Is Paying for Health Care a Good Investment in Health? The Economics of Prevention

Lewis G. Sandy, M.D.
Center for Global Health Systems, Management, and Policy
Wright State University Boonshoft School of Medicine
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United Health Foundation: Tracking Health Status for 20 Years

United Health Foundation
Partnership for Prevention
American Public Health Association

US Health Gains: Stagnation Since 2000
International Comparisons:

**Figure 2. International Rankings and National Health Expenditures**

<table>
<thead>
<tr>
<th></th>
<th>AUS</th>
<th>CAN</th>
<th>GER</th>
<th>NZ</th>
<th>UK</th>
<th>US</th>
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</thead>
<tbody>
<tr>
<td>Overall Ranking</td>
<td>4</td>
<td>9</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>6</td>
<td>2</td>
<td>3</td>
<td>6</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Patient-Centered</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>6</td>
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<tr>
<td>Timeliness</td>
<td>4</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Equity</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Health Expenditures per Capita</td>
<td>$2,003</td>
<td>$3,002</td>
<td>$2,005</td>
<td>$1,006</td>
<td>$2,231</td>
<td>$5,630</td>
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</table>

US: Last Place in Reducing “Amenable Mortality”

**Mortality Amenable to Health Care, 2002-03**

Deaths per 100,000 population

Health Care Costs Continue to Rise

**Increases in Health Insurance Premiums Compared to Other Indicators, 1986-2006**

*Note to graph: Data from the Health Care Cost Institute, which is included as an exhibit in this presentation.*
**Purchaser Concerns About Quality of Care**

- 45% didn’t receive recommended treatment
- 11% received care that wasn’t recommended or was harmful
- 35% of hypertensives not diagnosed or correctly treated
- 55% of diabetics not adequately monitored for glucose control

*“The system falls short in translating knowledge into practice and applying technology safely in a manner that decreases waste.”*

**Institute of Medicine**

- 30% of direct health care costs result from poor quality
- Poor quality care costs approximately $2,000 per covered employee year

**Social Security, Medicare, and Medicaid Spending as a Percent of GDP**

<table>
<thead>
<tr>
<th>Year</th>
<th>Medicare</th>
<th>Social Security</th>
<th>Medicaid</th>
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<tbody>
<tr>
<td>2000</td>
<td>10%</td>
<td>15%</td>
<td>5%</td>
</tr>
<tr>
<td>2005</td>
<td>15%</td>
<td>20%</td>
<td>10%</td>
</tr>
<tr>
<td>2010</td>
<td>20%</td>
<td>25%</td>
<td>15%</td>
</tr>
<tr>
<td>2015</td>
<td>25%</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td>2020</td>
<td>30%</td>
<td>35%</td>
<td>25%</td>
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</table>

*Source: CBPP calculations based on Congressional Budget Office data.*

**“Ah, Houston, We Have A Problem…….”**
What Determines “Health”?

Improving Health Means Focusing On All the Determinates of Health

"The significant problems we face cannot be solved at the same level of thinking we were at when we created them."

- Albert Einstein (1879-1955)
The Prescription for Improving Health:

- Health Care Reform (federal and state)
- Health (and more importantly, Non-Health) Policies that Promote Health
- Encouraging Clinical Preventive Services
  - Performance Transparency and Improvement
  - Consumerism
  - Incentives
- Supporting Healthy Behavior
- Delivery System Improvement

Health Reform: Consensus (apparently) on Prevention

<table>
<thead>
<tr>
<th>Policy Area</th>
<th>Clinton</th>
<th>Edwards</th>
<th>Obama</th>
<th>Giuliani</th>
<th>Huckabee</th>
<th>McCain</th>
<th>Romney</th>
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<tbody>
<tr>
<td>Expand coverage</td>
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<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>Yes</td>
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<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Performance transparency</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
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<td>Yes</td>
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<tr>
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<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Support healthy behavior</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Delivery system</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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</tbody>
</table>

States: The Laboratories of Democracy
Ohio: Middle of the Pack, Lower Heath Status

<table>
<thead>
<tr>
<th>Overall Rank</th>
<th>2.4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Rank</td>
<td>2.4</td>
</tr>
<tr>
<td>Health Rank</td>
<td>2.4</td>
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Brief Overview of State Indicators

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Policies that Improve Health

- Tobacco control
- Promotion of physical activity
- Healthy eating
- Improving education
- Economic policies that promote growth and reduce inequality

CBO: "Future Health Spending is the single most important factor determining the nation’s long-term fiscal condition" (Peter Orszag, Congressional Testimony Jan 2008)

Encouraging Clinical Preventive Services

- Incorporating into insurance benefits
- Reducing/eliminating financial and non-financial access barriers
- Using incentives to promote desired behavior
- Social marketing
**Partnership For Prevention: Prioritized List of Preventive Health Service**

- Most Cost Effective Preventive Services
  - Naloxone for opiate withdrawal
  - COPD prevention
  - Blood pressure checks
  - Vision checks
  - Depression treatment
  - Thyroid checks
  - Diabetic foot exams
  - HtN screening
  - Breast and cervical cancer screening
  - Colon cancer screening
- Medicare
- Medicaid

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**Performance Transparency Empowering Consumers (and their physicians) with Information**

- Not all healthcare is the same
- Physicians may not know how they are doing
- Consumers want information, may not know how to get it, or how to best use it
- We need to turn raw data:
  - First, into useful information
  - Second, into an "operating system" for improvement

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**Variation in Quality and Cost Efficiency**

- Distribution of Interventional Cardiologist: Atlanta
- Bubble size reflects number of UnitedHealthcare cases seen by physician

- High Quality, Lower Cost
- High Quality, Higher Cost
- Lower Quality, Lower Cost
- Lower Quality, Higher Cost

- Effort versus Outcome: 0.85 to 1.15

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Elyria has three times the rate of angioplasties of Cleveland, 30 miles away (8/18/06)—Why?
Individual Designation status identified online
• Quality and efficiency
• Quality only
• Specialty not evaluated
• Insufficient UnitedHealthcare data
• Not displayed upon physician’s request

Designation Display on myuhc.com

Consumerism:
• Consumers Want Health Information
• Consumers Will Have Greater Cost Exposure
• Consumer Behavior can Impact Health
  • It’s a “Forced March”
  • Consumers Want First $ Coverage (unless they are paying “their own” $)
  • Market is Nascent, but it’s Moving...

Engaging with Consumers
The health plan market is beginning to creatively link consumer engagement initiatives and developing fundamental/market changing consumer experiences that are creating new opportunities to extend the traditional health plan services (e.g. managing quality and reducing health care costs) directly to the consumer.
“P4P”: Delivery System Incentives

- Over 200 versions of “P4P”
- Initial results not promising, later programs showing positive effects
- Incentives usually part of broader, multi-component quality improvement programs
- “More research is needed….”

Supporting Healthy Behavior: The Role of Behavioral Economics and “Soft Paternalism”

Delivery System Improvement

- Major Gaps Between What Should Happen and What Does Happen in Health Care Delivery
- Focus of Current Improvement Efforts:
  - Safety and harm reduction (MRSA, never events, 100K Lives)
  - Some hospital/medical staff integration and improvement
  - Centers of Excellence for specialty services
- Areas Needing Attention:
  - Aligning financial incentives
  - The small practice
  - The death spiral of primary care
  - Hospital cost trends and capital expenditures
Pursuing “Perfect Care”......

Central Line Associated Bloodstream Infections (CLABIs)
(From Nick Shannon, MD, West Penn Allegheny Health System)

“Every System is Perfectly Designed to Achieve the Results it Achieves...”

Drivers of a Low-Value System
(Tom Nolan, PhD)

Low Value

Low Cost

Low Quality

The Economics of Prevention: Two Key Questions

- Does Prevention Reduce Costs? (and if not, does it matter?)
- To improve Health, Where should the “marginal” $ go?

Measuring Cost Effectiveness

Cost-effectiveness (CE) assessment estimates what is the cost of achieving a unit of health, and are multi-valued life years (QALYs). A QALY is a measure that accounts for both health status and health years of life lost.

QALY = health status x (1 - health years lost)

The more dollars per year a QALY, the more efficient and effective the service. Little dollars saved are precious if the dollars spent, the services not saving.

By way of contrast to QALY, does not distinguish between the service is not effective because there is an explicit, significant, or non-specific, other factors that are effective or efficient, or, is the service itself adequate or accurate?

On cost-effectiveness threshold, a lower threshold that is $150,000 per QALY, compared to a higher threshold that is $500,000 per QALY, requires the lower dollar to produce the same level of health. However, at any percentage of market health care services are considered “inappropriate” at less than $150,000 per QALY.
The Economics of Prevention: Two Key Questions

• Does Prevention Reduce Costs? (and if not, does it matter?)
  • While some preventive services save $, most do not
  • “Cost-effective” services still add costs
  • “Cost-effective” to whom?
• To improve Health, where should the “marginal” $ go?
  • Societal questions, needs societal answers

“Does Prevention Reduce Costs? (and if not, does it matter?)
• While some preventive services save $, most do not
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• Societal questions, needs societal answers

"The best way to predict the future is to invent it."
- Alan Kay

A Journey, Not a Destination……..