

**Is There A Business Case For Correcting UnderUse?**  
**Health Industry Forum**  
**Meeting Summary**  
**July 16, 2004**

The Health Industry Forum is a new research initiative committed to engaging leaders across the healthcare community in constructive dialog and action through cutting edge research on *improving the quality and value of health care services*. For its Inaugural meeting, the Forum brought together 60 senior representatives from industry, academia, and government to discuss underuse of health services. The morning session was devoted to identifying the nature and consequences of underuse, discussing the business case for correcting it, and examining strategies implemented by employers, health plans, and pharmaceutical firms to address this critical problem. The afternoon session was devoted to a planning meeting where Dr. Stuart Altman described the Forum's goals, organizational structure and funding model. A brief meeting summary is provided below..

**Elizabeth McGlynn**, Associate Director of Rand Health, presented results from the Community Quality Index study. This research was based on interviews and medical record reviews with more than 6,000 patients in 12 communities across the country. The Rand study concluded that Americans receive about half of recommended care and that the findings were consistent with respect to preventive, acute, and chronic care services across all 12 communities. Dr. McGlynn discussed the consequences of widespread underuse of health services including avoidable health complications and preventable mortality.

**Robert Galvin**, Director of Global Healthcare for General Electric, described the complexity of developing a business case for correcting underuse. Purchasers want to improve quality while simultaneously controlling costs. Dr. Galvin discussed the challenge of finding a solution for the "two-uses" problem. Much waste in healthcare is driven by overuse (and misuse) of services -- yet underuse is increasingly recognized as a serious problem. While potential savings from reducing overuse and misuse are immediate, the benefits of correcting underuse tend to be more long-term. There are specific instances where a positive business case for correcting underuse has emerged, but there is not yet a "global case." Quality initiatives will not succeed if healthcare providers are penalized financially for improvements. Mechanisms are needed to create a business case that is balanced across healthcare system stakeholders. This includes reinvesting savings from correcting overuse and misuse into new initiatives that will enhance population health and productivity. Bridges to Excellence is one example of a program that rewards physicians for meeting quality benchmarks, and is intended to enhance the business case for quality for participating providers.

**Jack Mahoney**, Chief Medical Officer, Pitney Bowes, described a recent initiative to understand the factors driving health care spending for the company's high cost claimants. Using predictive modeling software, Pitney Bowes discovered that lack of compliance with prescription medications for patients with chronic diseases was a strong

predictor of high medical costs in subsequent years. Based on these findings, Pitney Bowes moved all drugs for diabetes, asthma, and hypertension into the lowest cost tier of its three-tier formulary program. In the 18 months following program inception, Pitney Bowes found a substantial increase in use of impacted drugs along with improved compliance rates, but very little change in overall pharmacy spending per member. Total spending for patients in targeted disease categories declined between 9 and 15 percent. Dr. Mahoney concluded by observing that underuse of health services has the potential to drive up overall health spending. Traditional patient cost sharing structures are “blunt instruments” that can adversely affect beneficiary’s health seeking behavior. However, this experience illustrates that targeted benefit design can be used to improve health and reduce healthcare expenditures.

**Samuel Nussbaum**, Chief Medical Officer, Anthem Health Plans Inc., observed that underuse is affected by financial barriers to care, knowledge deficits among clinicians, and inadequate patient and physician support processes. Anthem developed a series of programs to address these issues including pay-for-performance reimbursement, disease management, consumer navigational guides, and point of care information support. In Anthem’s hospital quality program, annual rate increases are linked to performance on 39 quality measures reflecting outcomes, safety, and patient satisfaction. Dr. Nussbaum presented data from two controlled trials of disease management programs for chronic care patients with average annual costs of approximately \$25,000. These studies control for regression to the mean and show that the observed 50 percent reduction in total medical costs for the “managed” group actually represents a 15 percent reduction relative to the control group. Dr. Nussbaum also described an automated system that analyzes claims data and alerts patients and physicians when potential safety issues arise. In the past, consumers have not viewed health plan initiatives to influence clinical care in a positive light. Yet health plans are moving back towards this role, given the need for clinical performance improvement and evolving health plan capabilities to measure quality, structure incentives, and deliver targeted information.

**John Sory**, Vice President, Pfizer Health Solutions (PHS), discussed the challenge of relying on an overworked delivery system to address the chronic underuse of preventive services without improved support systems. Mr. Sory described PHS’s work with Florida’s Medicaid program providing support services for 150,000 members with chronic disease including 19,000 high-risk patients. The PHS program combines hospital and clinic-based nurse case management with a 24-hour advice line and a focus on proactive patient education. The program reported improvements in medication compliance and clinical performance benchmarks, and a 5.5 percent reduction in cost during its initial year of operation.

**Larry Lewin**, Executive Consultant, summarized the day’s discussion by commenting on the challenge of developing a business case for health improvement. A business case is typically defined as the ability of the organization making an investment to realize a financial return within a reasonable time frame. While many health enhancement activities have a positive economic case (financial benefits across all stakeholders) and a social case (non-financial benefits based on societal values), the business case is more

elusive. Mr. Lewin described the policy challenge for health improvement as re-aligning financial structures so that investing organizations can share in the economic benefits with other stakeholders and society.

**Discussion.** There was a wide-ranging discussion following each of the speaker presentations. Several points seemed to garner broad agreement from the discussants:

1. Although overuse and misuse of health services are often the focus of quality improvement efforts, underuse is widespread and is an important quality concern.
2. While it is difficult to make a broad business case for correcting underuse, a case clearly exists for specific well-defined domains.
3. Identifying these domains and designing effective strategies to correct them could be greatly accelerated by more rapid adoption of health information technologies and clinical communication tools.
4. Improvement strategies must be supported by appropriate financial incentives to ensure that insurers and caregivers are invested in these efforts.

**Afternoon planning session.** In the afternoon planning session Dr. Stuart Altman described the Forum's goals, organizational structure and funding model.