HEALTH & HUMAN SERVICES

The Price of Prevention

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BY JOSH GOODMAN | MARCH 31, 2008

Woody Allen once described death as "a very effective way of cutting down on your expenses." In the past decade, states all over the country have gone to great lengths to prove that the comedian was not only morbid but wrong. They have embraced the idea that keeping people healthy is both humane and fiscally smart; if the public is healthier, public spending will decrease. And they seem to agree that the way to keep people healthy is to prevent them from getting sick in the first place. They are investing in healthy-diet promotion and anti-smoking campaigns even as they cope with symptoms of diabetes and other chronic illnesses. "We're trying to drive people to understand that health status is the goal," says Marcia Nielsen, of the Kansas Health Policy Authority. "You don't want more medical care and you don't want more medical insurance, unless they're a means to an end."

To some hardheaded scholars and calculating critics, the problem is that, discouraging as it might seem, Woody Allen had a point. A large body of research suggests that preventive care may help people live longer, healthier lives (no small achievement) but doesn't actually save money. As a result, governments may be forced to come to grips with the notion that, when it comes to health policy, the right thing to do and the thrifty thing to do are very different.

The Ounce of Prevention

Steve Burd is an apostle of preventive care. He isn't a doctor or a public official -- he's the chief executive officer of Safeway Inc., the supermarket chain. Burd's company experienced a double-digit decline in employee health costs after signing up workers for a plan that stressed prevention and offered incentives for employees to live healthier. Now, Burd tells anyone who will listen that preventive care doesn't just improve health, it also saves money.

Politicians are listening. Presidential candidates from Hillary Clinton to Mike Huckabee have touted the cost savings of preventive care. Governors, from Rod Blagojevich in Illinois, to Arnold Schwarzenegger in California, have included prevention as a key component of major health reform proposals. Schwarzenegger's staff even consulted with Burd when formulating the governor's universal health care proposal.

In Kansas, Nielsen's organization, a quasi-independent state agency, possesses a broad mission to suggest changes to health policy. When the group handed Governor Kathleen Sebelius a reform plan last year, 16 of the 21 recommendations focused on prevention -- everything from emphasizing physical education in schools to expanding access to cancer screenings.

It's not just elected officials that are buying in. Missouri approved a major Medicaid overhaul last year, focused heavily on prevention and better coordination of care for chronic illnesses. Ian McCaslin, Missouri's Medicaid director, projects -- and he is using his most conservative scenario -- a one-to-one return on investment for every aspect of the plan. Some parts, he says, will be big money-savers.

A few governments are, in fact, starting to see savings. Travis County, Texas, for example, has operated a wellness clinic for county employees for the past three years. The county announced last year that it had saved $17 million on health spending since then, largely because healthier employees were consuming less health care.

Vermont was one of the first states to focus on wellness for employees, through a program that began a decade ago. Once a year, nurses conduct health risk assessments on employees. The nurses screen for illnesses, coach the workers on lifestyle choices and, when needed, direct them to care and counseling. The program has expanded to include retirees, too. Vermont's health care spending for state employees still has increased, but generally at a lower rate than other states.

"It's hard to say exactly where the savings have come from," acknowledges David Herlihy, commissioner of the Vermont Department of Human Resources. "There are very complex questions of trying to quantify what the return on investment is." And the returns aren't necessarily consistent. For several years in a row, the state maintained a surplus in its health insurance fund and used the leftover money to give employees a one-month reprieve from paying premiums, but that streak ended last year. Still, Herlihy notes that "everybody believes there's going to be a return on investment on these programs at the end of the day."

Mass Production

As it turns out, not everybody is a believer. The growing consensus in the medical research community is that preventive care usually does not save money.

Part of the problem is that the health system isn't always providing preventive care in targeted or well-planned ways. One of the most prominent examples is the checkup. Major clinical organizations don't actually recommend annual physicals as a preventive measure. Nonetheless, a lot of patients and their doctors pursue them. Ateev Mehrotra, a Rand Corp. researcher, crunched the

numbers and found that 44 million adults receive a preventive health exam every year and another 19 million women receive a preventive gynecological exam.

Mehrotra sees all of those checkups as a major waste of resources. His argument isn't that preventive care is bad. Preventive tests, such as mammograms and colonoscopies, are very important -- but they happen on a catch-as-catch-can basis. Many patients receive those services when they come in for other treatments -- when they may already be symptomatic. Yet many of the treatments that are common during physicals, such as blood cell counts and urinalyses, haven't been linked to improved health. Mehrotra argues that testing in this way is not just a waste of time, effort and money. "These physicals are limiting access for more important issues," he says, noting that one of the most common complaints from patients is that it's hard to see your doctor when you need to. He'd like to see insurance providers move away from paying for a physical a year and, instead, focus on paying for age-appropriate preventive services.

The skepticism toward preventive care, however, runs even deeper. Arthur "Tim" Garson Jr., provost of the University of Virginia and former dean of the medical school, is the author of "Health Care Half Truths." The myth that prompted him to write the book: the idea that preventive care saves money.

The trouble, Garson says, is that no one stays well forever. Prevention doesn't truly prevent -- it simply delays. And the financial benefits of keeping people healthy longer don't usually make up for the costs of doing so. "Stick a defibrillator in somebody," Garson says "and they live just long enough to get lung cancer."

Jay Bhattacharya, an assistant professor of medicine at Stanford University, adds another point. Prevention depends on providing care to a lot of people, knowing only a fraction of them will benefit. Say a government creates an anti-obesity program to prevent diabetes. Some of the recipients of preventive care will acquire diabetes anyway. And some of them wouldn't have gotten it, even without the program. That dynamic, Bhattacharya says, makes it difficult to save money on prevention. Garson agrees. "The problem with preventive care," he says, "is that everybody gets it. And if everybody gets it, you're wasting a bunch of money and a bunch of treatment."

Bhattacharya and Garson have evidence to back up their perspective. Most recently, a literature review of 599 articles on preventive care and savings appeared in the New England Journal of Medicine in February. The conclusion echoed early studies: Only about 20 percent of preventive measures actually produce savings. Garson offers the vaccine for measles as an example of one that does. Measles, he notes, rarely kills, but it can cause brain damage and a lifetime of associated medical costs. Preventing it, therefore, is financially advantageous. But most illnesses aren't like that. And, the research indicates, dying earlier usually is cheaper. "It's counterintuitive," Garson says "and it really irritates people."

Delayed Reaction

These findings create something of a puzzle. How can it be that governments and private companies, from Travis County to Safeway, report savings, if preventive care doesn't actually save money?

It's not that the doctors who have studied the issue think anyone's lying about their budgets or bottom lines. Rather, because preventive care delays costs, they may be spending less now only to spend much more later. But the researchers also stress that, when they say most preventive care doesn't save money, they're speaking in the broadest possible sense. The health system as a whole spends as much or more for a person who receives preventive care today than for one who doesn't.

Could a particular government save money on preventive care over the long term? It's possible. Preventive care is a little like a game of hot potato, with the goal being to keep patients healthy until they're passed to a different health insurance provider -- whether it's Medicare or a new employer. Garson's argument is that at some point the music has to stop and someone is stuck with the costs.

Nielsen is familiar with research showing that dying early saves money, but points to a phenomenon known as "compressed morbidity." People who live to old age without major illnesses, she says, tend to die relatively abruptly. Not only is that a more pleasant way to go, it's also cheap. So, if preventive care is effective enough to get people to the compressed morbidity stage, savings may be possible.

Garson doesn't disagree with this sentiment but considers talk of savings premature. He cites a piece of wisdom from his father: "The objective should be to make early old age as long as possible and late old age 15 minutes." To which Garson adds, "If you could pull that off, preventive care would save money."

There's hope for future savings for other reasons. As our understanding of genetics advances, doctors should have a much better way of knowing who is susceptible to certain illnesses. That could lead to better-targeted preventive services. "If you could apply preventive care to people who you knew would benefit from it," Garson says, "you'd come a whole closer to making it actually save money."

A Pound of Cure

Governments already have a simple way to target preventive care: Focus on the ill. In other words, it's possible that the mantra of the past decade -- encourage wellness over treating sickness -- is slightly off-point. If the problem with prevention is that it provides services to people who don't need it, why not target those who do?

Many states are doing just that. A decade ago, Florida started experimenting with disease management for Medicaid patients -- hiring nurses to call patients to remind them to take their medications and give them health advice. The program was considered groundbreaking. Today, everyone is doing it or looking into it. "Even folks who were not thinking about disease management or chronic care management are now thinking about it very seriously," says David Rogers, who is a consultant for Missouri's chronic care initiative. "There has been a widespread recognition, driven by financial concerns, that states need to focus on chronic care."

These programs also have been increasing in sophistication. When Florida started doing disease management, it focused on one

illness at a time. Now, states are investing in coordinating care for Medicaid recipients with multiple chronic conditions, a group that is very costly to treat.

From a financial standpoint, the principle here isn't all that different from preventive care. Disease management and chronic care aren't about preventing illnesses per se, but preventing the most costly side effects of illnesses, from heart attacks to hospitalizations. The underlying logic is the same: Good health policy is good fiscal policy. And, as Rogers, who oversaw disease management programs in Florida several years ago, says, these efforts really are driven by financial concerns. When states contract out disease management programs, as they often do, they typically demand cost savings.

Some are starting to see results. One example is Wyoming's Healthy Together! -- a program for which all Medicaid recipients are eligible. Healthy Together! runs the gamut from preventive services for beneficiaries without serious illnesses to coordinated chronic care and disease management for those who are sick. The results are impressive. The state has seen double-digit drops in emergency room visits and hospital re-admissions. Wyoming avoided $17 million in Medicaid spending in 2006 alone (the most recent year for which information is available) through the program.

Still, these efforts have their share of skeptics. Soeren Mattke, another Rand researcher, evaluated large-scale disease management programs and found little evidence that they save money. Mattke points out that for some conditions there's no reason to expect savings. For example, patients with untreated depression tend to cost the medical system little -- depression rarely lands someone in the E.R. Better management of depression entails medications and appointments, which cost more.

Mattke advises caution. "State governments try very hard to provide care to Medicaid patients, yet they have very constrained finances," he says. "Some vendors might have taken advantage of their desperation."

While preventive care may not save money, it nonetheless has enormous benefits. Even those who question its basis as a cost-saver -- Garson, Bhattacharya and virtually everyone else who studies prevention -- think it is good and valuable from a medical perspective. Preventive care, when administered intelligently, makes people healthier and helps them live longer. The same New England Journal of Medicine study that showed preventive care doesn't usually save money also indicated that prevention is often the most cost-effective way to improve health.

The same goes for disease management. Mattke found that disease management typically improves "processes of care." Patients are more likely to do the types of things associated with good management of illnesses, such as showing up for screenings and taking medications. There's not evidence yet that those process improvements actually make patients healthier over the long-term, but Mattke is hopeful they do. "Improving chronic care is good," he says, "even if it costs a little more."

In fact, there's a palpable frustration from many doctors that policy makers seem to judge preventive care and disease management through the prism of dollars and cents. Mark Fendrick, a University of Michigan physician who likes to cite Woody Allen's line, recently authored a study showing that small decreases in co-pays make it much more likely that patients will fill their prescriptions. Cutting co-pays might not save money, but he doesn't care. "There's an extraordinary focus on health care cost containment, without an equal focus on the amount of health we're achieving," Fendrick says. "We need to restore health to the health care cost debate."

Government officials agree. "Our foremost desire," Missouri's McCaslin says, "is to improve the health status of citizens." But it's not as though states can simply ignore the costs -- not when Medicaid and public employee health care keep eating up larger and larger portions of the budget.

There probably isn't an easy answer. If better health care always saved money, governments would be able to spend heavily on prevention with few concerns. But the situation isn't that simple. Governments need to focus on analyzing what types of health spending are most cost effective, whether they're investing in prevention or anything else. "There is a lot of hard work to prioritize where we spend scarce resources," Bhattacharya says. "You can't avoid that calculation."

Note: This online version has been modified to correct Arthur Garson Jr.'s title as it appeared in the print version.

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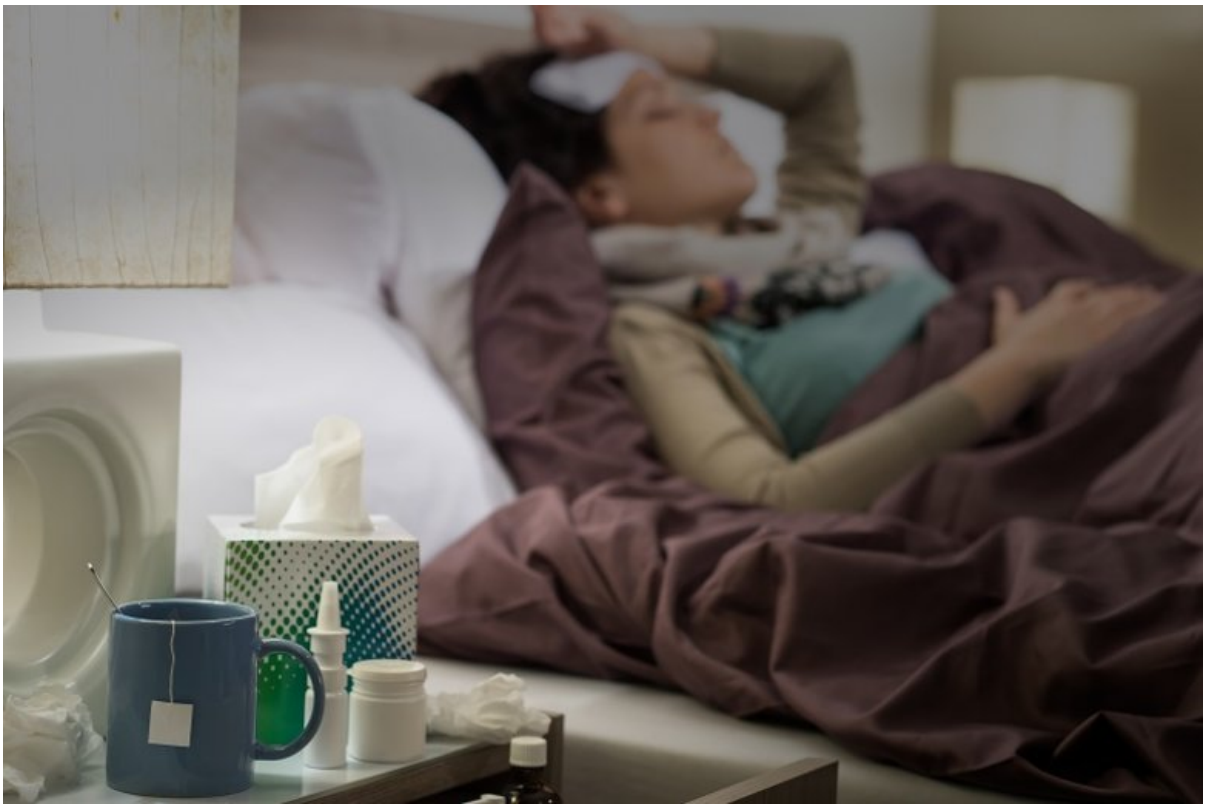

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