The James A. Baker III Institute for Public Policy
and the Baker Institute Health Policy Forum
Rice University

National Healthcare Reform: Policy Options and Imperatives

James A. Baker III Hall
Rice University, Houston, Texas

Friday, February 23, 2007
Opening Remarks at 8:30 am
Closing Remarks at 3:30 pm

Conference Presentation

The Value Equation in Health Care

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For more information about the Baker Insitute Health Policy Forum: www.bakerinstitute.org.

Summary: The Value Equation in Health Care

Health care analysts lament the access, cost, and quality of health care in America: access is limited, costs are too high, and quality is uneven. The access issue is straightforward: either the government pays for universal insurance coverage, or it remains unachieved. The relation between cost and quality, however, is more complex. Cost control is good if the care foregone when spending less has low health benefit, but bad if it has significant benefit. Put another way, a good health care system delivers high value care but avoids low value care.

In my talk, I consider the value of American medicine. How well are we doing at meeting this goal? I highlight two fundamental facts about health care. The first fact is that the average value of medical advance is very high. As a country, we spend significantly more on medical care than we used to, but with very good outcomes. The average 45-year-old will spend $30,000 more on cardiovascular disease care today than the equivalent person did in 1950. The same 45-year-old will live another 3 years because cardiovascular disease care has improved. Almost every estimate suggests that three years of life is worth well more than $30,000. We have spent a lot, but we have gotten a lot more.

The second fact is less happy. Even with all the procedural advances, there is a large mismatch between what should be done and what is done in medicine. Medical care is substantially overused; most estimates suggest that about 20 percent to 30 percent of medical spending could be eliminated with no adverse effects on patient outcomes. On the flip side, not everything that should be done is done. The vast bulk of people with chronic diseases have their risk factors uncontrolled, even when medications to control disease are safe, well-known, and inexpensive.

The key in all these cases, I argue, is money. Reimbursement that is generous for high-tech care leads to the development of substantial new innovations. These innovations cost more, but bring high value. At the same time, the innovations are overused. Why stop with the most important care when there is money to be made by doing more? On the other hand, care that is not reimbursed well is underperformed. Pharmaceuticals may be cheap, but they are a hassle for patients to integrate into their daily lives. Without reimbursement for monitoring and managing chronic disease care, such care remains poor. Money is thus the good and bad of medical care - good when it provides incentives for valuable care, bad when it does not.

Recognizing this principle leads me to a fundamental reconception of how to pay for medical care. Rather than paying doctors for what they do, we should pay doctors for how effectively they care for patients. In short, pay for value, not quantity. I give three examples of how value-based payment can be achieved: (1) reimbursing doctors that achieve superior health outcomes more than doctors that have poor outcomes; (2) encouraging the information technology that will allow us to measure and monitor good care; and (3) lowering cost sharing that patients face for care with very high value. Each of these steps can lead to a medical system more focused on doing what is right than on doing either everything or nothing at all.

The Value Equation in Health Care

David M. Cutler
Harvard University

One of the following is true…

- Money spent on new medical innovation is a major drain on the economy
- More R&D will lower health spending.
- Elvis is alive and haunting the Boston Red Sox

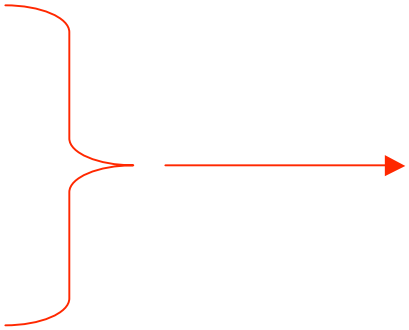
Background

Conventional Issues

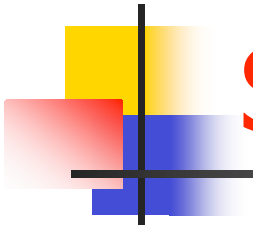
- Access
- Cost
- Quality

Real Issues

- Access
- Value



Spending money isn't bad. Wasting money is.



Summary

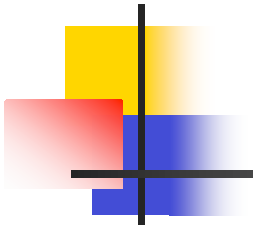
- On average, we get very high value for our spending.
- At the margin, we overdo some things and underdo others.
  - *Money flows are key.*

The Rise of Modern Medicine

- Why do we spend more on medical care?
  - Because we can do more.
    - Price increases are a small part of the story
    - Quantity and quality increases are
- Example: Cardiovascular disease

Changes in Medical Care for Severe Heart Disease (MI)

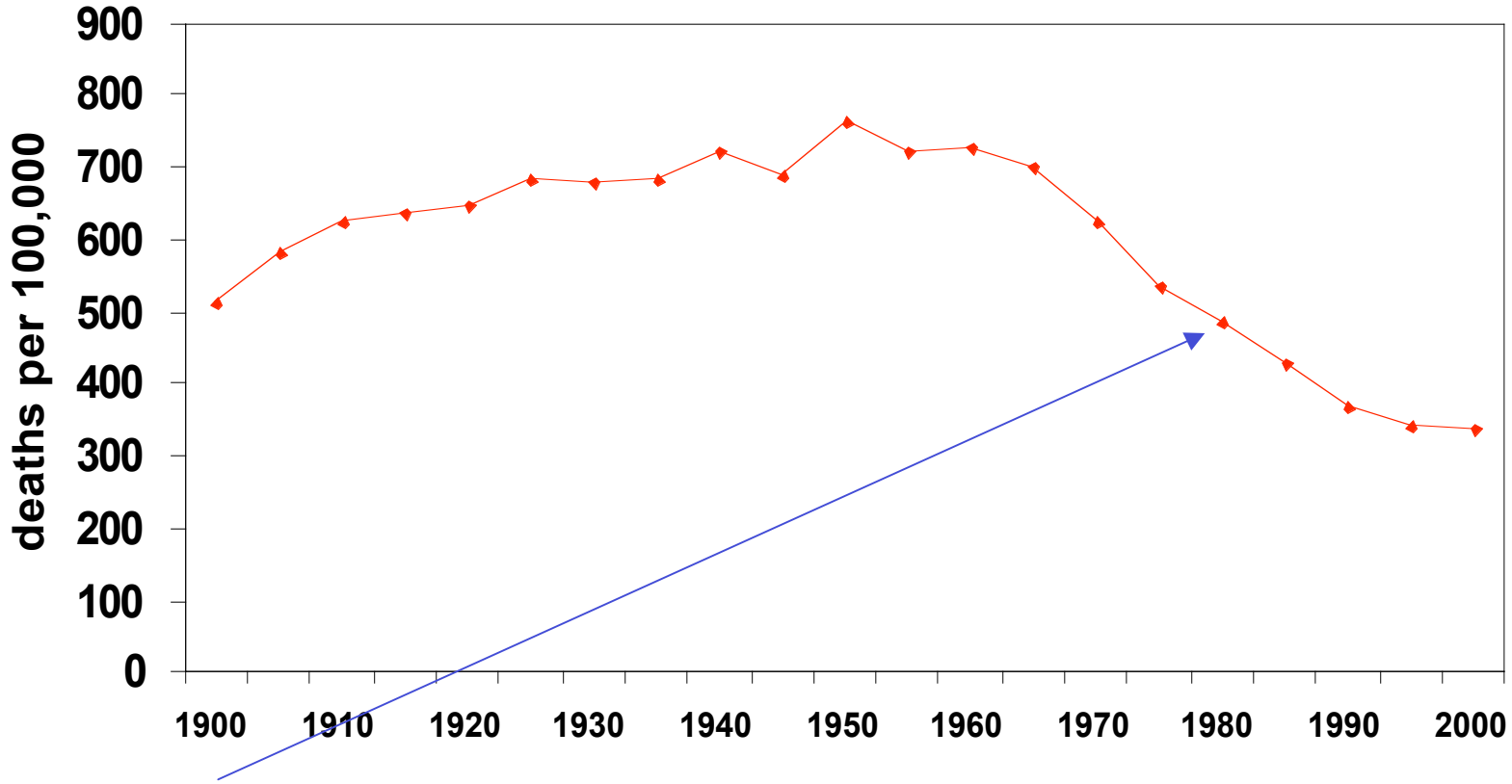
- 1950 Standard
  - Bed rest (6 mos +)
  - Cost ≈ $0
- Today's Standard
  - Pharmaceuticals to restore blood flow;
  - Intensive diagnostic therapies
  - Invasive revascularization
  - Cost ≈ $30,000 in present value at age 45



What Are the Benefits?

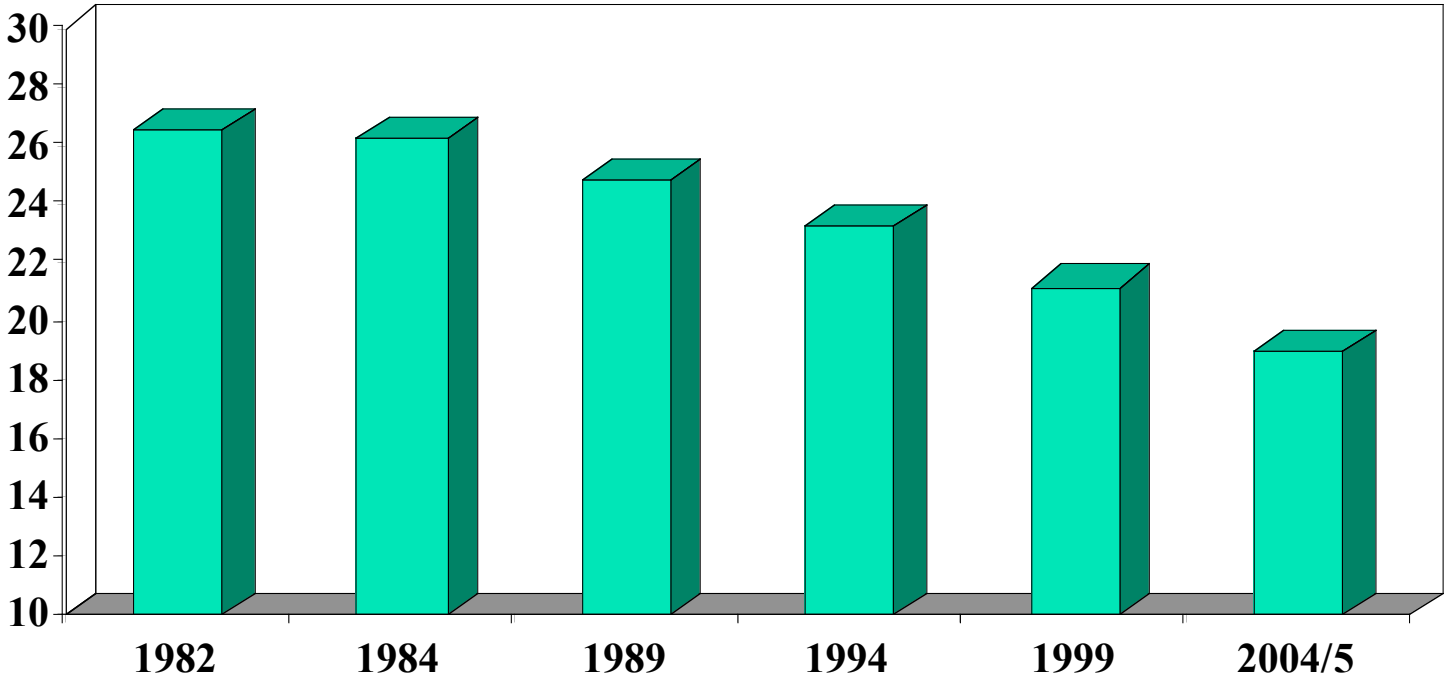
- Mortality
- Quality of life

The Single Biggest Factor in Reduced Mortality -- Cardiovascular Disease



Life expectancy at age 45 increased by 4½ years.

Fewer elderly have impairments in personal or living functions

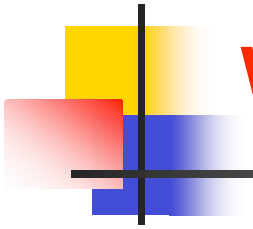


Decline between 1.0 and 1.5 percent per year.

Matching Benefits and Costs -- Cardiovascular Disease

- Benefits
  - About **3 years** of longer life (4½ in total for CVD) is a result of medical advance.
- Costs
  - Spending on CVD is about **$30,000** in present value from age 45 on.

Is it worth it?



What's A Life Worth?

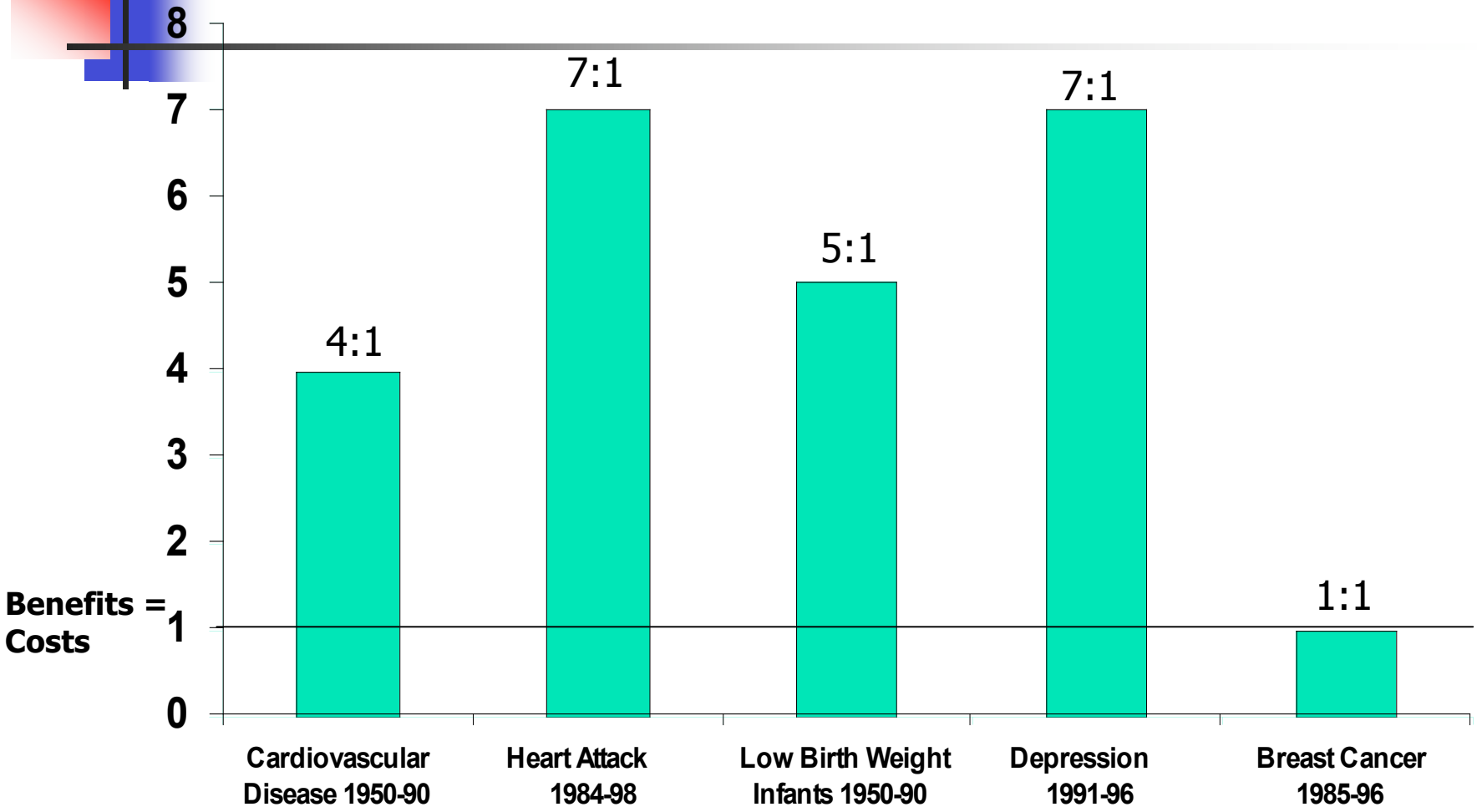
- How much are you willing to pay for an air bag, or a better braking system in your car?
  - $300 for an airbag → $100,000 per year of life saved.

Analysis of Cardiovascular Disease

- Benefits
  - Present value is about **$120,000**
- Costs
  - Increased spending of about **$30,000**.

Rate of return is **4:1**

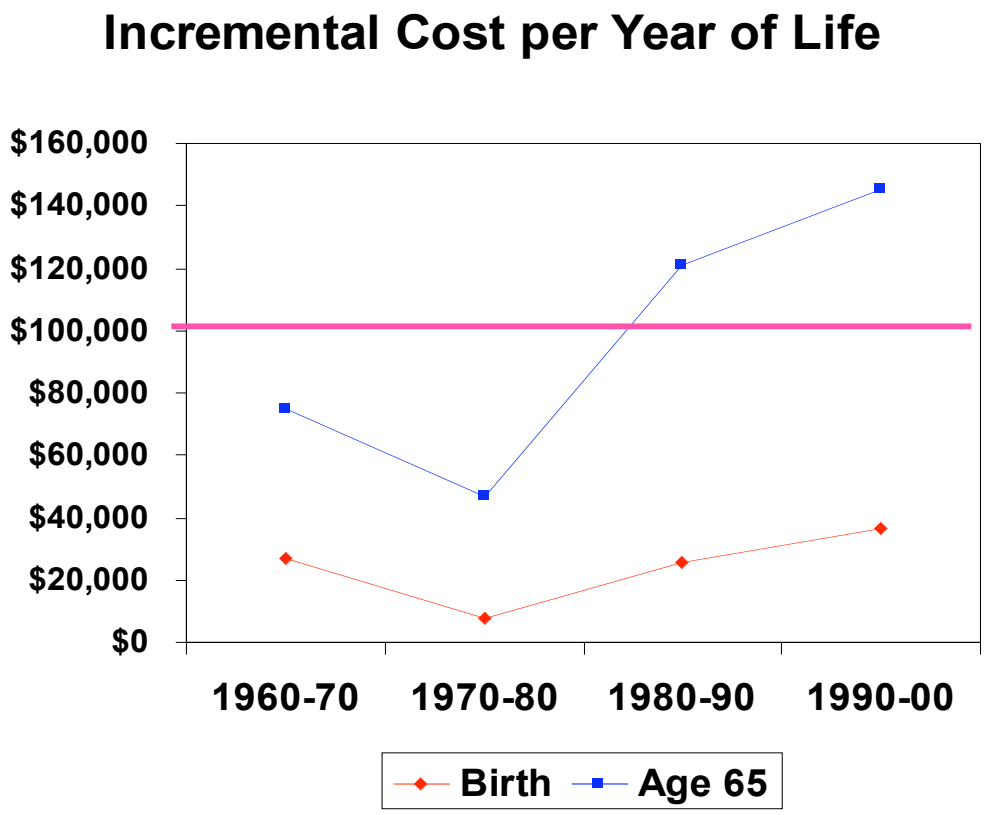
The Mortality Benefits of Medical Advance Are Significantly Greater than the Costs



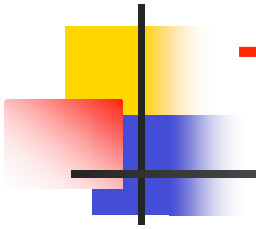
The Medical System As A Whole

- Form ΔCosts / ΔLE

As a whole, what we do is worth it.



Source: Cutler et al., *NEJM*, 2006.

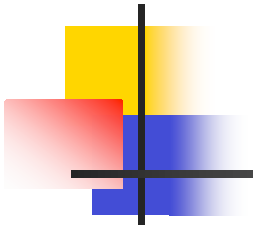


The Key

- People value their health highly
  - Two-thirds of Americans rank health care as a top item for an expanding economy.
- Medical advance costs a lot, but is worth it.
  - That's why the 'R' word (rationing) is not utterable in the States.

Is It All Worth It?

		Should Be Done	
		Yes	No
Is Done	Yes	☺	(perhaps 20%)
	No	(perhaps 10%)	☺



Waste: A Tale of Two Drugs

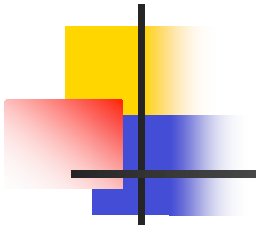
- Vioxx
  - Marketed aggressively (too much so) to physicians and patients
  - Suggestions of CVD problems not acted upon.
  - Thousands of people died before the drug was withdrawn.

The Other End: Aspirin and Heart Disease

- 1948: Dr. Lawrence Craven noted that none of 400 men who took aspirin had heart attacks. He recommended an aspirin a day. Studies continued into the 1950s.
- 1980: FDA approves aspirin for prevention of strokes in people with TIAs
- 1985: FDA approves aspirin as secondary prevention for heart attacks
- 1998: FDA approves aspirin as primary prevention for heart attacks and recommends aspirin during an MI.
- *Did this really need to take 50 years?*

What Do These Examples Have In Common?

- Both illustrate the role of money in medicine.
  - Strong financial incentive → lots of marketing / rapid production
    - May be good or bad
  - Weak financial incentive → no one has an interest in making them happen
    - May be good or bad
- "If you pay peanuts, you get monkeys."



The Value Proposition

- "Money is the opposite of the weather. Nobody talks about it, but everybody does something about it."
  - Rebecca Johnson, *'Vogue'*

- Three examples:
  - Pay for performance
  - Sparking the information revolution
  - Sensible cost sharing

Pay for Performance

- The most important reform we can make is to reimburse for better quality care, not just higher-tech care.

- Opportunities:
  - Physician payments in Medicare
    - Current policy calls for *25 percent* reduction in Medicare physician payments in the next 5 years.
    - This will not happen. Rather than dumping money in, pay more sensibly.
  - Regional reform

Information Technology

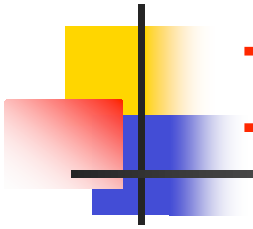
- The weakest incentives in medical care are for the use of information technology
  - It's expensive, and many of the benefits go to others

- Opportunities:
  - A new Hill-Burton Act for information technology.
    - About 2% of medical spending for 5 years
  - A 'side benefit' will be monitoring infectious disease outbreaks.

Sensible Cost Sharing

- In the Medicare drug benefit, patients pay the same amount for each prescription. Why?

- Opportunities:
  - When we fill in the 'donut hole', have patients pay less for particularly valuable drugs, more for less valuable ones.
  - An alternative to discussions about Federal discounts.



In Summary

- Elvis may be haunting the Red Sox, but with the right medical team, maybe he could beat the Yankees.