting in 1987, with a focus on gender issues and human development. Until 2006, she was Deputy Director of the United Nations Development Programme's Human Development Report Office. She has worked on four global *Human Development Reports* (HDR) and has contributed to national HDR's in every developing region. Sarah was founding Managing Editor of the peer-reviewed *Journal of Human Development*. As Deputy, she was the highest ranking UN Development Programme official in NY representing the *Human Development Report* for political negotiations and as media spokesperson.

In the year leading up to the Beijing Women's Conference (1994-95), Sarah headed UNIFEM's office in China where she carried out a global media campaign on gender issues, and supported Chinese women's organizations and the nascent NGO movement there. UNIFEM is the UN's agency for women and gender issues. Prior to this position, Sarah worked for four years with UNIFEM's Africa Section on food security issues and economic empowerment, and from 1998-90 in UNDP China as a Programme Officer. She has worked in 16 African countries.

In 2001, Sarah was Adviser and Editor to the non-profit Berlin-based Transparency International for their first *Global Corruption Report*.

Sarah received a Masters degree in International Affairs from Columbia University. Sarah has worked for a total of four years in China and has written and spoken on the effects of China's economic reforms on Chinese women. Sarah speaks fluent French and is proficient in Spanish and Chinese.

### *Kristen Lewis*

Kristen Lewis is Co-Director of the American Human Development Project and co-author of "The Measure of America: American Human Development Report 2008-2009." She has worked in international development for fifteen years, serving as a policy analyst and program officer at the United Nations Development Programme, then working as an independent consultant and writer. She has written extensively on gender and development, water and sanitation, and the environment. She was co-author, under the leadership of Jeffrey Sachs' Millennium Project, of the 2005 book "Health, Dignity and Development: What will it take?" Kristen holds an M.I.A. from Columbia University.

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*Sherry Glied, Ph.D.*

Sherry Glied is Professor and Chair in the Department of Health Policy and Management of Columbia University's Mailman School of Public Health. She holds a B.A. in economics from Yale University, an M.A. in economics from the University of Toronto, and a Ph.D. in economics from Harvard University.

In 1992-1993, she served as a Senior Economist for health care and labor market policy to the President's Council of Economic Advisers, under President Bush and President Clinton. She was a participant in President Clinton's Health Care Task Force and headed working groups on global budgets and on the economic impacts of the health plan.

Her research on health policy has focused on the financing of health care services in the U.S. Her book on health care reform, Chronic Condition, was published by Harvard University Press in January 1998. Her work in mental health policy has focused on the problems of women and children. She is a member of the MacArthur Foundation's Network on Mental Health Policy. She is co-author (with Richard Frank) of Better but Not Well: Mental Health Policy in the US Since 1950, published by Johns Hopkins University Press in July 2006.

Professor Glied is a member of the IOM, a member of the board of AcademyHealth, and a research associate of the National Bureau of Economic Research. In 2004, Professor Glied served as Chair of the AcademyHealth Annual Research Meeting. She was the 2004 winner of Research!America's Eugene Garfield Economic Impact of Health Research Award. She is a senior associate editor of Health Services Research; an associate editor of the Journal of Health Politics, Policy, and Law; a member of the editorial board of the Milbank Quarterly; and a member of the editorial committee of the Annual Review of Public Health.