What Have We Learned from Economic Analyses of Prevention?

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Sydney, Australia
March 13, 2009
The Prevention Agenda

• Australia: “Investing more in health promotion, prevention, and early intervention is on the policy agenda of State and Federal Governments in Australia. There is a wide range of options … ”

• U.S.: “Healthy People 2010 is a comprehensive set of disease prevention and health promotion objectives for the Nation to achieve over the first decade of the new century. ... [It] identifies a wide range of public health priorities ” [http://www.healthypeople.gov/About/hpfact.htm]
History and Expectations

• Prevention has brought major gains in health and life expectancy over the last two centuries.

• Today’s leading causes of death: heart disease, cancer, diabetes can now be prevented or delayed.

• Prevention’s appeal
  – Better to avoid the disease/injury than to repair it
  – Prevent the disease, prevent the costs of treatment
  – Expectation: Prevention improves health and reduces medical spending

• But does it reduce medical spending?
Radio advertisement

• Man about to undergo bypass surgery.
• Cost of the surgery: 50,000 $US.
• Wouldn’t it be better to avoid the need for surgery through prevention? By losing weight, quitting smoking, exercising, taking medications to reduce blood pressure and cholesterol?
• Better for health
• Cheaper for the medical system
But – prevention is complicated

• Medical science can only identify those at risk of heart disease, a much larger group than those who will someday be candidates for bypass surgery.

• Prevention must be delivered to all people at risk, often repeatedly over many years, to prevent some of them from developing disease → costs mount up.

• Some develop disease anyway, since prevention is not 100% effective; some do not develop it even without prevention → all receive prevention, but not all experience savings.
Cost-effectiveness Analysis

First applied to health and medicine in the 1970s


- Blood pressure medication extends life and reduces treatment costs for heart disease and stroke
- But the accumulated costs of medication over many years are greater than the savings
- Prevention costs more than treatment
Is Prevention Better than Cure?


• Examined vaccines, blood pressure medication, cancer screening, lifestyle change.

• Prevention usually adds to medical spending.

When is prevention worth the cost?
Outline of the rest of the talk

- How cost-effectiveness analysis (CEA) addresses the cost question
- Recent reviews of prevention CEAs
- Features that make prevention more, or less, cost-effective
- Points to consider in conducting analyses and developing policy
  - societal perspective
  - patients’ time
Three Types of Prevention

• Primary prevention prevents the disease from occurring, e.g., vaccines.

• Secondary prevention detects risk factors, or pre-clinical disease, and intervenes to prevent further development, e.g., antihypertensive medication, cancer screening.

• Tertiary prevention intervenes to prevent or moderate consequences of established disease, e.g., blindness from diabetes.

• Focus here: primary and secondary prevention
How CEA addresses the cost question

• CEA compares the costs and health outcomes of alternatives, e.g., self-management vs. traditional care for asthma (next slide)

• Usual practice to count only medical sector costs
  – Could count other costs and the societal perspective does
  – But medical costs are the point at issue

• Difference in costs and health outcomes between 2 alternatives: net costs and net health effects

• Cost-effectiveness ratio: net cost divided by net health effect, e.g., net cost per life-year gained
Annual Costs and Healthy Days per patient: 
Guided self-management vs. traditional asthma care, 1997$US

<table>
<thead>
<tr>
<th>Costs/Health effects</th>
<th>Self-management</th>
<th>Traditional</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling</td>
<td>348</td>
<td>179</td>
<td>169</td>
</tr>
<tr>
<td>Peak flow meter</td>
<td>32</td>
<td>0</td>
<td>32</td>
</tr>
<tr>
<td>Drugs</td>
<td>613</td>
<td>623</td>
<td>-10</td>
</tr>
<tr>
<td>Physician visits</td>
<td>47</td>
<td>80</td>
<td>-33</td>
</tr>
<tr>
<td>Hospital stays</td>
<td>33</td>
<td>52</td>
<td>-20</td>
</tr>
<tr>
<td><strong>TOTAL COSTS</strong></td>
<td><strong>1074</strong></td>
<td><strong>935</strong></td>
<td><strong>138</strong></td>
</tr>
<tr>
<td><strong>HEALTHY DAYS</strong></td>
<td><strong>359.2</strong></td>
<td><strong>344.3</strong></td>
<td><strong>14.9</strong></td>
</tr>
</tbody>
</table>

Cost-effectiveness ratio: $3,380 per healthy year
Terminology

- An intervention is cost-saving if its net costs are negative. No cost-effectiveness ratio is calculated.

- An intervention is cost-effective if it has positive net costs and net health effects and is judged to be good value for money.
  - The UK’s National Health Service uses £30,000 per quality-adjusted life-year as a rough guide.
  - The WHO guide: < 3 times gross domestic product per capita (< GDP per capita is very cost-effective).
  - Australia’s PBAC, 1991-1996: 37-69,000 $AUS, about 100,000 $AUS today (George et al. 1999).
Recent Reviews: United States


• Tufts-New England Medical Center CEA Registry
• 599 CEA studies published in 2000-2005
• 279 prevention comparisons
• 1221 treatment comparisons
• Less than 20% of preventive interventions, and a similar share of treatment interventions, reduced medical spending.
Distribution of Cost-Effectiveness Ratios for Preventive Measures and Treatments for Existing Conditions.

Data are from the Tufts–New England Medical Center Cost-Effectiveness Registry. QALY denotes quality-adjusted life-year.
Recent Reviews: Australia


- 245 Australian-based studies, 1966-2005
- Of the 245, 21 “were both more effective and cheaper than their comparator.”
- 78 prevention interventions, 33 screening.
- Total prevention: 111. If all 21 of the cost-saving interventions were prevention → 19% cost-saving, similar to Cohen et al.
- Probably lower (alternate count: 197 primary/secondary).
What makes prevention more cost-effective?

- Component costs
- Risk profile of patients
- Frequency of intervention
Blood pressure medication

Weinstein, Stason. *Hypertension: A Policy Perspective*

- Medication is a better value for those whose blood pressure at diagnosis is higher.


- No medication is cost-saving
- Some are more cost-effective than others
- Diuretics, currently the first line of therapy, are among the most cost-effective.
### Blood pressure medication
Updated to 2007$ in LB Russell, Prevention’s Potential

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Cost (2007$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>propranolol (beta blocker)</td>
<td>29,282</td>
</tr>
<tr>
<td>hydrochlorothiazide (diuretic)</td>
<td>44,057</td>
</tr>
<tr>
<td>nifedipine (calcium channel blocker)</td>
<td>84,890</td>
</tr>
<tr>
<td>prazosin hydrochloride (alpha blocker)</td>
<td>166,288</td>
</tr>
</tbody>
</table>
Statins to reduce cholesterol


- Cost-effectiveness of statins varies widely with patients’ risk profile
  - LDL
  - Blood pressure
  - Smoking
  - HDL
  - Existing heart disease

- Health gains and treatment savings are greatest for people at greatest risk.
### STATINS: cost per healthy year in people 55-64, 2007$US

<table>
<thead>
<tr>
<th>No CHD at baseline, high LDL cholesterol</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Men</strong> , LDL 4.2-4.9 mmol/L (160-189 mg/dL)</td>
<td></td>
</tr>
<tr>
<td>DBP&lt;95, nonsmoker, HDL&gt;1.3 (49)</td>
<td>344,000</td>
</tr>
<tr>
<td>DBP≥95, smoker, HDL&lt;0.9 (35)</td>
<td>165,000</td>
</tr>
<tr>
<td><strong>Women</strong> , LDL 4.2-4.9 mmol/L (160-189 mg/dL)</td>
<td></td>
</tr>
<tr>
<td>DBP&lt;95, nonsmoker, HDL&gt;1.3 (49)</td>
<td>539,000</td>
</tr>
<tr>
<td>DBP≥95, smoker, HDL&lt;0.9 (35)</td>
<td>224,000</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>No CHD at baseline, very high LDL cholesterol</th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Men</strong> , LDL≥ 4.9 mmol/L (≥190 mg/dL)</td>
<td></td>
</tr>
<tr>
<td>DBP&lt;95, nonsmoker, HDL&gt;1.3 (49)</td>
<td>210,000</td>
</tr>
<tr>
<td>DBP≥95, smoker, HDL&lt;0.9 (35)</td>
<td>88,000</td>
</tr>
<tr>
<td><strong>Women</strong> , LDL≥ 4.9 mmol/L (≥190 mg/dL)</td>
<td></td>
</tr>
<tr>
<td>DBP&lt;95, nonsmoker, HDL&gt;1.3 (49)</td>
<td>389,000</td>
</tr>
<tr>
<td>DBP≥95, smoker, HDL&lt;0.9 (35)</td>
<td>180,000</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>CHD at baseline</th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Men</strong></td>
<td>5,800</td>
</tr>
<tr>
<td><strong>Women</strong></td>
<td>12,600</td>
</tr>
</tbody>
</table>
Cervical cancer screening


- Another classic CEA
- Screening frequency is a major determinant of cost-effectiveness
- Compare interventions by intensity – screening every 3 years with screening every 2 – not just with no intervention (here, no screening)
Cervical cancer screening

<table>
<thead>
<tr>
<th>Cost per life-year, 2007 $US</th>
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<tbody>
<tr>
<td>at 3 years vs. no screening</td>
</tr>
<tr>
<td>at 2 years vs. 3</td>
</tr>
<tr>
<td>annually vs. at 2 years</td>
</tr>
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</table>

Institute for Health/Department of Economics
Pneumococcal pneumonia vaccine

• At 16 $US per person (1995) -- about 25 $US today -- vaccination against pneumococcal pneumonia reduces medical spending for adults 50-64 with congestive heart failure, chronic lung disease, diabetes, and other chronic conditions

• The 2008 cost/dose, excluding administration costs
  – 16-19 $US for the US Centers for Disease Control

• Vaccination would be cost-saving at the CDC price, not at the private price
What about those 5:1 savings claims?

- CEAs of childhood vaccinations typically estimate
  - savings in parents’ time, valued at the wage rate
  - children’s future earnings
- They compare vaccination costs with medical savings, savings in parents’ time, and children’s future earnings.
- The reported ratio: all dollars saved to dollars spent.
- Often a vaccination strategy that saves when time/earnings are considered, costs the medical system more than it saves.
Example of 5:1 savings


• Abstract: including parents’ time and children’s future earnings, varicella vaccine “would save more than $5 for every dollar invested”.

• Next line: medical costs of vaccination are greater than medical savings.

• Medical costs: vaccination saved 90 cents for every dollar spent (Table 4, “health care payer’s perspective”).

• Assumed a private-sector price of 35 $US per dose (1990). That is 75 $US in 2007, which is the current private-sector cost/dose.
CEAs and Policy: Points to Consider

• Societal perspective, recommended by the Panel on Cost-Effectiveness in Health and Medicine, includes costs and health effects for all who are significantly affected by the intervention.

• Costs = real resources

• Unpaid time of patients and caregivers is a real resource.
  – Affects patients’ decisions
  – Is taken from other societal uses
Self-monitoring of blood glucose

<table>
<thead>
<tr>
<th></th>
<th>Cost per healthy year, 2006 $US</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Without patient time</td>
</tr>
<tr>
<td><strong>Once daily</strong></td>
<td>7,856</td>
</tr>
<tr>
<td><strong>Three times daily</strong></td>
<td>6,601</td>
</tr>
<tr>
<td></td>
<td>2007 $US</td>
</tr>
<tr>
<td>--------------------------------</td>
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</tr>
<tr>
<td><strong>Chickenpox vaccine, pre-school children</strong></td>
<td>5,367</td>
</tr>
<tr>
<td><strong>Screening for colorectal cancer</strong></td>
<td></td>
</tr>
<tr>
<td>white men, sigmoidoscopy at 55</td>
<td>1,732</td>
</tr>
<tr>
<td>white men, sigmoidoscopy every 10 years vs. at 55</td>
<td>21,366</td>
</tr>
<tr>
<td><strong>Mammography</strong></td>
<td></td>
</tr>
<tr>
<td>all women aged 50-79, every 2 years</td>
<td>30,619</td>
</tr>
<tr>
<td><strong>MRI for women with BRCA1</strong></td>
<td></td>
</tr>
<tr>
<td>mammography alone</td>
<td>20,494</td>
</tr>
<tr>
<td>mammography plus MRI</td>
<td>514,660</td>
</tr>
<tr>
<td><strong>Screening for diabetes</strong></td>
<td></td>
</tr>
<tr>
<td>aged 55 with high blood pressure vs. no screening</td>
<td>51,211</td>
</tr>
<tr>
<td>all adults 55 vs. those with high blood pressure</td>
<td>537,756</td>
</tr>
<tr>
<td><strong>Screening once for HIV</strong></td>
<td></td>
</tr>
<tr>
<td>prevalence 1.0%</td>
<td>34,713</td>
</tr>
<tr>
<td>prevalence 0.1%</td>
<td>68,412</td>
</tr>
<tr>
<td><strong>Diet/exercise to prevent diabetes, high-risk adults</strong></td>
<td>191,635</td>
</tr>
<tr>
<td><strong>Smoking cessation, average of 15 programs</strong></td>
<td>5,221</td>
</tr>
</tbody>
</table>
When is prevention worth the cost?

“It will be important for decision makers to make decisions based on the individual merits of an intervention rather than rely on broad generalisations.” Dalziel, Segal, and Mortimer 2008
References


Institute for Health/Department of Economics


References, continued
