Last week we met Matthew Bishop, US Business Editor for 'The Economist'. He talked at length about the economic and social problems that the US faces. He believes that these problems will weaken US global competitiveness and its economic position in the years ahead. He also believes that American society is unwilling to face up to these problems. What does any of this mean for health care? It's unthinkable that health care should be 25% of US GDP, yet we are traveling at speed in that direction. Our view is that, "We haven't got the money, we need to rethink what we're doing".

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We Haven't Got The Money, We Need to Rethink...

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What would the Chief Executive of "US HealthCare Inc." do faced with this situation? As former Chief Executives, four strategies come to mind -- Prevent, Segment, Restructure and Innovate.

Prevent
In prior blogs we've discussed at length strategies and tools available today for disease prevention. According to the CDC, the three most common chronic diseases are preventable. 70% of strokes, diabetes and heart disease are avoidable, a potential annual savings of $400 billion in health care expense. Many large self-insured employers have had success with disease prevention/wellness programs, returning $3-$4 on every $1 invested.

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In the most graphic way NBC's *The Biggest Loser* illustrates the cost to the individual of chronic disease. Morbidly obese contestants are shown their real age in contrast to a computed, based on chronic disease onset, "Inner Age". A 27 year old, 300lb person can have an "Inner Age" of 63 years. Said differently this person has the health risks of a 63 year old – 30+ years of life lost.

STOP PRESS: a new study announced last week in the Journal of Epidemiology focused on young adult hypertension. Hypertension in

young adults shows no symptoms but the damage from this condition is irreversible and leads to acute and chronic disease.

For self-insured employers and payers, the time has come to embrace prevention.

Segment

"Segment the customer base and manage the business for expense" is the proven strategy for mature businesses. In health care this means segmenting care into the provision of services by the provider who can deliver the best care at the lowest cost and in the most appropriate environment. Hospitals need to treat patients with acute conditions and limit care that should be provided outside of the hospital setting – perhaps "ACO 2.0" (see later in the blog) has a role here? Rehabilitation, ambulatory care, home care settings are all viable alternatives for treatment of non-acute conditions. At every level of care, whether it is hospital, rehab, skilled nursing facility (SNF), ambulatory or home care, the US health care system needs to treat patients in the most cost effective environment. What services being provided in a SNF, can be provided in an assisted living facility? What assisted living services can be provided at home?

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Non-life threatening conditions (e.g. minor burns, simple fractures, lacerations) can be treated by urgent care centers that deliver a better patient experience -- dramatically lower wait times -- at a fraction of the cost of hospital ER departments. In the urgent care setting wait times are reduced from over 4 hours to under an hour and the average cost of treatment is reduced from $2000-$3000 to under $200.

"Today ACOs are like unicorns, imbued with magical powers but no one has seen one yet. "

The caregiver structure needs to be changed as well. Why treat a simple laceration in a hospital ER using high cost ER physicians when that same laceration should be treated in an urgent care center with less skilled, but equally competent care providers?

In Europe, pharmacists can write limited prescriptions for easily treatable diseases e.g. strep throat for a child. Telemedicine is a lower cost alternative for treatment of limited mobility patients in urban and rural areas. The patient experience is better without the wear and tear of travel to a specialist physician. Dermatology and psychiatry are two specialties already established in telemedicine.

"Pragmatic trials, recently discussed in the NEJM, are trials that address real world clinical application to improve quality of care and value -- they drive 'care efficiency'."

These examples have one thing in common. The businesses "shine a bright light" on the expense (increasingly paid for by consumers with high deductible plans) and patient experience. These businesses lower the cost of treatment significantly and improve the patient experience.

Restructure

Health care reform last year enabled the formation of ACOs. The goal was to reduce health care costs in new "accountable" organization

structures. The promise of ACOs is to reduce hospital admissions and readmissions. Today ACOs are like unicorns, imbued with magical powers but no one has seen one yet. The question is will we see one and will they perform the magic we expect? We believe that the best feature of the rushed ACO regulations are that it has got an important dialog and debate underway -- that is, how can large providers of care share in the savings of innovation and lowering expense? We don't believe that ACOs as currently regulated will be attractive to investors or all but a handful of providers. ACO 2.0, that is, whatever comes next, e.g. the Pioneer ACO Model holds more promise.

As a CEO of an organization considering becoming an ACO or as head of an Investment Committee considering funding an ACO, there are too many hurdles to overcome. Here are some of those hurdles:

- Beneficiaries can go outside of the limited capabilities of an ACO
- Until operational an ACO will not know who its beneficiaries are
- ACOs must report on 65 metrics
- High probability of anti-trust review -- a minimum of $1 million in legal fees to conduct the review
- 25% of savings are withheld for three years

We would adopt a watch and wait approach.

Innovate

Randomized clinical trials provide essential, high quality evidence about the benefits and harmful effects of medical interventions. However, they have limited relevance for clinical practice and finding new efficiencies. Placebo trials, for example, do not help a physician choose between a new and an existing medication. Pragmatic trials, recently discussed in the NEJM, are trials that address real world clinical application to improve quality of care and value -- they drive "health care efficiency". PBMs, for example, would be well positioned to commission these types of trials to drive efficiency and aid in clinical practice. The benefits are clear, less waste, right drugs, correct dosage prescribed. Pragmatic tests/trials are a component of the nascent field of pharmacoeconomics.

Coupling pharmaeconomics with pharmacogenomics (personalized medicine), there is a greater probability of successful treatments for specific patient populations and lower probability of side effects. Vectibix, a colon cancer chemotherapy, has 30-40% efficacy in a patient population, the side effects are unpleasant. Pragmatic trials of this regimen coupled with genomic testing could improve patient quality of life and significantly lower cost for payers. Similarly, Tamoxifen, a common treatment for breast cancer relies on the liver enzyme CYP2D6 to be metabolized. This enzyme has over 100 genetic variations. These variations can significantly reduce the effectiveness of Tamoxifen. Only a handful of the genetic variations of the enzyme allow effective metabolization of this drug. Combining pragmatic trials with personalized medicine drives cost down and improves patient experience. Medco has some promising applications in this area with personalized medicine services in leukemia, HIV, anticoagulants, breast

cancer and atherothrombosis -- the opportunity to grow this list of diseases is huge.

PBMs and potentially large diagnostic companies are well positioned to leverage this growing trend.

Conclusion

"We haven't got the money, we need to rethink what we're doing". 'Prevent, Segment, Restructure and Innovate' are strategic thrusts that many health care service providers whose business models are maturing or have matured need to be considering. If you're not thinking about how to re-invent yourself every 18 months, you'll be DOA.

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