

IS THERE A “BUSINESS CASE” FOR ADDRESSING UNDERUSE?

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OVERVIEW

- The prevailing notion of the “business case” focuses on the investing organization and is thus too narrow a mechanism.
- Clinical preventive services are especially vulnerable to underuse:
 - Always have been (major reasons: lack of physician time or inclination, lack of payment, difficulty for patients to carry out, lack of adequate data systems)
 - CDHPs exacerbate the problem
- More research is needed to document economic benefits of clinical preventive services, costs of their underuse, and to develop innovative payment tools.

Defining the term: “Business Case”

- ...A business case for health care improvement intervention exists if the entity that invests in the intervention realizes a financial return on its investment in a reasonable time frame, using a reasonable rate of discounting. This may be realized in bankable dollars, a reduction in losses for a given program or population, or avoided costs.
- ...A business case may also exist if the investing entity believes that an important indirect effect on organizational function and sustainability will accrue (e.g., competitive advantage)

Levels of “The Case for...”

- “Business Case” – from the viewpoint of the organization that must make the changes
- “Economic Case” – the financial consequences summed over all stakeholders
- “Social Case” -- primarily non-financial rationales for action based on society’s aspirations and values
- There is also the “Equity Rationale” that says that it is professionally responsible or necessary to provide the service whether or not there is a business case.

The Economic Case

- If there is an **economic** case for stakeholders, or for the “system” as a whole, the policy challenge is to re-align policy and payment so that the investing organization reaps some of the economic benefit.

Clinical preventive services (CPSs) are especially vulnerable to underuse

- Many examples of efficacious, life-saving/cost-saving procedures that are, or have been, substantially underused:
 - Pneumococcal vaccine for persons over 65;
 - Influenza vaccine for African-Americans 50+
 - Counseling for ending tobacco use
 - Retinal exams for diabetics
 - Colorectal screening
 - Mammograms
- Cost-effective CPSs are well-documented by the National Commission on Prevention Priorities
- CDHPs (high deductible plans) present a serious threat unless designated CPSs are carved out or otherwise protected against financial disincentives to use.

More research is needed on economic and social case for using CPSs

- Some CPSs (e.g. immunizations) are merit goods but are not so recognized
- Pure business case calculations need to be standardized and conducted (many are now considered “one-off”).
- New payment models that recognize harvested benefits need to be developed and evaluated.
- But, we already have a good deal of research that is not being used, so Mark Twain’s quip about reading applies here as well...

“The person who can read but doesn’t, is no better off than the person who can’t read at all.”

Mark Twain