Data, Information and Indicators

"If we could first know where we are and whither we are tending, we would better judge what to do, and how to do it …"
Abraham Lincoln

The Health of the Nation Initiative provides ongoing data and information that is relevant to the challenges facing our nation and the process and resources addressing them. We provide information where available and seek to create a political process to develop the needed data sources for public use. Taken together, the selected indicators reflect the overall health of the nation and the efficiency and efficacy of our political system. The data allows us to assess how we are doing and what we need to do to achieve excellent outcomes. The initiative will explore and address the challenges of transparency, accountability, and public reporting. In addition to the ongoing information, a periodic Health of the Nation event will take place. It can be thought of as a celebration of the benefits of the democratic system as a framework for our body politic.

The Health of the Nation Initiative provides data and information that will help you be part of the political conversation and take part in solutions. Current political decision making and government performance suffers from information asymmetry. It is crucial for decision making to have relevant, accessible, reliable and timely information. We will seek to provide information where available and to seek to create a political process to develop the needed data sources for public use. Taken together, the selected indicators reflect the overall health of the nation and the efficiency and efficacy of our political system. The data allows us to assess how we are doing and what we need to do to achieve excellent outcomes. The initiative will explore and address the challenges of transparency, accountability and public reporting.

Having an agreed upon base of data, or a way to challenge the data, will elevate the discussion to a more productive level, a more deliberative conversation built on respect rather than fear and that allows for problem solving.

We will provide data relevant to the healthcare challenges facing our nation, and document the source of the data.Taken together, the selected indicators reflect the overall health of the nation and the efficiency and efficacy of U.S. health systems.

For example,
It is well known that transparent data about function and outcomes is essential for learning about and "treating" complex evolving systems. To have a citizen-responsive healthcare system, there is a need to better understand and leverage the role of public reporting of healthcare outcomes and related performance information about hospitals and other healthcare systems. In particular to test the proposition that reliable, timely actionable data about health care organization's performance can inform citizens about their healthcare system and motivate them to play a role in improving healthcare outcomes.

Background

Current political decision-making and government performance suffer from information asymmetry. It is crucial for decision-making to have relevant, accessible, reliable, and timely information.

Having an agreed upon base of data, or a way to challenge the data, will elevate the discussion to a more productive level, a more deliberative conversation built on respect rather than fear and that allows for problem solving.

Data is a tool for more informed decision-making, not a decision itself. Data is crucial for scientific advancement, and in the policy arena crucial for comparison of options. Of course data, numbers can be manipulated to serve particular interests. It is nearly impossible to accurately project the future status of complex systems such as economics, human body, etc... The challenge is to present the information in a simplified manner that allows for utilization into the meaningful discussion and decision-making. Clarifying terms and concepts that are central to proper decision-making need to be aired and critically reviewed. Having an agreed upon base of data, or a way to challenge the data, will elevate the discussion to a more productive level, a more deliberative conversation built on respect rather than fear and that allows for problem solving.

It is crucial for decision making to have relevant, accessible, reliable and timely information. We will seek to provide information where available and to seek to create a political process to develop the needed data sources for public use.

Current political decision making and government performance suffers from information asymmetry. Indicators play an important role to monitor progress and to define outcomes. Most western societies measure **Gross Domestic Product (GDP)**, a measure of productivity of the national economy. What is not measured is the well being of the people.

The challenge with data is to agree upon what is important and relevant. Data is not an opinion; it is usually reproducible and verifiable. Data is a tool for more informed decision making, not a decision itself. The challenge is to present the information in a simplified manner that allows for utilization into the decision making.

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Rationale

The Health of the Nation Initiative provides ongoing data and information that is relevant to the challenges facing our nation and the process and resources addressing them.

Current political decision making and citizen assessment of government performance suffers from information asymmetry. Data is crucial for an objective presentation of a problem, not just to help the diagnosis, but also to decide on a course of treatment and monitor results. It is crucial for decision making to have relevant, accessible, reliable and timely information. The challenge with data is to agree upon what is important and relevant. Data is not an opinion; good data is reproducible and verifiable. Data is a tool for more informed decision making about, not a decision itself. The challenge is to present the information in a simplified manner that allows for utilization into the decision making.

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For example,

It is well known that transparent data about function and outcomes is essential for learning about and “treating” complex evolving systems. To have a citizen responsive health care system, there is a need to better understand and leverage the role of public reporting of healthcare outcomes and related performance information about hospitals and other healthcare systems. In particular to test the proposition that reliable, timely actionable data about health care organization’s performance can inform citizens about their health care system and motivate them to play a role in improving healthcare outcomes.

Approach

Today’s society (US) is characterized by a set of complex problems—such as inequality, climate change, gun violence and affordable access to healthcare to list a few— that are seemingly intractable. People have looked to traditional societal institutions—like government agencies and advocacy groups—to tackle these problems, and they have become frustrated by the inability of these institutions to act effectively and legitimately. Unsurprisingly, trust in existing institutions is at

an all-time low. To survive and flourish in the 21st century our nation must embrace the digital revolution that has transformed most aspect of personal and social life. Current technology allows us to rewire the body politic through information technology. These tools allow unprecedented opportunity to get access to information, mobilize, challenge misinformation and provide for a more deliberative dialogue. What is needed however, is a framework for meaningful dialogue and deliberations.

The U.S. Economy Is Racing Ahead. Almost Everything Else Is Falling Behind. - The New York Times

A National Progress Report

The State of the Nation Project is a comprehensive and objective national progress report assessing how we are doing as a country.

The purpose of the State of the Nation Project is to provide an overall assessment of how the country is doing on a wide range of factors that we, and the American people, believe are important. Below is a summary of our report: 37 measures across 15 topics. We report each measure in two different ways (where possible): our national trend and the percentage of middle- and high-income countries we outperform (a higher number is always better). All of these measures were supported by a supermajority of the authors and the ones with p next to the measure name were also supported by a supermajority of the general public. In the Executive Summary and topic sections, we also discuss how our international ranking is changing over time and provide more discussion of the conclusions we draw from these data

Our Mission

Our reports represent a broad consensus of leading experts and a cross-section of everyday Americans from across the political spectrum. Our work highlights key trends, dispels myths, and promotes dialogue and insights about the factors shaping our nation's prosperity.

Here are some suggestions for new salutogenic health metrics beyond just disease burden:

- **Quality of life** - Measures of self-reported quality of life, life satisfaction, happiness, and wellbeing through surveys and standardized scales like the WHOQOL.

- **Positive mental health** - Rates of positive emotions, optimism, resilience, self-efficacy, and sense of purpose measured via validated psychological assessments.

- **Social connectedness** - Levels of social support, community engagement, and loneliness monitored through social network analysis and community surveys.

- **Preventive care** - Rates of age-appropriate cancer screenings, vaccine coverage, routine physicals, and health counseling provided.

- Healthy behaviors - Rates of physical activity, healthy diet, substance non-use, and sleep measured through self-report and observational studies.

- Environmental quality - Air and water quality, urban green space, housing safety, and noise pollution assessed through environmental audits.

- Health equity - Disparities in health outcomes and determinants between groups tracked and addressed.

Some salutogenic metrics for healthy communities could include:

- Walkability/bikeability
- Access to parks, trails, recreation
- Resident involvement in community organizations and civic life
- Access to healthy, affordable food
- Graduation rates
- Gainful employment rates
- Perceived neighborhood safety and cohesion
- Accessible, affordable healthcare
- Clean natural environment
- Affordable housing
- Public transportation
- Cultural diversity and inclusion

Tracking these types of upstream, positive metrics can help drive community health promotion beyond just the absence of illness.

Data and Information
Building on the case presentation framework and the citizen briefs enabled by user friendly and citizen responsive technology allows for an informed deliberative process based on crowdsourced input. A shared information base framed as a foundation for exploration of possible solutions to challenges is crucially important in collaborative problem solving. It allows for a process to summon our fellow citizens to address the challenges confronting us as individuals, our communities and our nation.'

Crowdsourcing and Citizen Tools

Our Outcome Management

Citizenism will use indicators to monitor wellbeing in addition to GDP and develop reliable information to reliably capture that information. United States 6.0 will use indicators to monitor wellbeing in addition to GDP and develop reliable information to reliably capture that information.

In addition, most western societies measure Gross Domestic Product as a measure of productivity of the national economy. What is not measured is the well being of the people.

Data for Healthcare

Data is crucial for an objective presentation of a given medical situation, not just to help the diagnosis, but also to decide on a course of treatment and monitor results. The challenge with data is to agree upon what is important and relevant.

In order to achieve improvement in healthcare we need to get a snapshot of the current state of the health of individuals, communities and our nation that can serve as a base on which to build. Reliable, timely data is crucial for an objective presentation of a given medical situation, not just to help the diagnosis, but also to decide on a course of treatment and monitor results. Data is crucial for transparency and accountability, the foundations of our democracy. The challenge with data is to agree upon what is important and relevant. It is not possible to have meaningful outcomes if the data is difficult to understand, unreliable and inconsistent and understood differently by the various stakeholders. Data is not an opinion; it is usually reproducible and verifiable.

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DATA ABOUT US HEALTHCARE SYSTEM AND THE NATIONAL DEBT

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Clarifying terms and concepts that are central to proper decision making need to be aired and critically reviewed. Having an agreed upon base of data, or a way to challenge the data, will elevate the discussion to a more productive level, a more deliberative conversation built on respect rather than fear and that allows for problem solving.

Provide the relevant data needed for a rational discussion

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Identifying measures for salutogenic informed well being and promoting them.

The Gross Flourishing Index (GFI) is a salutogenic measure that assesses society's well-being by considering a wide range of factors that contribute to health and well-being. The GFI is based on the idea that well-being is not just the absence of disease, but rather a state of optimal functioning and flourishing.

The GFI takes into account factors such as physical health, psychological well-being, social connections, economic stability, and access to resources. It also considers the presence of protective factors, such as resilience, self-esteem, and a sense of purpose. By assessing these factors, the GFI provides a more comprehensive understanding of a society's well-being than traditional measures such as GDP or life expectancy.

One of the key benefits of using a salutogenic measure like the GFI is that it can provide a more accurate picture of a society's well-being by considering a wider range of

factors. This can help policymakers and practitioners identify areas where interventions are needed to improve well-being. Additionally, by focusing on protective factors, the GFI can help to identify opportunities to promote health and well-being, rather than just treating illness.

Another benefit of GFI is that it can be used as a tool to monitor changes in well-being over time, allowing us to track progress towards a goal of optimal well-being. This can help to identify trends and patterns that can inform policy decisions and program design.

Overall, the GFI is a valuable tool for assessing society's well-being, providing a more comprehensive and accurate picture of the factors that contribute to health and well-being, and informing interventions to improve well-being.

Suggested Individual Outcomes to be Monitored

- ☐ Change in well being measures
- ☐ Work related indicators
- ☐ Change in SOC scores
- ☐ Higher engagement in political sphere
- ☐ Indicators of flourishing
- ☐ Initiate contact to incorporate the salutogenic formulation and resources within the electronic medical record.
- ☐ Design salutogenic interventions and change processes in complex systems: e.g. intervention theories related to the three SOC dimensions; relation of Salutogenesis to the five action areas described in the Ottawa Charter (WHO 1986); examples of interventions clearly based on the salutogenic model.

The 100 Questions Initiative

Unless we define the questions well to unlock the potential of data and data science, how can we provide answers that matter? Hundred questions to leverage data Gov Lab
100 Questions
Unless we define the questions well...
To unlock the potential of data and data science
How can we provide answers that matter?
Who is the Citizen Communicator that is the consumer?

- Meet residents where they are, locally , cognitively and with belief.

The 100 Questions seeks to improve the set of questions that if answered— using new data sources and data science—could transform the way we solve a variety of 21st century challenges. In addition, this project introduces and expands the concept of "bilinguals"—individuals that possess both domain expertise and data science capabilities -- as being essential to define questions that matter to particular fields and can be addressed through data science.

Data intelligence to decision (actionable) intelligence

The home of the U.S. Government's open data Here you will find data, tools, and resources to conduct research, develop web and mobile applications, design data visualizations, and more. For information regarding the Coronavirus/COVID-19, please visit Coronavirus.gov.

The U.S. Economy Is Racing Ahead. Almost Everything Else Is Falling Behind. - The New York Times

The Tyranny of Metrics Jerry Muller reported on the use of metrics in government, education, business, medicine, and more.

Social and political indicators of human well-being (Pdf) susan harkness

Unpacking the American Opportunity Index www.americanopportunityindex.org

Data For Civic Engagement
Cities can use data to gather the insights they need to respond to challenges, maximize resources and predict the future. How can city leaders leverage public investments to

strengthen local decision making? This panel will explore the current moment and how cities and organizations can prepare for federal funding opportunities.

Data Literacy Geek(s) are focused on how we can help deliver inspiration, instructions and even when needed from our individual employer's professional consulting services help people and organizations to become data literate.
2021 Knight Smart Cities Lab

Raw data won't solve our problems — asking the right questions will

Health Impact Assessment (WHO)
Health Impact Assessment | Healthy Places (CDC)
Health Impact Assessment Resources | Tracking Program
10th WHO Global Health Promotion Conference
Opening of the 10th WHO Global Health Promotion Conference Health Promotion for Well-being, Equity and Sustainable Development

Wellbeing economy: An effective paradigm to mainstream post-growth policies?

Why governments should prioritize well-being Nicola Sturgeon
In 2018, Scotland, Iceland and New Zealand established the network of Wellbeing Economy Governments to challenge the acceptance of GDP as the ultimate measure of a country's success. In this visionary talk, First Minister of Scotland Nicola Sturgeon explains the far-reaching implications of a "well-being economy" -- which places factors like equal pay, childcare, mental health and access to green space at its heart -- and shows how this new focus could help build resolve to confront global challenges.

Scottish Government | Explore

- ☐ "National Performance Framework"

Find information about Scotland's Performance Framework and how the government is performing against it.
OECD | Explore

- ☐ "Measuring Well-being and Progress: Well-being Research"

Find out more about the OECD's work on well-being.
New Zealand Treasury | Explore

- ☐ "The Wellbeing Budget 2019"

A well-being budget published by the Government of New Zealand in May, 2019.
First Minister Nicola Sturgeon | Article

- ☐ "Wellbeing Economy Governments (WEGo) Policy Labs: First Minister's speech"

A speech by First Minister Nicola Sturgeon at the Wellbeing Economy Government's Forum meeting in Edinburgh.

https://www.ted.com/talks/nicola_sturgeon_why_governments_should_prioritize_well_being

Learn more about the network of Wellbeing Economy Governments. Wellbeing Economy Governments (WEGo) - gov.scot

Wellbeing Economy Governments (WEGo) policy labs: First Minister's speech
Help build a well-being economy.
Participate

Overview

Building a Wellbeing Economy is a top priority for the Scottish Government. This means building an economy that is inclusive and that promotes sustainability, prosperity and resilience, where businesses can thrive and innovate, and that supports all of our communities across Scotland to access opportunities that deliver local growth and wellbeing

Scotland is a founding member of the Wellbeing Economy Governments (WEGo) group, an initiative where member countries are working together to understand the key priorities for a wellbeing economy. The group enables cross-government engagement, learning and collaboration to utilise the advice of experts and deepen their understanding of delivering a wellbeing economy for citizens and environment.

The group was formally launched at the OECD's World Forum in Incheon, South Korea, in 2018. This included participation of senior officials from the Governments of Scotland, Iceland and New Zealand along with Professor Joseph Stiglitz, a member of the Scottish Government's Council of Economic Advisers and Chair of the OECD's High level Group on the Measurement of Economic Performance and Social Progress.
Membership of the group has grown organically since its launch in 2018 and currently involves the Governments of Scotland, Iceland, New Zealand, Wales and Finland.

Objectives:

- collaborate in pursuit of innovative policy approaches aimed at enhancing wellbeing through a broader understanding of the role of economics – sharing what works and what doesn't to inform policymaking
- progress toward the UN Sustainable Development Goals, in line with Goal 17, fostering partnership and cooperation to identify approaches to delivering wellbeing
- address the pressing economic, social and environmental challenges of our time

Policy labs

The Economic Policy Labs are the platform through which officials from the respective governments can share experience and expertise. They provide a forum for officials to engage in practical exchange on specific policy areas of shared interest, in pursuit of enhanced wellbeing for current and future generations.

The group held their first series of economic policy labs in Edinburgh in May 2019 at the former home of Adam Smith, Panmure House. An opening session was held, inviting actors from the third sector and civic society to hear about the aims and ambitions of the group. First Minister Nicola Sturgeon, Icelandic Prime Minister Katrín Jakobsdóttir and the OECD's Carrie Exton delivered the welcome address.
More recently in 2020, the group held a series of virtual policy labs which included participation from Governments of Scotland, Iceland, New Zealand, Wales, Finland and Canada. The group plan to continue to hold virtual policy labs at frequent intervals throughout 2021.
Since the launch of the group, a wide range of topics have been covered in the policy labs, including: performance frameworks, wellbeing budgeting and inclusive growth; sustainable tourism and natural capital; child poverty and predictive analytics; the challenges arising from the Covid-19 pandemic; and climate change.

Gallup Measuring Human Development
Hunger. Safety. Security. Happiness. There is no "good enough" when you're responsible for people's lives. And the needle doesn't move unless you measure for it.
Through our independent research and collaboration with global development organizations such as the United Nations on sustainable development goals, our global statistics and metrics find the parameters of the challenges facing humankind and track the progress toward change.
Metrics for a Better Future
We work with organizations that have such big ideas, we needed a new way to measure them.
Global Happiness Center: Official statistics for global wellbeing
Wellbeing is a vital indicator of a nation's economic and social development. Gallup helps global organizations measure and track progress toward happy, thriving societies.
CONNECT WITH US
CLICK HERE TO CONTACT US

How Can Policy Makers Use Behavioural Science? | LSE Festival Online Event

Gov 2.0 Summit 09: Chris Hoenig, "The State of the USA"

- ➢ The Data: The Pain Opioid Epidemic

Opinion: To see the potential of data, we need to tap into the wisdom of bilinguals

"If I had only one hour to save the world, I would spend fifty-five minutes defining the questions, and only five minutes finding the answers," is a famous aphorism attributed to Albert Einstein.

Behind this quote is an important insight about human nature: Too often, we leap to answers without first pausing to examine our questions. We tout solutions without considering whether we are addressing real or relevant challenges or priorities. We advocate fixes for problems, or for aspects of society, that may not be broken at all.

The Health of the Nation:

A yearly gathering of citizens and stakeholders will convene in Philadelphia to assess the health of the nation. The gathering will review the progress toward the goals we set for the Health of the Nation.

Snapshot: Health of the Nation 2025 provides you with information that will help you be part of the healthcare conversation.

I am a firm believer in the people. If given the truth, they can be depended upon to meet any national crisis. The great point is to bring them the real facts.
Abraham Lincoln

“If we could first know where we are and whither we are tending, we would better judge what to do, and how to do it …”
Abraham Lincoln

"Our society faces multiple systemic crises, requiring unprecedented collaboration among stakeholders and across levels and sectors, with enormous stakes and little time. Public officials, civic leaders, and concerned citizens are eager to gain easier access to objective, trusted sources of information on how their nation, state or city is really doing. They want to cut through biased agendas and find reliable facts for more productive public dialogue and action on a broad range of issues: Are our cities safe and secure? Are we getting the best education and health care? Are our levels of economic competitiveness, workforce development, and innovation up to global challenges? Are we providing effective stewardship of our environment?

Yet our democratic process has no widely- shared factual frame of reference to underpin problem solving and decision-making across highly interdependent issues. We do not have a freely available, easy-to-use, comprehensive source of the best and most relevant data to help American leaders and the public to understand and assess progress for themselves. Hence, choices are too often framed, discussed, and made on the basis of inadequate, hard-to-find, or incomplete data"

THE COUNCIL OF STATE GOVERNMENTS
RESOLUTION ON A KEY NATIONAL INDICATOR SYSTEM FOR THE UNITED STATES OF AMERICA

HEALTHCARE STATUS OF AMERICANS

Goal: **By September 2026 the healthcare status of Americans is optimal as measured by predetermined measures**

Health of the Nation Goal for 2024: Healthcare status of Americans

1. Identify the health status of population according to established indicators
2. Describe the community rating of health in various populations
3. What is the quality of life of people with chronic medical conditions? Verify clearly established excellent outcomes for all the population groups

Current status
Health of the Nation Metrics:
The number of Americans reporting that their health is good or excellent.
The number of Americans experiencing various medical conditions.
What is the quality of life of people with chronic medical conditions?
Verify clearly established excellent outcomes for all the population groups

Quality of life, health and community health involves more than medical care; it entails access to food, shelter, transportation, clean air and water, education, physical safety, social ties and meaningful jobs paying sufficient wages. This expands on the idea that no person is an island — everyone's life is bound by the family and community in which they live. We all share the aspiration to live a healthy life in a healthy community.

- National Health Interview Survey
- Mortality data
- National Center for Chronic Disease Prevention and Health Promotion
- National Institute of Diabetes and Digestive and Kidney Diseases
- City Data

The Data: Pain Opioid use, abuse and complications The war on Drugs (Google Doc)

Children living in poverty even in healthiest counties

Nearly 1 in 10 children live in poverty in the healthiest counties. Black, Hispanic and Native American children are disproportionately burdened, often experiencing poverty at rates at least twice those of white children.

Children are living in poverty, even in the healthiest communities in the country, and a disproportionate percentage are children of color.

Our data spotlight takes a closer look at some of the healthiest counties in the country, such as Fairfield County, Connecticut, where poverty can be overlooked in data. Dig into this interactive resource to understand more about:

- Disparities by race and ethnicity in the healthiest county in each state
- Differences in childhood poverty rates in your own county
- How poverty impacts health
- Resources to help communities create a more equitable future for all children

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Incorporating The Subjective Into Wellbeing Measurements

In this, our sixth CCH seminar in our series at the WHO Collaborative Centre on Culture and Health, 'Incorporating the Subjective into Wellbeing Measurements' we heard from Mr Adolfo Morrone, who is an experienced Senior Manager in cultural statistics and was senior researcher at the The Italian National Institute of Statistics (ISTAT), working on a project of measuring and monitoring the well-being of the Italian Society. He also managed the design and the publishing of the first Report on "Equitable and Sustainable Well-being", which is the first results of this inter-institutional initiative of great scientific importance, which places Italy in the forefront of the international panorama for the development of well-being indicators going beyond GDP. We also heard from Dr Mauro Fornasiero, University of Exeter.

Adolfo's presentation focused on the importance of subjective indicators in measuring and evaluating quality of life. He briefly summed up 10 years of debate starting from the work of the Stiglitz, Sen, Fitoussi report and the efforts made by the OECD to stir the debate on going beyond GDP. Adolfo then gave an overview of the Bes (Equitable and sustainable well-being) project carried out by the Italian national statistical Office since 2013. He concluded by presenting some evidences of the relationships between objective indicators and cognitive evaluation of its own life satisfaction.

Mauro looked at 'measuring wellbeing in Italy: a cultural perspective'. Drawing from the indicators of Equitable and Sustainable wellbeing in Italy, this presentation showcased three case studies, which inform wellbeing from a cultural perspective.

Due to slight technical difficulties for a brief period of the recording, we have also included the slides for information.

Kidney Disease
Data are for the U.S.

Morbidity

- Number of noninstitutionalized adults with diagnosed kidney disease: 3.9 million
- Percent of noninstitutionalized adults with diagnosed kidney disease: 1.7%

Source: Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2012, tables 7, 8 [PDF - 1.3 MB]

Mortality

- Number of deaths from nephritis, nephrotic syndrome, and nephrosis: 45,591
- Deaths per 100,000 population: 14.6
- Cause of death rank: 9

Source: Deaths: Final Data for 2011, tables 9, 10, 11 [PDF - 1.5 MB]

More Data

- Average length of stay in nonfederal short-stay hospitals, by sex, age, and selected first-listed diagnosis Health, United States, 2013, table 98 [PDF - 9.8 MB]
- Discharges in nonfederal short-stay hospitals, by sex, age, and selected first-listed diagnosis Health, United States, 2013, table 96 [PDF - 9.8 MB]
- Discharge rate in nonfederal short-stay hospitals, by sex, age, and selected first-listed diagnosis Health, United States, 2013, table 97 [PDF - 9.8 MB]>
- Incidence and prevalence of end-stage renal disease Health, United States, 2013, table 47 [PDF - 9.8 MB]
- Key statistics from NHANES
- Search Tables for Kidney in Health Data Interactive

"The nongovernmental sector continues to grow in importance as the crucible where government, business, academia and other sectors of society can work together for meaningful societal change. The State of the USA represents a strategic investment in the underpinnings necessary for a 21st century civic dialogue and policy process where collective accountability for results is the norm rather than the exception."
State of US measures (2010)

Taken together, the selected indicators reflect the overall health of the nation and the efficiency and efficacy of U.S.health systems. The committee recommends that the State of the USA website include the following indicators for the health/health care domain:

Health Outcomes

Life expectancy at birth • (number of years that a newborn is expected to live if current mortality rates continue to apply).Steady increase in years of quality life for all Americans.
Infant mortality • (deaths of infants aged under 1 year per 1,000 live births)
Life expectancy at age 65 • (number of years of life remaining to a person at age 65 if current mortality rates continue to apply)
Injury related mortality • (age-adjusted mortality rates due to intentional and unintentional injuries)
Self-reported health status • (percentage of adults reporting fair or poor health)
Unhealthy days physical and mental • (mean number of physically or mentally unhealthy days in past 30 days)
Chronic disease prevalence • (percentage of adults reporting one or more of six chronic diseases [diabetes, cardiovascular disease, chronic obstructive pulmonary disease, asthma, cancer, and arthritis])
Serious psychological distress • (percentage of adults with serious psychological distress as indicated by a score of > 13 on the K6 scale, with scores ranging from 0-24)

Health-Related Behaviors

Smoking • (percentage of adults who have smoked > 100 cigarettes in their lifetime and who currently smoke some days or every day)
Physical Activity • (percentage of adults meeting the recommendation for moderate physical activity [at least 5 days a week for 30 minutes a day of moderate intensity activity or at least 3 days a week for 20 minutes a day of vigorous intensity activity])
Excessive Drinking • (percentage of adults consuming four [women] or five [men] or more drinks on one occasion and/or consuming more than an average of one [women] or two [men] drinks per day during the past 30 days)
Nutrition • (percentage of adults with a good diet [conformance to federal dietary guidance] as indicated by a score of > 80 on the Healthy Eating Index)
Obesity • (percentage of adults with a body mass index > 30)
Condom use • (proportion of youth in grades 9-12 who are sexually active and do not use condoms, placing them at risk for sexually transmitted infections)

HEALTH SYSTEMS
Health care expenditures • (per capita health care spending)
Insurance coverage • (percentage of adults without health coverage via insurance or entitlement)

Unmet medical, dental, and prescription drug needs • (percentage of [non-institutionalized] people who did not receive or delayed receiving needed medical services, dental services, or prescription drugs during the previous year)
Preventive services • (percentage of adults who are up-to-date with age-appropriate screening services and flu vaccination)
Childhood immunization • (percentage of children aged 19-35 months who are up-to-date with recommended immunizations)
Preventable hospitalizations • (hospitalization rate for ambulatory care-sensitive conditions)

Liberating the 990 data for healthy communities
Liberating the IRS 990 Data for Healthy Communities synthesizes community health data from multiple sources into a database suited for a variety of audiences such as individuals, community groups, healthcare providers and the media.

Health of the Nation:
Health of our Communities: (Snapshot of the state of our communities for 2020 Health of the Nation.)

County Health Rankings - An interactive website providing access to 50 state reports with rankings of each county within each state according to its health outcomes and health determinants.

See government financial data: Including revenue, spending balance sheets, government employment, and government-run businesses

Vision: Public Health and Community Health

Vision for Optimal Community Health:
We will focus on health and illness at the community or population level, including social determinants of health, health crises, challenges to health promotion and disease treatment, and the tensions between community health and individual liberty.

Take Action
Take Action for Community Health (General information about taking action, link to Take action get social)
Start > Take Action > Get Social (Six step approach to taking action. Tie in with Liberating the 990 form)
Health of our Communities: Snapshot of the state of our communities for 2021 Health of the Nation.

The healthiest communities in the U.S. are the ones where people can afford homes
The Robert Wood Johnson Foundation's 2019 list of the healthiest places in the U.S. found that a lack of secure housing is a pressing health issue.

Fastcompany.com

My Healthcare Environment (Give my community a check up)
Health of the Community (Community Health Needs Assessment)
Community Health Ranking (Utilize existing data bases)
Initiatives and programs (Government, state, local, foundations)
US Communities (Sampling of what communities are doing)
Organizations (Listing of organizations associated with public health)
Prescription Drug Abuse (An example of topic for community focus)
Resources Public Health (General resources about community health)
Initiatives > Philly > Community Benefit > (Explanations of hospital requirement for community benefit)
Community benefit activities (Listing of activities, need assessment for all Delaware Valley hospitals)
Executive compensation (Listing of executive and other key personal compensation for all Delaware Valley hospitals)
Governance
Conflict of interest
Collections policy
Financial performance
Environment (How the hospital is contributing/ affecting the environment)
Resources for Community Benefit
Hospitals (Guideline for hospital related to meeting requirements)
Organizations
IRS 990 Form
Take Action for Community Health (General information about taking action, link to Take action get social)

Start > Take Action > Get Social (Six step approach to taking action. Tie in with Liberating the 990 form)

How Governance Drives Well-Being

An Interview with Nobel Laureate A. Michael Spence

For decades, GDP was the measure of all things. Government leaders relied heavily on GDP growth—or the lack thereof—as a barometer of their policies' success. But over the past several years, measures such as well-being (essentially, the quality of life in a given country) have taken on increasing importance. Among the most vocal supporters of that broader view is A. Michael Spence, Nobel laureate and professor of economics at the Stern School of Business at New York University.

As chairman of the Commission on Growth and Development from 2006 to 2010, Spence helped lead an effort to understand which policies and strategies drive rapid and sustained economic growth and poverty reduction. This effort was based on the view that rising prosperity and expanding economic opportunity create the opportunity to address difficult challenges such as environmental degradation, poverty, and the wide disparity in living standards within and across countries.

Spence's work underscores one of his core beliefs, that governance and smart policymaking play a critical role in raising levels of well-being. In 2001, he was the winner—along with economists George A. Akerlof and Joseph E. Stiglitz—of the Nobel Memorial Prize in Economic Sciences for work in the area of asymmetric information. Recently, Spence and BCG senior partner Douglas Beal met to discuss the increasing attention being paid worldwide to well-being, the critical role of governance in raising living standards, and what government leaders can do to maximize the impact of their policies. Edited excerpts of their conversation follow.

Global Community

Establishing a More Global Understanding of Wellbeing, Mission
The Global Wellbeing Initiative aims to expand the conceptualization and measurement of wellbeing with globally inclusive perspectives to better understand how to promote wellbeing for all.
GALLUP PODCAST JUNE 5, 2020 How Wellbeing Concepts Can Be Globally Inclusive

Blog Making the Study of the World's Wellbeing More Inclusive (Gallup) July 7, 2020

OECD:
Better Life Initiative: Measuring Well-Being and Progress Are our lives getting better? How can policies improve our lives? Are we measuring the right things? The OECD Better Life Initiative and the work program on Measuring Well-Being and Progress answer these questions. They allow understanding what drives the well-being of people and nations and what needs to be done to achieve greater progress for all.

Better Life Index: This Index allows you to compare well-being across countries, based on 11 topics the OECD has identified as essential, in the areas of material living conditions and quality of life.

Pan American Health Organization: Regional Briefing on the Social Determinants of Health in the Americas (PDF 2012)

UK Office of National Well-being: Measuring well-being

ONS is developing new measures of national well-being. The aim is to provide a fuller picture of how society is doing by supplementing existing economic, social and environmental measures. Developing better measures of well-being is a long-term program. ONS is committed to sharing ideas and proposals widely to ensure that the measures are relevant and founded on what matters to people.

Rio Political Declaration on Social Determinants of Health Rio de Janeiro, Brazil, 21 October 2011

United States: Federal Government
United States: States
The State of Utah: Social Determinants (Link)
United States: Cities & Counties
Community Partnership Strategy: Neighbourhood Well-being Index

United States: Civil society

A gathering place for stories illustrating community investment—creating neighborhoods that promote health and wellbeing for all. Produced by the Build Healthy Places Network.
Aetna Foundation: Creating a healthier world
We work to promote better nutrition and physical activity, enhance health equity and advance innovations that enable better health.
The Aetna Foundation is dedicated to improving health in local communities and large populations alike. How do we make it happen? Through community-based programs, dynamic partnerships and proven models that can help people accelerate progress everywhere.

Building a Culture of Health
The Robert Wood Johnson Foundation today announced the seven communities selected to receive the 2016 RWJF Culture of Health Prize. Chosen from nearly 200 communities across the country, the following Prize-winning communities reflect a Culture of Health vision in action

The snapshot is divided into the following categories:

US Economic Overview
Health Status of Americans: By November 20201 the healthcare status of Americans is optimal as measured by predetermined measures
Health Status of US Communities: Citizens4health's community health assessment provides a framework for citizen engagement in their local communities to assess and improve health care related outcomes. We do this by highlighting best practice of community based public health efforts, relevant and easy

The Healthcare Ecosystem :

Healthcare Insurance Coverage: Coverage of all Americans with basic medical care, including prevention, acute care, chronic care, and end-of-life care. The coverage is citizen-based, lifelong, portable, and is independent of preexisting conditions, employment status, and age.
Access to Quality Health Care: Access to care that is timely (no needless delays), equitable (no unjustified variation) comprehensive, available, and easily accessible, offering choice of provider and treatment options that are evidence-based.
Cost of Healthcare: Cost of care that is affordable and sustainable for individuals, businesses, and government.
Quality Healthcare: Quality care based on the latest evidence for healthcare that is:
Safe (no harm)
Efficient (no waste)
Effective (no needless failures)
Patient Centered (no helplessness or unjustified routines) and competent healthcare.
Coordination of Care: Care must be more cooperative and much more efficiently coordinated. The patient should be central in the care.
Healthcare Innovation: Innovation through research in services and products that leads to continued improvement in the health status of the population.
Public Reporting: By November 2021 every American has access to meaningful and actionable information of all healthcare stakeholders

NCoC's Partners in New Hampshire Release the 2020 New Hampshire Civic Health Index
2020 New Hampshire Civic Health Index

Climate Change Indicators

Indicators for accountability with regard to climate change.
https://docs.google.com/document/d/1pdv55TL9tglCr0D7PIihq0K9ceb3pRsiHkCy0Iw4jUo/edit#heading=h.kpd62wgc8mc3

Climate Change (CC) related transparency can lead to more accountability of the relevant stakeholders. The accountability focus is crucial and will be developed along the following areas and specific indicators.
General comment:

Additionally we focus on both monetary—paying for the effects of CC—and ethical—watchdogs for what politicians and stakeholders are saying—how far are they willing to go to lie, confuse, and delay positive actions.

Here is a link to a section about data and indication of well being..
https://www.healthofthenation.us/data

A. The Political Ecosystem

The political stakeholders are those who have made CC both a political and policy issue. Accountability looks like for these folks whether they are supporting appropriate policies that would mitigate against the dire consequences of CC. So that would mean supporting

- ❏ Budgets for the appropriate regulatory agencies (What are the agencies?)
- ❏ Bills that would put lids on emissions, would put controls on emission sources, would establish the primacy of renewables (including tax incentives, etc.)
- ❏ Opposing bills that would remove regulatory agencies' authorities, allow increased pollution

B. The Economic Stakeholders

Economic Stakeholders-businesses that generate pollution are opposed to impediments to their business development and business models. The opposition over the years has even descended into downright lying, beyond the usual obfuscation, dissembling and misrepresenting scientific studies and data.
So, accountability would look like

- ❏ Truth in advertising
- ❏ Liability for CC misinformation; enhanced liability for CC disinformation—liability means for damages caused to personal and environments
- ❏ Reparations for developing countries who have been, basically, victimized by the enormous power of oil & gas sectors.
- ❏ Unions supporting only their workers without a passing wave to the public-at-large: we should judge their standing to participate based upon their public record and roles.

C. Public at Large

Public at large—accountability regards what percentage of the population becomes sick

- ❏ Measures of human health
  - ❏ CV and respiratory morbidity and mortality due to CC
  - ❏ Infectious Disease — kinds, types, including their spread
- ❏ Costs to individuals, insurance plans, our taxes

D. Environmental Effects

- ❏ Sea level flooding, erosion, inundation-costs of clean up, loss of habitation, decrease in tourism
- ❏ Plant productivity—surely a mixed bag—but food prices & food security
- ❏ Severe weather (hurricane, severe rains—flooding infrastructure damage, forest fires)

E. Repair Costs (e.g. public infrastructure damage from flooding in PA cost the taxpayers ~$125 million in 2019)

F. Habitat Loss

- ❏ Biodiversity loss-how does one account for this and get the public interested in something that requires evolutionary biology and ecology explanations
  - ❏ There are plenty of measures of biodiversity loss.

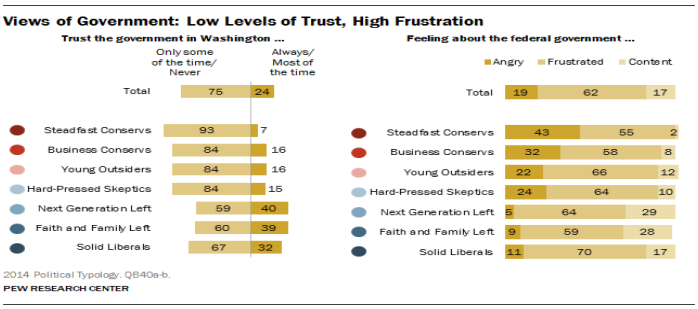
Resources:
Sources for data ….
Health System Data Center
Explore state health system performance and policy data through custom tables, graphs and maps

- U.S. Department of the Treasury, Bureau of the Public Debt
- U.S. Bureau of Labor Statistics
- Congressional Budget Office
- Government Accountability Office
- Medicare Trustees
- Commonwealth Fund
- Robert Wood Johnson Foundation
- Brooking Institute
- Kaiser Family Foundation
- Institute of Medicine
- The California HealthCare Foundation
- Rand corporation
- Center for Studying Health System Change
- National Institute for Health Care Reform
- The Health System Measurement Project
- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare and Medicaid (CMS)
- Food and Drug Administration (FDA)
- Health Resources & Services Administration (HRSA)
- Office of the Assistant Secretary for Planning and Evaluation (ASPE)
- Office of the National Coordinator (ONC)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- Health Research & Educational Trust.
- Alatarum
- The Deloitte Center for Health Solutions (DCHS)
- Bureau of Economic Analysis (BEA),

- National Health Expenditure Accounts (NHEA).
- U.S. Census Bureau Fact Finder
- U.S. Census
- New England Journal of Medicine articles
- The Policy Map
- Pew Research: https://www.journalism.org/datasets/
- USFacts
- Ourworldindata

Institute for Health Metrics and Evaluation, Global Burden of Disease Results Tool, Online: http://ghdx.healthdata.org/gbd-results-tool
Global Happiness and Wellbeing Policy Report 2019 (SDSN, 2019).
Is your county a healthy place to live?
Explore the impacts of Social Determinants of Health
Analyze which Social Determinant of Health impacts your patients and drill down to every measure at national, state, and county level and strive for continuous outcome improvement.

Recent Pew Research has given a statistical credence to what is clearly felt by most Americans, They found that Americans trust in government has reached an all time low. Only 19% of those surveyed believe that government can solve major problems. This finding as well as others surveys have also found that support for politicians is in the single digits.

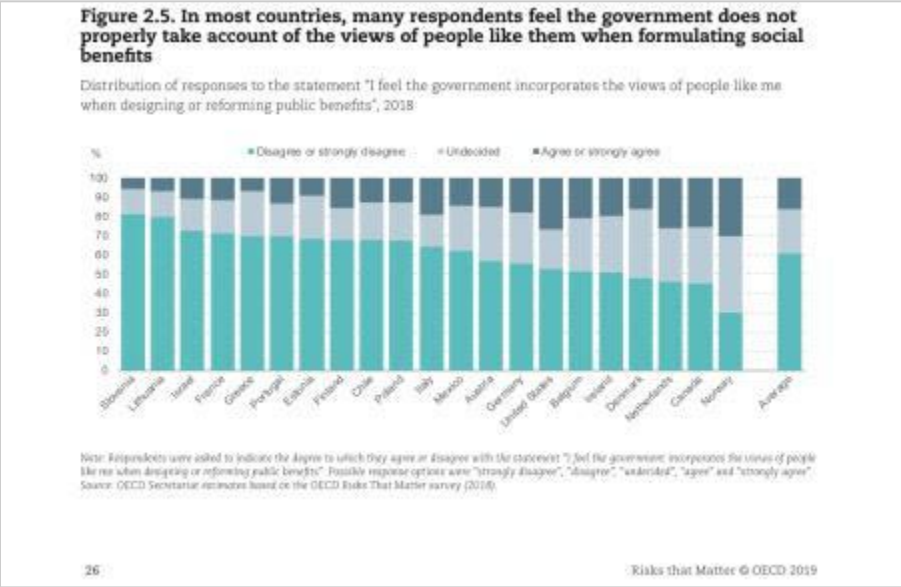


Views of the Nation, the Constitution and Government

Large majorities in most OECD countries believe that government ignores them when setting social benefits

by Yoram Gat

"Risks that Matter 2019", a new OECD report [PDF], shows a familiar public opinion pattern. Most people in most countries (in this case OECD countries) feel government does not serve their needs and does not take their opinions into account when formulating policy.



Big Data And Better Government Margaret Levi

Simultaneously, another group of actors are stepping up to the plate to adapt and improve current technologies, data platforms, and analytic advances in the service of citizen voice. Providing individuals with mobile phones to take pictures, send texts and emails, and otherwise document what they see offers citizens a means for reporting on where things are broken and for demanding that they be fixed. It is also a new and important form of quality control over elections, services, and bureaucrats.

We proposed that all of the nations of the world begin to measure poverty, inequality, injustice, and sustainability in a scientific, transparent, accountable, and comparable manner. Surprisingly, this proposal was approved by the UN General Assembly in 2015, as part of the 2030 Sustainable Development Goals.

“Data are the lifeblood of decision-making and the raw material for accountability. Without high-quality data providing the right information on the right things at the right time, designing, monitoring and evaluating effective policies becomes almost impossible. New technologies are leading to an exponential increase in the volume and types of data available, creating unprecedented possibilities for informing and transforming society and protecting the environment. Governments, companies, researchers and citizen groups are in a ferment of experimentation, innovation and adaptation to the new world of data, a world in which data are bigger, faster and more detailed than ever before. This is the data revolution

Community Partnership Strategy: Neighborhood Well-being Index
(Updates – July 1, 2011: The NWI is has been re-branded and launched as Wellbeing Toronto. July 29, 2010: This should now be referred to as the Neighbourhood Well-being Indices. Revised by the City researchers.)

Statistics and geography is about to get a whole lot more fun in the City of Toronto. City staff are working to create interactive, flash maps which allow users to explore neighbourhood-level indicators.

This fresh concept of a way to measure the vitality of a neighbourhood has now evolved into a first draft of the Neighbourhood Well-being Index (NWI). The NWI will collect neighbourhood-level information from a broad range of sources, including Statistics Canada demographic data and the City's own administrative databases.
The NWI is a new and separate initiative from City of Toronto staff, but it dovetails neatly with Council's newly adopted Community Partnership Strategy, providing the broad evidence base for the strategy. The NWI also complements the move towards open data initiative, OpenTO, acting as an open data warehouse.

Some of the data to be mapped data is already available, in less friendly formats, through the City's neighbourhood profiles, the Community Social Data Strategy and TO iMapit. The NWI will enable users to identify key populations groups or services of interest and then produce a user-friendly map of the data.
Several good examples from the U.S.A. give a preview of what the NWI might look like:

- The New York City website Envisioning Development Toolkit is a friendly tool which compares neighbourhood rent and incomes.
- California's Healthy City is a more data-rich site which allows users to map local services and demographics.
- The Reinvestment Fund's Policy Map compares a range of data across numerous American cities.

In a sophisticated web-based interface, Toronto residents will be able to select the indicators and identify their own "priority neighbourhoods," a shift from the current Priority Neighbourhood Areas that were selected using more universal indicators which don't always match specific local priorities. Service-providers for youth or newcomers or seniors will able to identify the highest need neighborhoods for each of their own populations.

Two overarching data clusters will be used as measures of a neighborhood's wellbeing, allowing a more granular examination of Toronto neighborhoods. These are

- Population Characteristics, such as Age, Gender, Language, Ethnicity, Family structure, Income.
- Human Service Infrastructures, from and about Community Centres, Libraries, Parks, Police Stations, Schools, etc.

The NWI's ten domains and particular indicators will likely expand as additional neighbourhood-level data becomes available. The first draft is exploring the following areas:

- **Arts, Culture and Heritage:** Agency Funding & Grants; Community programs; Neighbourhood-permitted events
- **Civic Engagement and Social Inclusion:** Agency Funding & Grants; City Beautification Initiatives; Community Meeting Spaces; Donations; Volunteerism; Voter Participation
- **Economic Security:** 211 Calls for Service; Child Care; Community-based Services; Debt Load (excluding mortgages); Local Neighbourhood Employment; Long-term Employment; Social Assistance; Unemployment; Variety of Local Businesses; Wages & Benefits.
- **Education:** Community-based Services; Early Development Instrument (EDI); High School Students applications to college/university; High School Drop-out Rates; High School Students passing Ontario Secondary School Literacy Test (OSSLT); Library Circulations
- **Environment:** Open Space; Pollution/Toxic sites; Soil conditions
- **Housing:** social housing waiting lists; property taxes; affordability (sales); adequacy (standards); rooming houses; Streets-to-Homes placements; Long-term Home Care Services survey; Toronto Community Housing tenant profiles; Homelessness & Hidden Homeless; 211 calls for information; and community-based services.
- **Recreation and Leisure:** Participants and drop-ins users of parks and recreation programs; waiting lists; facilities capacities
- **Safety:** By-law inspections/Standards complaints [although these tend to rise with the income of a neighbourhood]; Calls for EMS; Community-based Services; Crime by major categories; Domestic Violence; Fire Code inspections; Firearms shootings and victims; Fires & Arsons; Grow Ops; Pedestrian & Cyclist Collisions & Injuries; Toronto Community Housing Safety and Incidents;
- **Transportation:** Commuting; Public Transit Access; Wheel-Trans Use; Traffic volumes. [One potential but unnoted measures is walkability]
- **Personal and Community Health:** Birth Outcomes; Communicable Diseases; Community-based Services; Vulnerable Children (with data from Children's Aids Societies)

Reviewers, both academic and from the community sector, are being asked to review the indicators, help identify priorities for the roll-out, and advise in the creation of an index for each domain.

The hope is that the NWI will be ready to launch in the next 16 – 18 months.
In comparison, in 2005, the 13 Priority Neighbourhood Areas were selected using two sets of measures:

- need (including crime), and
- services available.

Communities which were high in need and low in service (defined as being further than one kilometre from the population requiring that service) were identified as priority neighbourhoods.

The key service areas evaluated were

1. Recreation and community centers
2. Libraries
3. Schools (every city neighborhood was identified as having one – the only category with full coverage)
4. Community health centers and hospitals
5. Community-based children's services
6. Community-based services for youth
7. Community-based services for seniors
8. Settlement services
9. Community-based employment services
10. Food banks, and
11. Community kitchens, gardens and markets.

An aggregate measure of neighborhood service levels was then created for each neighbourhood. See the City reports on the Strong Neighbourhood Task Force for more detail.

Check out how healthy your neighborhood really is

Curious how healthy — or unhealthy — your neighborhood is? Now you can look at smoking rates, obesity prevalence, and binge drinking habits in your neck of the woods. You can even see how many of your neighbors are going for an annual dental visit. The 500 Cities Project has a new interactive map that pulls health data on 27 chronic disease measures and breaks it down both by city and by neighborhood. The project could help local public health officials and policymakers identify problems and design health interventions for the areas that need them the most.

500 Cities data complements existing data sources by providing information on unhealthy behaviors, health outcomes and prevention practices in small geographic areas. For example, public health officials can use the following data sets to paint a more complete picture of the health of their regions:

The annual County Health Rankings measures county level health factors (obesity, smoking, food access, income, housing etc.) for all counties in the U.S. The site also includes a Roadmaps to Health Action Center section that provide guidance and tools to help communities take action.

America's Health Rankings, a project of the American Public Health Association, the United Health Foundation and Partnership for Prevention is a source for trends in nationwide public

health and state-by-state rankings using 34 measures of behaviors, community and environment, policies, and clinical care data.

VCU Life Expectancy Maps illustrate how opportunities to lead a long and healthy life vary dramatically by neighborhood. In some cases, life expectancy can differ by as much as 20 years in neighborhoods only about five miles apart from one another. The maps help raise awareness of factors that shape health and spur discussion and action on a complex web of issues that influence health.

SHADAC State Profiles
Find analysis of healthcare access at the state level that goes beyond standard indicators of health insurance coverage.

Preventing Epidemics. Protecting People.

http://healthyamericans.org/states/

Trust for America's Health (TFAH) is a non-profit, non-partisan organization dedicated to saving lives by protecting the health of every community and working to make disease prevention a national priority.

From anthrax to asthma, from chemical terrorism to cancer, America is facing a crisis of epidemics.

As a nation, we are stuck in a "disease du jour" mentality, which means we lose sight of the bigger picture: building a public health defense that is strong enough to cover us from all points of attack – whether the threats are from a bioterrorist or Mother Nature.

By focusing on PREVENTION, PROTECTION, and COMMUNITIES, TFAH is leading the fight to make disease prevention a national priority, from Capitol Hill to Main Street. We know what works. Now we need to build the resolve to get it done.

- **End of life costs:** 5 percent (2.5 million) of Medicare beneficiaries die each year; expenditures are $125 billion (25 percent of total Medicare funds). (Source: CMS)
- **Government benefit:** low income individuals—those in the bottom fifth by household income—receive $4,600 in annual income from government health services. (Source: Congressional Budget Office [CBO], July 2012)
- **Mobile payments:** mobile payments will be $171.5 billion in 2012—up 62 percent from $105.9 billion in 2011. (Source: Yankee Group)
- **Redacted science:** researchers analyzed 2,047 redacted papers: three of four were redacted due to misconduct of the researchers. (Source: Proceedings of the National Academy of Sciences)
- Hip resurfacing reliability: analysis of 32,000 patients followed by the National Joint Registry of England and Wales revealed that resurfacing was less efficacious than total hip replacement except for younger men. (Source: Alison Smith et al., "Failure rates of

metal-on-metal hip resurfacings: analysis of data from the National Joint Registry for England and Wales," The Lancet, October 2012)

- Federal budget 2012: total spending: $3.8 trillion: $709 billion defense, $773 billion social security, $872 billion health programs, $1.3 trillion deficit (24.3 percent of budget). (Source: Fiscal Year 2013 Budget of the U.S. Government, Office of Management and Budget)
- Knee replacement market: 600,000 annually, 238,802 Medicare vs. 93,230 in 1991; 9 billion market—demand will reach 2.5 million by 2030. (Source: Peter Cram et al., "Total Knee Arthroplasty Volume, Utilization, and Outcomes Among Medicare Beneficiaries, 1991-2010," JAMA, September 26, 2012)

Democracy suffers when government statistics fail The United States must change how it measures society, argues metrics maven Julia Lane. By Beth Simone Noveck

Overview of measurement

The Impact of Data-Driven Journalism on Public Policy Discourse

Transparent data about function and outcomes is essential for learning about and "treating" complex evolving systems. This presentation will explore the role of public reporting of healthcare outcomes and related performance information about hospitals and other healthcare systems. In particular we will focus on our work that tests the proposition that reliable, timely actionable data about health care organization's performance can inform citizens about their health care system and motivate them to play a role in improving healthcare outcomes.

Measure What Matters: Realigning Measures of Economic Success with Societal Well-Being
https://youtu.be/uVGml8TwAn8

By all the usual measures, the US economy is healthy. Unemployment is low, job growth continues to be robust, GDP is growing and 2019 was a great year on Wall Street. But while economic measures indicate a strong economy, too many people's economic lives are precarious. Stagnating wages, rising expenses, uncertain incomes, and limited opportunities to get ahead leave far too many people across the country feeling left out of today's economic success.

The Economic Opportunities Program's latest *Opportunity in America* event, "Measure What Matters: Realigning Measures of Economic Success with Societal Well-Being," explored the disconnect between measures of the success of our economy and indicators of people's economic well-being and offered ideas for indicators that would address this disconnect. **The event featured an introduction from Heather Boushey, president and CEO of the Washington Center for Equitable Growth,** whose new book considers how inequality is restricting growth and imagines how a more equitable economy would function. Daniel Alpert, who helped develop the Job Quality Index, and Sapna Mehta of the Groundwork Collaborative also joined Heather on a panel, moderated by EOP Executive Director Maureen Conway, to explore additional measures of our economy and to discuss how we can make our economy work better for all. This event was held in collaboration with our Aspen Institute program colleagues in Ascend, the Financial Security Program, and the Program on Philanthropy and Social Innovation.

Hans Rosling: Let my dataset change your mindset

Talking at the US State Department this summer, Hans Rosling uses his fascinating data-bubble software to burst myths about the developing world. Look for new analysis on China and the post-bailout world, mixed with classic data shows.

How to Measure a New Economy

What measures, beyond gross domestic product, can you use for taking the temperature of economic growth and productivity? Well-being, happiness, ease of living? This session looked at how to redesign statistics and policy frameworks for the new economy we live in.

Global Analytica @AnalyticaGlobal
How to Measure a New Economy, author @MazzucatoM joins a panel discussion around gaging economic progress.https://buff.ly/3aCziXV #WEF20

The session kicked off with a question to **Peterson** around how GDP is used. He explained that GDP is vital for all businesses and economies, but it is antiquated and doesn't capture huge sections of the market. Professor Mazzucato agreed that GDP misses large areas of value - from care to wellbeing. She made the case that we could start to improve the situation by trying to get more detail out of GDP as it stands.

Professor Takenaka commented that we live in a new economy with the Fourth Industrial Revolution, so we need to adapt how we measure performance. "There is a need to focus on intangible assets."

Professor Mazzucato made the point that GDP is too blunt an instrument that is often not understood properly, which in turn can lead to poor policy decisions.
The debate moved to what should be included in economic performance calculations. Professor Takenaka said: "We should not depend too much on one single indicator. GDP is useful, but we should consider supplemental indicators."
Professor Mazzucato agreed that if there was more of a 'dashboard approach' to the health of an economy, it would be possible to give specific advice to countries that need it that is tailored to the areas that need to be addressed.
Peterson explained that a mix of big data and machine learning could be used to provide more detailed data much more quickly than the current quarterly GDP updates, although Mazzucato questioned whether minute-by-minute data would be a good thing.
The final stage of session looked at the more fundamental issue of what sort of data is used to measure success.
"The conversation is changing from just the economic measures, to what countries actually want to do," said Professor Mazzucato. "The UN SDGs are having an impact on what metrics are being used to judge performance in businesses. Can we then take that company-level work and link it up to the macro-economic picture at a country level?"
Petersen was in agreement with the principle, saying that while looking at the indicators at a corporate level is a great start, there needs to be more consistency in reporting areas such as ESG - something that is being discussed at Davos this week.

Advances In Measuring Impact Are Guiding Our Future Course

Critically, we cannot build a Culture of Health without coming to an agreement with stakeholders on how to measure our progress. We've seen advances in this area in the past two years. For example, the Department of Health and Human Services' National Committee on Vital and

Health Statistics developed the Measurement Framework for Community Health and Well Being," which recommended domains for measuring population health that include metrics for factors outside the health care setting that contribute to our health.

A key component of the research enterprise and our ability to measure progress that has been explored at the conference is the growing availability of various data sources and data linkage efforts across sectors. The volume, variety, and velocity of data available today enable unprecedented opportunities to build the evidence base for improving health and addressing the broader social determinants of health. A number of groups are working at the forefront of these issues. The Social Interventions Research & Evaluation Network (SIREN) is synthesizing and disseminating rigorous research focused on the integration of social and medical care. Other collaborations to improve access to, and use of, data include: Data Across Sectors for Health (DASH), the National Interoperability Collaborative (NIC), and Health Data for Action (HD4A) to name a few. As the field explores how best to leverage the wealth of new data sources, key considerations around risks, ethics, and privacy must also be addressed. The pace of innovation in the technology and data space is such that each year we are learning and will continue to learn how to best leverage these advances to build a Culture of Health, emphasizing equity and community engagement.

US Census: Noemi Mendez Eliasen
I833 Chestnut Street
5th Floor, Suite 504
Philadelphia, PA 19107-4405
(215) 717-1820 or 1-800-262-4236
FAX: (215) 717-0755

The Health System Measurement Project tracks government data on critical U.S. health system indicators. The website presents national trend data as well as detailed views broken out by population characteristics such as age, sex, income level, and insurance coverage status.

Data Partners
The County Health Rankings are made possible thanks to partnerships with numerous primary data collection organizations. In many cases, our Rankings data team obtains information via publicly available data sources (e.g., the American Community Survey, Federal Bureau of Investigation Uniform Crime Reporting), but in other cases, data are specially prepared for us to include in the County Health Rankings.
The following partners have been instrumental in supporting the Rankings through their willingness to create unique data sets for the project, provide advice,or share our data:

- America's Health Rankings
- Dartmouth Institute for Health Policy & Clinical Practice
- Health Indicators Warehouse
- National Center for Health Statistics

Explore 500 Cities data to learn more about what's happening in your neighborhood!

https://chronicdata.cdc.gov/health-area/500-cities

State Health Facts (Kaiser Family Foundation)

Show Your Work: Healthcare Coverage Breakout for the Entire U.S. Population in 1 Chart Mon, 03/28/2016

The challenge of data/information…

- Who do we trust
- What assumptions do we make
- Real fact vs. projections
- How to present the information

Here are some of the thoughts about data related to healthcare

- Health status of Americans by State

Overview of health insurance (Data associated with insurance coverage in the various populations)

1. the number of individuals who have various health insurance arrangements
2. the expenses of the different health insurance arrangements
3. cost per person

Healthcare expenditures in the US

1. federal
2. state and local
3. employers
4. others

US debt

- Gross Debt is the sum of publicly-held and intragovernmental debt. Since May 16, gross debt subject to the debt limit has totaled $14.294 trillion.
- Publicly-held Debt includes all federal debt held by private investors—including individuals, corporations and foreign governments. As of June 24, publicly –held debt totaled $9.74 trillion.
- Intragovernmental Debt includes the debt that Treasury owes to accounts within the federal government. Much of this debt results from surplus in the Social Security trust fund, which is required by law to be invested in federal securities
- Intragovernmental debt amounted to $4.61 trillion as of June 24.

The various stakeholders by the numbers

- Hospitals and delivery systems
- Medical schools
- Insurance companies
- Healthcare professionals
- Foundations
- Non for profit and governmental organizations
- For profit companies

· Data associated with the cost per type of service (Link to Medicare and various insurance companies pricing)
· Data associated with the cost per common conditions
· Data related to politics and healthcare services (special interests)
· Healthcare obligations (Medicare, states, company pension plans etc)
· Access to healthcare services
· Data on quality of Healthcare
· Data about the various healthcare conditions (Link to visions section)

TOTAL U.S. POPULATION: 323.2 million
As of this moment, the entire U.S. population is...

- 318.8 million, according to Google.
- 323.2 million, according to Wikipedia.
- 323.5 million, according to WorldOMeters
- 323.2 million, according to the U.S. Census Bureau

...which is up from 321.4 million in July 2015 and 318.8 million in July 2014 (again, according to the Census Bureau). Needless to say, I'm gonna go with the U.S. Census Bureau data here: 323.2 million.
UNINSURED POPULATION: 29.0 million (The RED Section)

Most of this is based on estimates from the Kaiser Family Foundation in their "New Estimates of Eligibility for ACA Coverage Among the Uninsured". In the January 22, 2016 update to this report, they estimate the total non-elderly uninsured population of the U.S. as being around 32.3 million. When you include seniors 65 and older, this increases slightly. According to the HHS Dept., in 2012, around 1.7% of seniors were uninsured even with Medicare, Medicaid, the VA and so forth, which would've been around 700,000 people (out of appx. 41 million seniors total in 2012, according to the Census Bureau). Assuming this stayed roughly even over the past 4 years, Kaiser's total would be an even 33 million uninsured.

HOWEVER, the actual methodology of the Kaiser report says:

This analysis uses data from the 2015 Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC). The CPS ASEC provides socioeconomic and demographic information for the United Sates population and specific subpopulations. Importantly, the CPS ASEC provides detailed data on families and households, which we use to determine income for ACA eligibility purposes.

> The CPS asks respondents about coverage at the time of the interview (for the 2015 CPS, February, March, or April 2015) as well as throughout the preceding calendar year. People who report any type of coverage throughout the preceding calendar year are counted as “insured.” Thus, the calendar year measure of the uninsured population captures people who lacked coverage for the entirety of 2014 (and thus were uninsured

> at the start of 2015). We use this measure of insurance coverage, rather than the measure of coverage at the time of interview, because the latter lacks detail about coverage type that is used in our model. Based on other survey data, as well as administrative data on ACA enrollment, it is likely that a small number of people included in this analysis gained coverage in 2015.

In addition, the National Health Interview Survey from the CDC, which I believe is considered the "gold standard" for this data, states that:

The number of uninsured persons has declined in the past 2 years. In the first 9 months of 2015, 28.8 million persons of all ages (9.1%) were uninsured at the time of interview—7.2 million fewer persons than in 2014 and 16.0 million fewer than in 2013.

Note that the NHIS only runs through September 2015...which means it doesn't include any data from the most recent open enrollment period, nor does it include the implementation (or continuing progress) of additional Medicaid expansion efforts in states like Alaska, Montana, Indiana and Pennsylvania since last fall. Finally, the economy has continued to improve over the past 6 months, so there should have been some further improvement via employer-sponsored coverage, and so on. In other words, the current uninsured number is likely at the lower end of the Kaiser (33.0 million) / NHIS (28.8 million) range.

Finally, the just-released CBO budget projection report says that they expect the **full 2016 calendar year** to average just 27 million uninsured for the under-65 population. Even throwing in 700K seniors, that's still just 27.7 million for the full current year.

There are various other respected surveys from outlets like Gallup, the Commonwealth Fund, the Urban Institute and the RAND Corporation, but I'm pretty comfortable using **a flat 29.0 million here.**

As for how to **slice up** that 29 million, that's where I'm going back to rely on the **Kaiser report**. While their total number was higher, **percentage-wise** they broke it out as:

- 18% Adults eligible for Medicaid (either traditional or via expansion) (5.8 million based on 32.2 million total)
- 10% Children eligible for Medicaid/CHIP (3.2 million)
- 22% Eligible for subsidized ACA exchange policies (7.0 million)
- 9% Caught in the Medicaid Gap (2.9 million)
- 15% Undocumented Immigrants (4.8 million)
- 27% Not eligible for subsidized ACA exchange policies (either income too high or standing ESI offer) (8.6 million)

I could have simply lopped each of these numbers down by about 12%, but the number caught in the Medicaid Gap is determined by individual state policy, not by time simply passing. Kaiser's 2.9 million figure already accounts for Louisiana expanding Medicaid, for instance, even though they haven't actually implemented that policy yet. On the other hand, some of those folks may have moved to an expansion state, gained a job with benefits and so on, so there's likely to have been some shifting around. Here's how I revised these totals:

- **Adults Medicaid Eligible: 5.0 million**
- **Children Medicaid/CHIP Eligible: 3.0 million**
- **Medicaid Gap: 2.8 million**
- **Undocumented Immigrants: 4.7 million**
- **Eligible for Subsidized Exchange policies: 6.5 million**
- **Ineligible for Subsidized Exchange policies: 7.0 million**

OK, that leaves us with around **294 million people** who are covered by either employer-sponsored insurance, Medicare, Medicaid, CHIP, ACA exchange policies, off-exchange individual policies or some other program:

EXPANDED COVERAGE SPECIFICALLY DUE TO THE ACA: 23.6 million* (The Blue Section)

I debated greatly whether to bundle together Subsidized/Unsubsidized exchange policies, since all of them are technically enrolled in **through** the ACA exchanges specifically. However, my gut tells me that most of those who enrolled in **unsubsidized** polcies via the exchange (ie, paying full price) would have, absent the ACA, simply enrolled directly through their insurance carrier anyway (as millions of others are still doing).

Since the primary point of the color-coding in this chart is to group the **expanded coverage due specifically to the ACA itself**, I've instead moved unsubsidized exchange enrollments in with off-exchange policies. For similar reasons, I'm grouping "ACA Medicaid expansion" in with subsidized exchange policies (and the Basic Health Program) instead of with Medicaid/CHIP where you'd normally expect.

With that in mind:

- **Subsidized Exchange Policies: 9.1 million**
- **According to the official APTC report, 10.47 million exchange enrollees** were eligible for APTC subsidies (federal tax credits). However, experience over the 2014 and 2015 enrollment periods has made it pretty clear that **around 10-12% of exchange enrollees never pay their first premium** and are never actually enrolled in effectuated coverage or are kicked off due to a lack of legal residency verification. Combine this with normal attrition as people get jobs with ESI, age into Medicare and so forth, and **the effectuated**

exchange number is likely down around 13% of the total QHP selections by the end of the first quarter...or **around 9.1 million people.**

- **Medicaid/CHIP Expansion: 11.0 million**
- **Medicaid/CHIP Woodworkers: 3.0 million**
- The official **November 2015 CMS Medicaid/CHIP report** shows that the total number is up about 14.1 million over what it was pre-expansion. However, as I've noted many, many times before, **around 25-30% of these are actually "woodworkers"**...people who were already eligible for Medicaid/CHIP pre-expansion but either didn't realize it, didn't know the process for enrolling or were too embarrassed to do so...yet were encouraged to do so thanks to the ACA's outreach/education efforts. **The recently-released CBO report** puts the official "expansion only" number at **11 million**, which sounds about right to me, leaving **about 3 million Woodworkers.**
- **ACA Basic Health Program (BHP): 500K**
- This one's fairly easy: One of the lesser-known provisions of the Affordable Care Act allows for states to (voluntarily) implement a "Basic Health Program", which is sort of a **"Medicaid on Steroids"** (or, alternately, a potential **blueprint for a Public Option**). Only two states have done so to date: Minnesota (which actually already had their program in place pre-ACA called "MinnesotaCare", but retooled it and had it approved for BHP purposes) and New York, which just launched their BHP program this year. **New York enrolled around 380,000**, while **Minnesota has a total MinnesotaCare enrollment of around 100,000** (although, confusingly, **only about 40,000 of these** appear to have been run thorugh their ACA exchange website). Add them up and that's around 480,000 in BHPs. I debated whether Minnesota's program should be

considered "ACA specific", but decided that the program's membership has definitely increased substantially since the exchanges were launched **and** I believe the HHS Dept. is picking up the bulk of the cost now, so it counts. Rounding up, that's 500K BHPs.

It's important **not to confuse this figure (23.6 million) with the **net increase** in covered lives under the ACA to date (appx. 20 million). Bear in mind that only perhaps 5 million of the 9.1 million subsidized exchange enrollees are **newly** covered via the ACA; the rest switched over from some form of existing coverage. Similarly, not **all** 14 million of the Medicaid/CHIP enrollees listed here are newly covered, although the vast bulk are (perhaps 12 million). The remaining 3 million or so "newly covered" are mostly part of the "young adults on their parent's plans" (which, in turn, are mostly part of the large Employer Sponsored section), along with smaller numbers among other sections.*

OK, that's 10 sections down, 14 left to go!

UNSUBSIDIZED INDIVIDUAL MARKET: 9.1 million (the Yellow Section)

- **Unsubsidized Exchange Policies: 1.9 million**
- Again looking at the OE3 APTC report, out of 12.67 million QHP selections, 10.47 million are APTC-eligible...leaving 2.2 million which aren't. Again assuming that roughly 13% of these folks have dropped off as of this week, that's appx. 1.9 million still effectuated. I suspect that subsidized enrollees are more likely to drop their policies than unsubsidized, but that's getting even more nit-picky than I like.
- **Off-Exchange Individual Market (ACA Compliant): 6.0 million**

- As I've noted repeatedly, the off-exchange market is difficult to track since most states don't require private carriers to report enrollment numbers on a regular basis (if at all). However, I've long estimated that this number is likely around 7-8 million people, and **the CBO report recently gave their estimate at around 9 million**. However, it's important to remember that this includes **grandfathered and transitional policies** (see below). Subtract those and assume some amount of attrition (perhaps 10% instead of 13%) and you're down to **around 6 million people** enrolled in off-exchange policies which **are compliant with ACA requirements**...although this is a **strengthening** of the policy due to the ACA, not actual coverage expansion, which is why these aren't listed in the blue section.
- **NON-ACA Compliant Grandfathered/Transitional Policies: 1.2 million**
- This is kind of a mystery number; the best I've been able to do is to **extrapolate out from Florida data**, which gives a very shakey 1.2 million estimate. However, this fits well within my "7-8 million" range anyway, so I'll go with that for the moment. Note that this entire section should disappear entirely within another year or two.

MEDICARE: 55.5 million (the Orange Section) *(includes **around 9.2 million "dual eligibles" enrolled in both Medicare & Medicaid**)*

The **total** number comes from the **Kaiser Family Foundation's 2015 Total Number of Medicare Beneficiaries report**. I'm sure it's a bit higher than this by now, but this is the most solid, recent figure I have at the moment.

- **Medicare enrollees under 65: 8.9 million**

- **Again, according to the Kaiser Family Foundation**, about 16% of Medicare recipients are disabled individuals under 65 years old.
- **Medicare Advantage: 17.2 million**
- Again, Kaiser is the name to beat here: 31% of **all** Medicare recipients are in Medicare Advantage plans. I'm not sure if these are split between the Over 65 and Under 65 crowd, but I'm just gonna carve them out of the Over 65 chunk, which leaves...
- **(Traditional) Medicare enrollees 65 and older: 29.4 million**

TRADITIONAL MEDICAID/CHIP: 49.0 million **(The Brown Section)** (not including Expansion & Woodworkers)

TOTAL Medicaid/CHIP enrollment was **71.8 million people as of December**. It's probably a bit higher now, but that's the most recent enrollment data.

Of that, as noted above, about 9.2 million are "dual eligibles" who I'm lopping off as they're already listed under the Medicare section. That leaves about 62.6 million total.

Of those, I've already accounted for 14 million via ACA expansion and Woodworkers, leaving about 48.6 million.

- **CHIP (Non-ACA): 8.1 million**
- Of those, **around 8.1 million children** were enrolled in the CHIP program (formerly known as S-CHIP) as of 2014 according to CMS. The "**ever** enrolled" wording had me confused at first (I thought it might be cumulative since the program was started in 1997, which wouldn't make much sense), but the yearly

comparison numbers clearly show that it's referring to children who were enrolled **for any period of that calendar year**, which is fine.

- **Children's Medicaid (Traditional): 29.9 million**
- The December CMS Medicaid report also specifically states that across the 46 states which broke out the categories, "children enrolled in the Medicaid program and individuals enrolled in CHIP make up nearly 53 percent of total Medicaid and CHIP program enrollment." Out of 71.8 million people total, that's about 38.0 million. If 8.1 million of those are enrolled in CHIP itself, that leaves 29.9 million children enrolled in Medicaid proper. Subtract **those** from the total, and you're left with...
- **Adult Medicaid (Traditional): 11.0 million**
- Yes, that's right: As far as I can tell, there are nearly 3 times as many children enrolled in Medicaid itself as adults (and 3.7x as many as are enrolled in CHIP). This really surprised me, as I honestly thought that "Children's Medicaid" and "CHIP" were just two different names for the same program; it turns out that they **aren't** the same at all, although the distinction might only be one of where the funding comes from. At the same time, this actually makes sense when you look at **this absurd table showing all the different "eligibility threshold" categories** for different residents of each state, especially the non-expansion ones. For instance, Alabama enrolls children in Medicaid if their families make up to 141% of the Federal Poverty Line...but their parents only qualify up to an absurd 13% FPL, and adults without kids are SOL since this is a non-expansion state.

- I **think** the way it works is this (again, using Alabama as an example): Medicaid covers children in households from 0 - 141% FPL; CHIP covers the kids in households from 142% - 312%. It varies by state, of course.

OK, what does that leave? Well, I believe we're down to "Other" and the Big One: Employer Sponsored Insurance. Let's take a look at the tally so far:

- **Employer (total): 153 million**
- Medicare (total): 55.5 million (includes 9.2 million dual-enrolled in both Medicare & Medicaid)
- Medicaid/CHIP (non-ACA): 48.1 million
- ACA-Specific: 23.6 million (Med. expan., woodwork, sub. QHPs, BHPs)
- Non-ACA Individual Market: 9.1 million
- **Other: 4.0 million**
- UNINSURED: 29.0 million

OTHER: Around 4.0 million **(The Grey Section)**

- "Other" is a catch-all category covering anything which didn't seem to belong anywhere else:
  - The Indian Health Service, which (according to Wikipedia) "currently provides health services to approximately 1.8 million of the 3.3 million American Indians and Alaska Natives"
  - An unknown portion of the 2.3 million people incarcerated in prison/jail nationally** (some prisoners have been/are being transferred over to Medicaid via the ACA, but I don't know the numbers...perhaps half of them?)
  - An unknown number of college students enrolled in student health plans nationally
  - Around 215,000 children enrolled in New York's unique "Child Health Plus" (CH+) program (which has no connection with CHIP even though they sound the same)
  - Other various & sundry (permanent residents with healthcare coverage via other nations, etc).

****I should also note that it's even possible that a portion of the 2.3 million incarcerated population is actually lumped in under "government employee" coverage. What I mean is this: It's possible that some states include all healthcare costs for their correctional departments under a single line item in the state budget--i.e., "healthcare" including coverage for guards, administration and the prison population. I don't know if this is the case, but it might account for some of that group.**

Subtract all of that and you're left with the largest major section:
EMPLOYER SPONSORED INSURANCE: 153 million (Green Section)

I'm well aware that this number seems a bit low. Out of 323 million total, that's only 47.4% of the population, compared with the following estimates:

- **Kaiser Family Foundation, 2014: 49%** (158.4 million equivalent today)
- **Congressional Budget Office, March 2015:** 154 million full-year average for 2015; 156 million for 2016
- **Congressional Budget Office, March 2016:** 155 million full-year average for 2016

However...what can I say? I'm doing a lot of rounding off and estimating here, and I'm pretty sure that the Medicare/Medicaid "Dual Eligible" category isn't the only area where some of them overlap by a few hundred thousand or so. There's some amount of uncertainty in all of the categories, so if I'm gonna trim one category down a bit to cover the difference, it might as well be the one where the difference is the least visible.

With that in mind, while it's been trending downwards over the years (even pre-ACA, I believe) Employer-Sponsored Insurance still covers **nearly half** of the country's

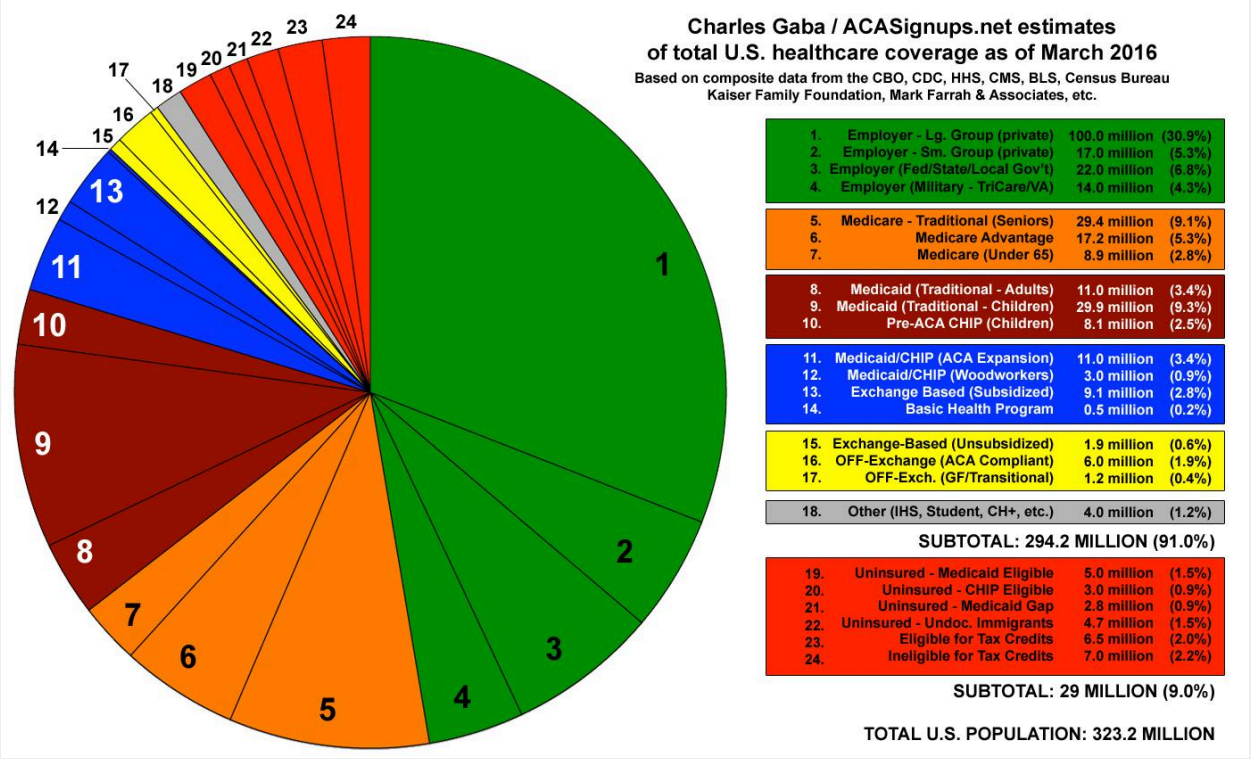
population, which is one of the reasons why messing with it can be so difficult to do. I have it broken out into 4 chunks:

- **Military (Tricare/VA): 14.0 million**
- The last time I tried this last summer, Julie Rovner of Kaiser Health News helped me cobble together rough numbers: Around **1.5 million active duty military personnel** and **around 12.5 million non-active personnel.**
- **Government Employees/Families (Federal, State & Local): Around 22.0 million**
- According to a report from the Bureau of Labor Statistics, there are a total of roughly 22 million federal, state and local employees. I don't **think** this includes the military, but if someone can clarify this I'll edit the chart accordingly. I recognize that not all of these employees may have coverage due to being part-time, union concessions and so forth, but again, until someone can provide better data, I'll stick with it.
- **Private Sector: Small Group: Around 17.0 million**
- This number comes from **Mark Farrah and Associates**, a respected healthcare industry/insurance analytical firm. They had the sm. group market at around 16.7 million in 2013. I assume it's grown slightly since then, but not necessarily that much given the **anemic numbers to date from the ACA's SHOP program.**
- **Private Sector: Large Group: Around 100 million**
- Simple math: 153 million, minus 14 million, minus 22 million, minus 17 million leaves a nice even 100 million Americans enrolled in private, large group policies nationally.

So, there you have it. Am I way off on some of the above? Possibly. Am I off by a little on some? Definitely. Have I shown my work and my sources? Yes. Am I in the right ballpark overall? I'm pretty sure I am.

Put **all** of it together, and here's the **FINAL** version (yeah, I said that this morning but this time I mean it!):

(Click image for a high-res version)



In addition, it's important to remember that while the ACA is only **directly** connected to those 4 blue sections (yes, there's 4 of them, not 3...don't forget #14, BHPs), it also impacts large chunks of the rest of the pie, since the pre-existing condition, free

preventative care & some other provisions covers **all** private policies (including employer-sponsored in most cases).

UPDATE: I'm not going to revise the actual chart anymore for awhile (it takes time to make even minor tweaks), but I am going to start listing additional suggestions for future reference here:

- Healthcare "data wizard" Mike K thinks that Section 2 (Small Group Employer) should be larger relative to Large Group, pointing out that:

"1. SHOP is anemic because it's a burdensome system and does not reflect the size/growth of the market;
2. Although the national rollout was delayed, NY changed SG def from 50 to 100 EEs on 1/1/16 so there's a large increase"

UPDATE: Jamey Harvey, tech lead for the DC exchange, suggested breaking out exchange-based vs. off-exchange **employer**-based coverage. This is a good idea, but as far as I can tell, that really just refers to SHOP enrollees, which I'm fairly certain are barely a rounding error here--perhaps 200,000 people nationally at most (for comparison, the BHP program (#14) is around 500,000 people, and that's barely visible in the chart above). I'll be posting about SHOP soon and will consider adding one more tiny sliver for that.

US Economic Overview

Gross Domestic Product (GDP)
Source: US Department of Commerce: Bureau of Economic Analysis
Total government expenditures:
Total income:
Taxation
Deficit: this year's federal deficit is over $1.3 trillion

The Debt to the Penny and Who Holds It

See what the roles and responsibilities of this legacy Bureau were – to borrow the money needed to operate the government and to account for the resulting debt.
Visit Bureau of the Public Debt

Current	Debt Held by the Public	Intragovernmental Holdings	Total Public Debt Outstanding
10/04/2012	11,314,031,454,864.60	4,847,848,402,292.06	16,161,879,857,156.66

Employment Numbers: Source: U.S. Bureau of Labor Statistics

Current	Unemployment Rate	Payroll Employment	Average Hourly Earnings
September/2012	7.8%	+114,000(p)	+$0.07(p)