Health System Transformation Lecture
The Missing Link in Health Reform
Questions and Answers

This podcast is presented by the Centers for Disease Control and Prevention. CDC—safer, healthier people.

I'm going to have to ask you to come to the mic because we are filming this, as we do all these seminars. So please queue up and come to the mic. And if you just want to shout from your chair, one of us will repeat the question.

Man: Excuse me. Ah... Many decades ago, there were very aggressive efforts—for instance, in the tobacco area. And now, there seem to be—everybody seems to be pretty benign. We still allow cigarette advertising in this country. And we do know that it's mainly oriented toward the people who are most likely to get addicted—low-income population. But there's not much of a voice, really, at all, in reference to this issue, particularly from the CFOs or the national organizations. Everybody's dancing around this issue. But it's like advertising arsenic. And it's very, very sad for young teenagers who come from low-income communities. And I wonder why, just from your standpoint, people are such pansies about this issue and they're not being much more aggressive with legislators. I mean, if you—obviously, if you took a straw vote in America, and we were a pure democracy, people would say, well, let's do away with cigarette advertising. There's one group that really wants cigarette advertising in this country, and they control that decision—the tobacco industry.

Anybody want to take that softball, or...?

[Chuckling]

Because it's an excellent question, let's look at the flip side of it. The good news part of it is, if you go back to the 1960s, we had smoking rates of 50 percent. Now, they're down in the low 20s—21 percent, 22 percent. We've made enormous progress. Not enough. You're absolutely right. There's plenty of room for improving and pushing it below 22. But at the same time, if you look at the data on cardiovascular mortality rates, they are declining, and declining fairly rapidly. Both due to, I think, declining smoking rates and also due to the fact that we're doing a much more effective job of managing hypertension. So if you look at controlled hypertension rates in this country, they're substantially higher than what you find in Europe and some other—the European communities. I think that, you know, our coalition is raising this whole issue, once again, in terms of the policy lovers that we should put on the table to look at seriously. And I can tell you that this coalition is looking at advertising on T.V. and the coalition includes PhRMA, who's looking at advertising on T.V. and raising serious questions with their member companies about whether they should really be advertising on T.V. or not. So at least within our group, I think that we're throwing around some issues that we want to present next fall that have, you know, perhaps been off the table a little bit, but advertising is certainly one. The direct-to-consumer component of some of the PhRMA stuff is another one, as well.

I would just, you know, add that we need to know more about how to invigorate these issues and maintain them at high levels of visibility and attention. There's a sort of a natural, I think, ebb and flow of public engagement and then it turns to obesity, and the tobacco message sort of wanes, even though, obviously, it's the most important public health issue on our plate. I think there are some positives to look at though. We have FDA regulation on the horizon, I think that's going to be a huge and important debate that's going to reenergize. And we released, about a year ago, the Surgeon General's report on secondhand smoke, saying, for the first time ever, that there is no safe level of secondhand smoke, that really energized decisions around Marriott hotels and a variety of locales and counties coming through with much more comprehensive secondhand smoke legislation. So, you know, there are some good things happening, but we need to build on that to keep the energy and the attention high.

Just one another comment: if you look at the progression of smoking rates from what Ken noted, back in the '60s, you know, 40 percent, 50 percent down to today, the factors that have influenced that have been multidimensional. So it is not just advertising, but it's taxation policy, it's no-smoking policies, it's smoke-free campuses, it's social mores. It's a whole host of different things that have contributed to the sharp decline in smoking rates, and you can't really say it's one thing or another, it's really everything combined that has contributed to that success story, which can also be replicated in other areas, such as obesity.

I have to say, as a plus, it also includes more effective smoking cessation programs.

Woman: Good afternoon. Thank you for being here. I'm with a firm called Pricewaterhouse Coopers and we've spent a lot of time really thinking strategically about economic implications of health and prevention. My question is going back to a couple of things that I heard, particularly as it relates to health disparities and inequities. And are you aware of any research that's looking at quantifying the return on investment, if you will, of being able to really close those gaps between certain populations and how much our country would stand to gain by achieving true parity in health status?

I know of one research study that's underway right now that's funded by Medicare, and it's Racial and Ethnic Disparities in Prevention and Treatment of Cancer. So it's a multiyear demonstration project. If you go to the CMS website, you'll hear about it. But there are six communities around the country that have provided more intensive care in treatment of cancer prevention—in cancer prevention and treatment, so that's underway right now.

The other one I would like to highlight is that, you know, there certainly are a lot of people rethinking the whole notion of how we can build or even rebuild a primary health care base in this country, which is eroding very quickly. Primary care physicians are—we're losing them rapidly. And to understand the economic incentives and dilemma that medical students face as they come out. But one of the challenges that we face in that is that we know the infant mortality rates in terms of different races differ dramatically. They've all come down, but there's still very important differentials in underlying infant mortality rates between African American women and white women, and that's a scenario that I think is a continuing cause for concern; that we need to think about how we build an effective prenatal care delivery model. And I may not want to say this too loud, because you're not supposed to talk about cross-country comparisons,

comparing our health care system to others, but there are certainly examples from Europe where they have effective prenatal care delivery systems—and France and some others come to mind—that are really good at what they do, in terms of real basic prenatal care and real basic primary care, that we don't do a very good job here.

Hi, I'm Linda McKibben from Arlington, Virginia. How are you doing today?

Good.

McKibben: That's great. I wonder about a bigger-picture problem, which is the innovation in our country. Are we losing the edge, and how is that affecting health care? Some people say government has a role in that, in decreasing regulation, perhaps increasing incentives to innovate, somehow maybe changing culture so it's less top-down, maybe even decreasing competition so that businesses have a higher profit margin. So teach me about the economics of innovation so that we can add that to the mix about improving quality.

Well, my take on it—if you look at sort of the next twenty years, what's in the pipeline in terms of innovations with respect to dealing with Alzheimer's, dementia, Parkinson's disease—a whole host of conditions that we don't have the medical capacity to deal with now—there is a lot in the pipeline that, ten, fifteen years from now, I think, we'll see some marvels in terms of innovations in treatment. You know, a big part of that that we haven't talked about is the NIH budget. It sounds a little self-serving for a medical center to talk about NIH budgets, but the bottom line is, it's been flat.

The research budgets from the CDC and ARC and other agencies like that, that really spur a lot of the innovations and partner with the private sector to help develop these, I think we're underinvesting it, and we have for the last several years. So I think we have to recognize that these budgets, whether it's NIH or whether it's parts of CDC and ARC really should be looked at in an investment portfolio in a different way. That you are making investments in understanding what works and what doesn't, not just in terms of the clinical innovations, but in terms of some of the types of things that we're talking about here, whether they be behavioral innovations, workplace innovations, and so on. That we spend very little, as a country, on making those investments and understanding what works and what doesn't.

I'll just make one more pitch on this, is that there's a lot of discussion now going on nationally about putting together a comparative effectiveness apparatus that is a joint public/private-sector operation that really provides more information on what works and what doesn't, and I think there's a lot of promise there. Even our friends at the Congressional Budget Office who are loath to score savings linked to things that are not regulatory in nature have found savings associated with the potential for comparative effectiveness analysis. So I think part of it is, will we continue to be innovative and will we continue to be new in part depends on us making the right investments in an investment portfolio that allows us to innovate as we have over the last twenty, thirty years.

Thank you.

Interesting question: I guess I'll just try to be a little bit provocative, to say I'm not as worried about the new technology/biomedical research side as I am the research into understanding diffusion and dissemination, coverage, and application of what we already know to be effective. In some cases, these new technologies can actually drive a greater gap in inequity in health. Nevertheless, you know, this is what we do well, is innovate and develop. And all of that's good, as long as we spend the money that it takes to make the innovations reach the populations that they need to serve. And that's where I see us fall down more so.

McKibben: I totally agree with you.

Just one other comment. You know, there's a lot of innovation, but nobody, usually, evaluates the cost-effectiveness of innovation A versus innovation B. And has been noted, 56 percent of U.S. Preventive Services Task Force recommendations for clinical preventive services for Medicare population are not adhered to. So the things that we know that are simple, oftentimes very cheap, those things are not being applied.

Man: Ron, I'd like you to follow up on your excellent discussion about the contributions to production and tobacco prevalence by sharing with us the lessons learned from workplace health promotion. Which elements of those strategies are most effective and cost-effective?

All right, well, just a few things. One, of course, is policy. If you start banning tobacco use anywhere on campus or in vehicles, in parking lots and so forth, that's a pretty strong motivator. Another is differential premiums for life insurance. Not necessarily for medical insurance—I think that begins to cross the line, but life insurance, certainly, that works. And providing financial incentives for people to participate in health promotion programs certainly works well, and then, finally, removing the barrier.

So we're working, for example, with Michigan State University. We've just introduced a very terrific smoking cessation program that combines pharmacological treatment with behavioral treatment, and pays people—I mean, there's a fee, but it's much, much lower than what they would normally pay for that kind of care, and they're achieving significant quit-rates and potentially some savings. So those are some of the strategies that work very effectively in terms of smoking.

Man: Thank you.

Thorpe: Oh, we got a ringer here.

[Collins and Goetzel laugh]

Man: Thanks, Ken, Janet, and Ron, for terrific talks and also for promoting public health. You three are among my favorite nonsmoking ectomorphs.

[Laughter]

Man: However...

[Laughter]

Man: I'm not as optimistic, I guess, as you are because it seems to me that, as the baby boomers become Medicare-eligible and the states become increasingly unable to pay for Medicaid over time, and the companies are abandoning health insurance, the motivation to shift costs around, which may not even decrease costs, along with the old bugaboos of all of the people who don't really want to do primary care because they have so much invested in gains from the rest of the system, and the capacity of the cherry-pickers like Wal-Mart and Rite Aid and all these other people—Walgreens—to have little primary care clinics picking up all the common colds and the people—the things that the family doctors make money on—is possibly going to lead to a less-controllable, still financially escalating mess. And the escalation in health costs have been sort of worldwide, not just U.S.-wide, we just start from a more dysfunctional base. So you have to convince me that you and your coalitions will be able to somehow make more sense of this and make some tough decisions.

Thorpe: How much time do I have?

[Laughter]

Ogden: Three minutes.

Okay, thank you. Here's my pitch on that. To me, if you look at the major drivers of most of the change in the health care system over the last, say, forty years, much of the innovation—and people can debate this, but my take is—much of the innovation has come through Medicare, whether it's through payment policies. Everything on the payment side flows from Medicare. The commercial sector plays off of Medicare; it plays off the Medicare methodology; they base themselves on Medicare. So the change is going to come into the system, I think, through the Medicare program, and potentially through the Federal Employees Health Benefit Plan, because it affects the private sector at the same time.

We're going to face a choice, in the next couple of years, about what to do with this Medicare program. And there's going to be the same choices that CBO puts up every year. We're either going to increase the age of eligibility, we're going to pay providers less, we're going to have individuals pay more, we're going to cut back the benefits, or we're going to do all the above. You're right, none of those have any political legs. None of those solve any of the problems, they're just moving money around the system. We're putting another option on the table that says this is not a panacea, but it's the right thing to do. And I think what you'll see is that, once we understand the architecture and technology about how to do some of the payment reforms in the traditional Medicare program—and we have some ideas about how to do that—and how to expand the use of electronic health records in the Medicare program, and in the population in general—that we're going to make a dent. Not in two years, three years, or four years, but this is a 10-year planning scenario that we're going to make a dent in policy.

And the reason we're going to go there is because the forces in the system are moving us there right now. And I'll just close with these two issues. One is that Medicare is going to move in this

direction, it's just a matter of how fast they make the move. Because the other policy options, obviously, don't work. You cannot build a political coalition around those other things. This, you can. And two, you're seeing a rise in some of the big self-funded players out there that have been active in doing some of these HRAs. What they have found is that the old way of doing health care cost containment—through negotiating over deductibles, negotiating over copays—is so contentious and so divisive that it's a lose/lose for them.

Safeway, the United Food and Commercial Workers—you can go through a whole bunch of examples of people that have gotten rid of that approach and are now working collaboratively. And where it's really going to come to play is the growth in the VIVAs. So now, the United Auto Workers owns this pot of money. They used to rely on GM to do the innovations in managing those benefits—not anymore. And you're going to see more and more of that movement towards self-funded operations where the auto workers now are looking at how they are going to manage this pot of money to make sure it works, and they're going to go to the core of the issue.

So I think the innovations will happen. I think the nature—I'm going to go 30 more seconds. I was just at the World Health Care Congress. This is the fifth year of the World Health Care Congress, sort of the biggest, you know, industry health care conference, probably in the world. Five years ago, when I looked at the program, 90 percent of the program was on HRAs, HSAs, high-deductible plans, benefit design, and so on. The program this year, 90 percent of it was on this issue because the debate has morphed in a fairly short of period of time around this issue of system redesign, payment reform, and technology. Because I think people have seen that this is where the money is, it's the right way to go, and it's also a way that people have seen that they can work collaboratively to do something, whether it's Wal-Marts and PhRMA, working together on the same types of proposals. So I think we're there because people have a clear understanding of some of the things we talked about, the problem, and they're seeing that it's not the contentious cost-shifting debate that's gone on for years, that people are tired of having.

Ogden: Last two questions, and know that you're standing between people and food.

Man: Lot of pressure.

Man: Right, well, I can't help you, as a clinician or a public health person related to food since we don't want obesity. That's my problem over the last forty or whatever years, and that what you've discussed here is terrific in terms of some of the issues that we can do something about from a public health preventive point. But I also hear, like, your statements about the tremendous things that we're going to expect from NIH. And just take what you said about a neural degenerative disease like Alzheimer's, or neural mental disorders that are mounting in my field of pediatrics, and so on, and are hurting the quality of life, for which we have no prevention for a large majority of them because we don't know the etiology. So we've got to know the etiology, we've got to know the genes.

So we're going to have a bunch of people that are going to have their genome measured, et cetera, and we're going to find an easier way to diagnose Alzheimer's, and now, you have 20 percent, 30 percent, or whatever, by the time you get old, all of you, I wish you would be 90 years, with a 50 percent chance of not getting Alzheimer's. And then you're talking about

treatment. The trouble is that NIH—I love NIH, I work with NIH. But the basic point of view and from the chemical point, if you look at this focus, the focus they have, it's treatment. If you look at the focus of industry, it is treatment. There are only, what, two industries that make vaccines in the United States? Maybe it's three. And look at the hundreds of venture capital in treatment, for the drugs and so forth. But they make money. So if you're going to talk about research for treatment and not talk about research for public health in causality of diseases that you can do something about, like environmental health, with the possible chemicals or infectious agents or whatever, because we can do a lot in infectious agents. We've done a lot with our environment. But if you're talking about the great things that are happening in the future, with the discoveries of treatments or of genes—and I can also say that, from the point of view of public health intervention—and Dr. Khoury from CDC has said that, from a public health point of view, it's unlikely to be particularly effective. From the clinical point of view, yes, most likely, but it's going to cost a lot. So I'd like you to just take into consideration the fact that these wonders that are coming in science are going to be very expensive unless you get at the root cause of these problems.

I think that's well said, and I don't think I can add much more to that—I completely agree with that. What I'm hoping, on the investment side, on the research side, this issue, when I think of comparative effectiveness, I'm really thinking broadly about looking at programs that intervene, whether it's public health, population, health interventions. I'm looking at the ARC budget; parts of the CDC budget, which are research agenda items that have been just flatlined that would deal with these issues so we could have a better understanding of some of the causation, some of the—a better understanding of how we can do a better job with smoking cessation and lifestyle issues, that we have just underinvested in for years.

[Inaudible response]

There is a history of that.

Ogden: Last question.

Hi, I'm Charlotte Kent, from the Division of STD Prevention at CDC, and I recently, about a month ago, went to an interesting seminar about complex systems clients, by Yaneer Bar-Yam. And one of the things he talked about, he gave a case about, if we're going to be doing prevention activities, maybe we need to take them out of the traditional medical model because they might be very amenable to working in such places as the Wal-Mart or the, you know, in the shopping center where you're delivering care about health care or these lifestyle changes. And I wonder if you have any thoughts or are familiar with this.

Yeah, let me respond to that. I agree, it's asking a lot of physicians in their 15-minute encounter in which 9 minutes are spent talking, for them to do a whole lot of prevention and health promotion, given all the, you know, the long list of things that they have to check for and treat. So there are opportunities and there are experiments out there about using other people to support in these health promotion activities.

In particular, Ken mentioned CMS and Medicare being kind of the forefront for innovation in terms of health care reform issues. Medicare, as of this month, started a demonstration called Senior Risk Reduction in which they're taking corporate health promotion disease-prevention programs and providing those programs to Medicare beneficiaries to see if they can improve health and save money. But they're not doing it through the physician's office, they're doing it through outside vendors who independently contact beneficiaries and provide coaching and counseling and health education services. So I think there are other opportunities to basically circumvent and run around the traditional Medicare delivery system.

Ogden: Do you have anything to add?

No, just in agreement that a systems and structures and policy approach to getting this work done—if we depend on moving upstream within the health care system alone, it's not going to get us where we need to go—agreed.

Okay. Before we break, I have an exciting announcement of our student essay contest winners. Those of you who've come to several of these—and I hope that's many of you—know that we sponsored a student essay contest. And the winning essays were all incredibly thoughtful and thought-provoking and addressed issues of health care finance, of insurance provision, of the role of the market in health care and health disparities—all the topics that we talked about today. And so it was quite a challenge choosing among the essays. Each essayist was very passionate about his argument or her argument, and it was a very difficult selection, but I do want to honor our three winners. So I'm hoping they're here. First place and $1,000 goes to Morse Abdullah, who is a Health Policy and Management Solutions.

Do I get it here?

Stay up here.

[Laughter]

Yeah. You can take it to Sun Trust and see if—the second place and a prize of $500 go to Jennifer Parker, who is also Health Policy and Management Solutions. Not here? And third place, honorable mention, goes to Yuriko Lee, who is a nursing student. Thank you very much—come. These prizes were cosponsored by the Institute for Advanced Policy Solutions and the Partnership to Fight Chronic Disease, as well as CDC. So we thank our sponsors. And now, please thank our speakers and help yourselves to food outside.

Collins: Well done, congratulations.

Man: Can I take a picture?

Ogden: Yeah, get a picture.