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Beyond Health Promotion: Reducing Need And Demand For Medical Care

Health care reforms to improve health while reducing costs.

by James F. Fries, C. Everett Koop, Jacque Sokolov, Carson E. Beadle, and Daniel Wright

PROLOGUE: Most of the recent reforms in health care delivery have been aimed at providing services more efficiently, and very few have considered the economic advantages of actually improving health. The authors of this paper argue that we have been too much consumed with the supply side of the health care equation and too little concerned with the demand side. The best way to reduce costs and improve health at the same time, they suggest, is not just to control the services provided but also to reduce the need and demand for care. An integrated system of population-based health care delivery would join the tenets of health promotion—self-efficacy, behavior modification, and long-term management of health and disease—with traditional approaches to diagnosis, treatment, and prevention. This paper presents three models for such a system.

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ABSTRACT: A population’s medical need represents its illness burden. Medical demand represents the service level requested for a particular need. Medical care costs are, in large part, a function of need and demand. Our review of health education programs designed to reduce health risks and reduce costs identified thirty-two programs with documented effectiveness, generally achieving claims reductions of 20 percent. Specific program features including chronic disease self-management, risk reduction, and increased self-efficacy appear important. A broadened definition of health promotion focused on increased personal responsibility for health-related actions and directed at improvement of long-term health outcomes also could reduce health care costs.

Most health care reform discussions speak little if at all of the prospects and strategies for improving health and of encouraging equity in use of health services. Instead, they emphasize management of the supply side of the equation by imposing barriers to access. Such approaches are not likely to improve health and are likely to prove unpopular over the long term. However, we now have the knowledge that could improve population health and at the same time reduce medical claims costs by 20 percent or more. The strategy is based upon reduction in need and demand for medical services.¹

Medical need represents the medically modifiable morbidity (illness) burden of a defined population. It is the integrated sum of all heart attacks, vehicular trauma, strokes, lung cancers, arthritis, and all other forms of human morbidity in a population. The costs of medical care are in large part a function of the amount of illness in a population. The amount of morbidity, in turn, is related in part to the prevalence of smoking, dietary fat intake, seat belt use, lack of exercise, and other behavioral risk factors in the population.

Medical demand, as we use the term here, represents the request of the patient (or the physician or the patient’s family) for medical care services. It is related to, but surprisingly independent of, medical need. It represents the variability of response to the same need and, beyond this, a bias toward demanding the more expensive of available alternative services. Demand for medical care is, unlike demand in many other economic settings, inducible in part by the supplier of services and is included in our broad use of the term. Further, it is important to recognize the connotations of demand reduction as used in this discussion. Demand reduction does not imply the withholding of treatment or a decrease in access. Rather, it indicates that the informed consumer is best served by selective, thoughtful requests for medical services and emphasizes the autonomy of the individual and the need for appropriate, accessible information. By these means it seeks to reduce both variability in the responses to similar medical problems and the mean level of response.
Our current “demand” results in high rates of utilization of resource-intensive services, without an optimal balance among self-management, preventive, and curative services. For persons with similar upper respiratory infections, for example, many different levels of demand exist, and the cost of the illness episode may range from nothing at all to as much as several hundred dollars. The expected health outcome, of course, is the same regardless of the intensity of service. Thus, the marked variability in demand at a given level of need is not, in general, linked to better outcomes for those with the greatest demands. Expected outcomes are similar regardless of which reasonable management pathway is selected, and the socially optimal response in many instances will be the lowest level of service that remains consistent with the best expected outcome.

Conceptual developments and empirical data have taken the theory and practice of need and demand reduction to improved levels of documentation over the past ten years. Established techniques, empirical studies, and large demonstration programs have been presented and documented in the peer-reviewed literature. The data and the argument have gone far beyond “substitute prevention for cure” and traditional concepts of health promotion and disease prevention. Reduction in need coupled with reduction in demand should be an essential part of all health care reform proposals, since it may improve health while moderating costs.

Conceptual Base Of Need And Demand Reduction

Compression of morbidity. The compression of morbidity hypothesis is important to the concept of reduction in need for medical care. It is based on the observation that more than 80 percent of our present illness burden is a result of chronic illness occurring between age fifty-five and the age of death (currently averaging age seventy-five in the United States). If the age at the onset of the first chronic infirmity can be postponed more rapidly than the age of death, then the lifetime illness burden may be compressed into a shorter period of time nearer the age of death. Evidence for this hypothesis thus must take two forms: first, that it is possible to substantially delay the onset of infirmity; and second, that the accompanying increases in longevity will be comparatively modest. Since the introduction of the concept in 1980, evidence on both issues has steadily accumulated. Thus, age-adjusted health status has been improving, while life expectancy from advanced ages has been constant. For example, average U.S. life expectancy from age eighty-five has been constant at 6.0 years since 1980. (The much ballyhooed “most rapidly increasing population group” over age eighty-five refers to percentage increases resulting from larger birth
cohorts and better survival to age eighty-five, not from substantial increases in individual life expectancy after age eighty-five.)

- **Self-efficacy.** Conceptually, various persons and definable groups of persons place differing values on health, with some investing substantially in “health capital” and others not. Personal investment in personal futures, whether through health, education, savings, or relationships, is of obvious importance to outcomes over time. Personal “self-efficacy,” the belief that by personal behavior one may be able to affect health or other futures, is an essential prerequisite for subsequent changes in health risk behavior.

Favored population groups, such as those with regular vigorous physical exercise, those in higher socioeconomic classes, and those with higher educational attainment, have been shown to have strikingly decreased disability with increasing age compared with less favored groups. Those with favorable risk-factor levels for postponement of chronic illness have only one-fourth to one-half the amount of disability in the seventh and eighth decades of life as do their counterparts.⁵

- **Long-term versus short-term outcomes.** The concept of long-term outcome, essential when considering chronic illness and the phenomena associated with aging, is equally important. Medicine traditionally has focused on the processes of medical treatment and the short-term outcomes of a particular episode of illness. For example, the goal of treatment for high blood pressure is often considered literally as reduction of the elevated blood pressure. The outcome perspective, on the other hand, sees the goal of antihypertensive treatment to be prevention of heart attacks and strokes. From this perspective, treatment of hypertension must be accompanied by increase in exercise levels, reduction in dietary fat, cessation of cigarette smoking, and control of serum cholesterol levels if heart attacks and strokes are to be made less likely. The ultimate outcome goals are improvement in both the duration and the quality of life, enjoyed over many years.⁶ Cumulative lifetime disability, for example, becomes a major endpoint and its reduction a major policy goal. Risk-factor models for disability overlap heavily with the set of cardiovascular disease risk factors identified long ago.⁷

- **The nature of need.** Preventable illness makes up approximately 70 percent of the burden of illness and its associated costs. Well-developed national statistics such as those outlined in *Healthy People 2000* and *Health, United States, 1995* clearly document this central fact.⁸ J. Michael McGinnis and William Foege have carefully reclassified the causes of death in the United States, using underlying actual causes of death rather than the traditional disease-oriented classifications.⁹ They found that preventable causes (led by cigarette
smoking, lack of exercise, and suboptimal diet) represent eight of the nine leading causes of death and account for 980,000 deaths per year in this nation. Low-birthweight babies, associated in large part with modifiable behavioral risk factors, represent another large cause of medical need, as do preventable injury related to lack of a seat belt or safety helmet use, trauma associated with alcohol or other substance abuse, and sexually transmitted diseases. Morbidity associated with generally nonlethal conditions, including disability from osteoarthritis and osteoporosis, also is often preventable.

■ The nature of demand. Variability in demand for medical services is huge, costly, irrational, and ultimately indefensible. International variations indicate that our expenditures are roughly twice those of most of our economic competitors among the developed nations. Variations at the physician level are substantial. U.S. cesarean-section rates range from 8 percent to 35 percent in various settings. Geographic variations are large and are linked to medical capacity rather than to medical need. Hospital expenditures per capita are twice as high in Boston as they are in New Haven, similar cities only 100 miles apart. Hospital admission rates correlate with the number of available hospital beds per capita rather than the prevalence of illness. John Wennberg calls this “supply-driven demand”; it indicates the complex relationships that exist among supply, need, and demand. Variations in demand at the individual level, similarly large, may be the most important.

Ultimately, demand is determined by the individual, although in current practice the demand drivers also may include the provider, the system of care, and the various commercial forces that market technology or pharmaceuticals. The variability in individual demand has been linked to the presence or absence of personal self-efficacy (health confidence) and to the availability of well-presented information to guide the most appropriate decisions. It is not in the interest of the individual, and often is against that interest (lost time, out-of-pocket expenses, or side effects), for that individual to seek a more intensive level of medical services than that which can be shown to be equally effective.

■ A role for self-management. Good health is, in large part, a function of the assumption of much of the responsibility for health by the individual. Educating the consumer so that more informed decisions are made decreases the frequency with which certain procedures are performed.

Multiple studies have demonstrated that providing medical consumers with information and guidelines for self-management can lower service use 7–17 percent at very low cost (Exhibit 1). The central concept is that self-care, when appropriate, is to be preferred
to professional care and that individuals can determine when professional care is required if provided with relevant information.

These approaches appear to work through two mechanisms: better consumer information and increased confidence (personal self-efficacy) that much illness can be effectively treated at home. Education that increases confidence about health decisions has been shown to reduce substantially the cost of long-term care, even in persons with chronic illnesses such as arthritis or Parkinson’s disease. Many millions of copies of the classical self-management guides, which provide guidelines for personal choices, have been distributed, often in the context of systematic demand reduction programs. Similar algorithms have been central to the development of telephone-based nurse triage systems.

### End-of-life care.

The costs of medical care in the last year of life are high, and a portion of these represent overly intensive approaches to the treatment of terminal illness. This is another form of unnecessary demand, aggravated by incentives that encourage providers to recommend intensive services. Some 18 percent of lifetime costs for medical care, or more than $40,000 per person, is estimated to be incurred in the last year of life, and nearly 28 percent

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### EXHIBIT 1

Exemplary Studies Of Self-Management Educational Programs

<table>
<thead>
<tr>
<th>Study</th>
<th>Subject</th>
<th>Design</th>
<th>Outcome</th>
<th>Estimated benefit/cost per person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fries et al., 1997</td>
<td>809 arthritis patients</td>
<td>Randomized 6-month trial</td>
<td>Pain decreased 9%, disability decreased 5%, days confined to home decreased 52%, doctor visits reduced 16%</td>
<td>$200–$800/75</td>
</tr>
<tr>
<td>Montgomery et al., 1994</td>
<td>290 Parkinson’s disease patients</td>
<td>Randomized 6-month trial</td>
<td>Clinical improvement 10%, doctor visits decreased 24%, hospital days decreased 50%, days confined to home decreased 28%</td>
<td>$600–$900/100</td>
</tr>
<tr>
<td>Lorig et al., 1993</td>
<td>343 arthritis patients</td>
<td>Randomized 4-month trial</td>
<td>Pain decreased 20%, doctor visits reduced 40%</td>
<td>$418/75</td>
</tr>
<tr>
<td>Vickery et al., 1988</td>
<td>1,009 Medicare subjects</td>
<td>Randomized 12-month trial</td>
<td>Doctor visits reduced 31%</td>
<td>$37/17</td>
</tr>
<tr>
<td>Lorig et al., 1985</td>
<td>5,200 California employees</td>
<td>Quasi-experimental time series</td>
<td>Doctor visits reduced 5–17%</td>
<td>$130/14</td>
</tr>
<tr>
<td>Vickery et al., 1983</td>
<td>1,200 health maintenance organization households</td>
<td>Randomized 12-month trial</td>
<td>Total medical visits reduced 17%, visits for minor illnesses decreased 31%</td>
<td>$50/18</td>
</tr>
<tr>
<td>Moore et al., 1980</td>
<td>700 insured Californian families</td>
<td>Randomized 12-month trial</td>
<td>Total medical visits reduced 7.5%</td>
<td>$90/10</td>
</tr>
</tbody>
</table>

**SOURCES:** See Note 13.
of U.S. Medicare and Medicaid payments for those over age sixty-five are for persons in their last year of life.\textsuperscript{14} Although imminent death is not always predictable, irreversible terminal illness often can be identified in advance. Current literature suggests that the potential for reduction in terminal demand equals 3 percent of lifetime medical costs, lower than sometimes estimated but still equal to $30 billion a year.\textsuperscript{15} Seventy percent of people do not desire aggressive, invasive technical treatments when they are dying, and 85 percent express a desire for living wills and other advance directives.\textsuperscript{16} Yet only 9 percent of the population have executed such directives, and fewer yet have distributed the signed documents to providers, caregivers, and medical records so that they may be available when needed. Clearly, we need to better understand the paradox of conflicting personal desires and personal actions.

\textbf{The Health Project Consortium.} The Health Project Consortium, a public/private volunteer group that has met unofficially at the White House over the past seven years, is dedicated to improving health and reducing costs through identifying and publicizing effective programs that reduce medical need and demand.\textsuperscript{17} The consortium has recognized thirty-two programs to date. These programs, provided by employers or insurers, average first-year cost savings of about 20 percent and have been presented with the C. Everett Koop National Health Award.

A recent critical review of thirty peer-reviewed studies of health promotion in the workplace has documented the effects of the best programs on medical costs, with cost savings generally being two or more times greater than the costs of the programs.\textsuperscript{18} For example, a low-cost intervention delivered by mail had a return on investment between six and eight to one.\textsuperscript{19} A well-executed study sponsored by the National Institutes of Health in Birmingham, Alabama, showed a nine-to-one return.\textsuperscript{20} Increasing research collaboration between universities and corporations has substantially improved the quality of recent studies; many of these studies have had sound experimental designs using randomized or parallel control groups. Savings have frequently been confirmed by analyses of claims data.

Thus, there are already multiple model programs that have both improved health and substantially decreased costs (Exhibit 2).\textsuperscript{21} It is not the basic knowledge that is lacking as much as the lack of penetration, until recently, of effective programs into a greater number of settings. Our analyses of the characteristics of programs most successful at both need and demand reduction suggest the need for a broadened definition of health promotion.

\textbf{Expanded definition of health promotion.} Health promotion, in an expanded definition, includes “all activities that educate,
guide, and motivate the individual to take personal actions which improve the likelihood of sustained good health and increase the appropriateness of requested services.” The autonomous individual who is enabled to make better decisions in his or her own interest can improve health and moderate costs. The physician and medical care organization move, wherever possible, from the provision of paternalistic “doctor’s orders” toward the role of health advocacy. Greater individual responsibility for health is a necessary, although not sufficient, requirement for optimal national health.

Through analysis of the Koop award–winning programs, we have observed an evolution from single-purpose programs, directed for example at smoking cessation, to multiple-intervention programs, and now toward programs that systematically approach both need and demand reduction. A central goal of health promotion, of course, remains improvement in health habits, and ultimately the postponement and prevention of major chronic illnesses requires reduction in risk factors. Available data, however, suggest a minimum lag period of two to three years between improvement in health habits and achievement of better health and reduced costs. Yet the Koop award programs generally have achieved cost reductions within their initial year.

### EXHIBIT 2
Exemplary Studies Of Cost-Reducing Health Education Programs

<table>
<thead>
<tr>
<th>Study</th>
<th>Subject</th>
<th>Design</th>
<th>Outcome</th>
<th>Estimated benefit/cost ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aldana et al., 1993</td>
<td>680 city employees</td>
<td>2-year randomized trial</td>
<td>Per capita claims costs decreased 11.5%</td>
<td>$3.6/1</td>
</tr>
<tr>
<td>Bertera et al., 1990</td>
<td>43,000 Dupont employees</td>
<td>2-year randomized trial</td>
<td>Number with 3 or more risk factors reduced 34.5%, sick days reduced 14%</td>
<td>$2.05/1</td>
</tr>
<tr>
<td>Bly et al., 1986</td>
<td>8,300 Johnson and Johnson employees</td>
<td>5-year randomized trial</td>
<td>Inpatient claims reduced 13%</td>
<td>—</td>
</tr>
<tr>
<td>Fries et al., 1994</td>
<td>57,000 public employee retirees</td>
<td>12-month randomized trial</td>
<td>Risk factors decreased 8–13%, claims costs decreased $400 per participant</td>
<td>$6–$8/1</td>
</tr>
<tr>
<td>Fries et al., 1993</td>
<td>4,712 Bank of America retirees</td>
<td>12-month randomized trial</td>
<td>Health risk scores reduced 23% at 2 years, cost reductions 20% (survey) and 10% (claims)</td>
<td>$6/1</td>
</tr>
<tr>
<td>Golaszewski et al., 1992</td>
<td>36,000 Traveler’s insureds</td>
<td>Return-on-investment analysis</td>
<td>Absenteeism reduced 19%</td>
<td>$3.4/1</td>
</tr>
<tr>
<td>Harvey et al., 1993</td>
<td>4,000 city of Birmingham employees</td>
<td>5-year trend analysis 1975–1980, state of Alabama comparison group</td>
<td>Claims cost increases of only 2.5% per year, 70% reduction in hospital days over expected</td>
<td>$9/1</td>
</tr>
</tbody>
</table>

**Sources:** See Notes 19, 20, and 21.

— Not available.
“Early detection of illness has been proved to improve health. There is little evidence that these efforts reduce medical care costs.”

The additional elements included in the broadened health promotion definition account for the immediate cost savings. Examples include self-management materials and programs that raise individual confidence (personal self-efficacy) in making health-related decisions, that improve a person’s level of confidence in dealing with chronic illnesses, and that reduce the number of low-birthweight babies. Actions such as beginning regular seat-belt use decrease health risks immediately. And advance directives, such as a living will or durable power of attorney, that emphasize humane and dignified care at the end of life can reduce costs as well as ensure desired care. Identification of high-risk persons and interventions to assist these persons in reducing need and demand for services also produce measurable outcomes over the initial year.

In contrast, caveats are required when assessing the cost consequences of preventive medical services urged under a medical model of diagnosis and treatment. These approaches, including mammography, colonoscopy, pap smears, hypertension screening, and cholesterol screening, represent early detection programs rather than programs that reduce medical need. Early detection of illness has sometimes, but not always, been proved to improve health. However, there is little evidence that these efforts reduce medical care costs, although the case can be made that ultimately they may reduce costs given studies of sufficient duration. Arguments for implementation of those early detection programs shown to improve health, however, are already strong, since their cost-effectiveness (rather than cost savings) is relatively high compared with most other medical interventions.

Three Complementary Models

The present evidence of our ability to reduce need and demand suggests the potential for evolution toward ever more effective implementation and development of truly integrated systems of care. We propose consideration of three models.

- **Long-term outcome improvement.** Comparing organized systems of medical care on the basis of “report cards” is a growing movement. If it is granted that providers’ behavior may change according to the grading variables selected, then the report card represents a powerful agent of change. It follows that we must design the report card to reflect the most important products that might be
delivered by an organized system of medical care. From the long-term outcomes assessment perspective, the ultimate outcome variables are age-adjusted mortality rates and changes in these rates over time and age-adjusted disability (quality-of-life, morbidity) rates and changes in these measures over time. Below this ultimate level are elements such as age-adjusted disease-specific mortality. In contrast, present measures of quality focus on easily measured variables such as mortality following open-heart surgery, a small subset (less than 1 percent) of coronary artery disease mortality.

The irony behind this difference in emphasis is perhaps obvious. Given one medical care organization that emphasizes quality in prevention of coronary events and a second that emphasizes surgical excellence, it is probable that the system emphasizing prevention will have lower coronary artery disease mortality rates and lower total mortality rates than the center with the better report card for postoperative mortality. With present grading systems, the organization with the better long-term coronary outcomes might have the worst report card, and the incentives for outcomes improvement might be, in part, perverse.

An ideal organized system of care, then, conceptually might contain two tracks, one directed at reduction in need and demand, and the other at the best possible application of scientific medicine. The health education (population-based) arm will be applied by mail, telephone, cable, and computer, and the personal medical care arm, under evolving professional disease management principles. This population-based intervention will use relatively few resources and actually will contribute resources from cost savings to the organized system of care and to the personal medical care arm.

**Complete disease management.** The concept of “chronic disease management” is evolving rapidly, but it usually maintains a narrow traditional focus on systematizing professional medical care for a specific illness, such as diabetes or asthma, through the use of clinical guidelines or “critical pathways.” A broader disease management concept for chronic illness, essential if long-term outcomes are to be improved, has three complementary goals: (1) prevention, (2) optimal self-management, and (3) optimal professional care.

For example, in maturity-onset diabetes the first goal is to prevent the disease whenever possible by exercise, diet, and weight control. The second goal is for patients to self-manage the disease to prevent complications, by measures such as foot care to minimize skin ulcers and amputations, medication compliance, lifestyle changes, and appropriate decisions about use of medical services, such as entering the care system promptly after a day of nausea and vomiting rather than two days later in diabetic coma. Third, when
self-management fails, the medical care system must efficiently react to the problem, as with best-practices management of diabetic ketoacidosis. Medical management and self-management must interact in a complementary fashion. The medical care system, absent the help of the patient, cannot accomplish optimal long-term outcomes in chronic illnesses.

- **Five lines of health defense.** An organized outcomes-oriented health care system should consider its central purpose to be to defend the health of its defined population. To foster physical, psychological, and social well-being, five concentric circles of defense need to be established. An integrated, computer-based medical information system keyed to the individual member is needed for full development of this model.

The first and most important line of health defense is made up of programs that prevent or postpone illness and that promote health. When a new symptom is encountered, the second line of defense is self-management; the patient consults self-management resources to determine if home care is appropriate and what action should be undertaken. Failing resolution at this level, the third line of defense is triage, perhaps through the call center nurse. The telephone conversation with a nurse may again triage the patient toward home care but also may establish the probable need for professional care. At this point the triage algorithms assess the urgency with which care is needed and the appropriate physician and provider level for that care. The fourth level of defense then is the medical professional response to the acute problem. An appropriate appointment is made at the initial triage telephone call. When the member arrives at the medical facility, the provider, with a computer terminal on the desk, has access to the medical background, the health risk status, and the results of the nurse call center interaction. Guidelines for “specifications of acceptable care” assist the physician in selecting an efficient and effective approach to management. When an acute problem becomes chronic, the fifth level of defense, chronic disease management, comes into play. A comprehensive disease management program, as discussed above, has both chronic disease self-management and professional management components, directed at long-term outcomes improvement, coordinated by the computer data system, and guided by the organized system toward application of the best standards of medical practice. Each of these five levels of health defense exists today, at least in partial form, and the ideal system would fully integrate all levels.
AN IMPROVED HEALTH CARE SYSTEM for the year 2000 and beyond would serve a defined population and be dedicated to achieving the best short- and long-term health outcomes for that population. It would provide for yearly health assessment questionnaires and computer-guided recommendations for the health improvement of each individual, usually delivered by mail to each family in written form. The questionnaires would collect health risk data but also data on outcomes and quality to define the needs of both individuals and the population. Self-management resources would be made available to each member and each family in written form, over the Internet, or through other media. A computer-based medical record would be established for each individual, organized longitudinally, and augmented by health risk and outcomes data provided by self-report. A computer data platform would integrate health-relevant information of all types, indexed to the individual, accumulated longitudinally, and accessible (with appropriate confidentiality restrictions) by the patient, the call center nurse, the doctor, the administrator, research teams, quality assurance managers, outcomes assessment epidemiologists, and health services researchers. Model systems integrating these concepts are now in development.

Health Policy Implications

It may seem overly simplistic to argue that we may solve many of the most vexing economic problems of our medical care system by systematically doing those things that we already know how to do and that, at the same time, would improve health outcomes. Yet reducing need and demand for medical care is a theoretically sound approach and is well documented as effective. It is readily funded through use of the savings that accrue to the present “at-risk” payers; the benefits exceed the costs. The approach complements any plan for health care financing reform and may be considered essential to all such plans, which all face the difficult problem of reducing costs while maintaining access.

Health policies that encourage persons to place a higher value on health and that provide them with the tools necessary to take greater charge of their own health are required. The movement toward including outcomes measures in quality assessments will be helpful, since this encourages attention to measures that improve long-term outcomes, which in turn leads to risk-factor identification and programs to reduce risk. The management of health risk is clearly central to successful managed care.

The Health Project Consortium does not believe that all programs
purporting to reduce need and demand, or proposed to manage chronic illness, will be equally effective at meeting their goals. Rigorous evaluation of all programmatic approaches and use of proven programs and principles are essential. The quality of need and demand reduction programs is even more important than their quantity at this stage of evolution. Reducing the need and demand for medical services is a doubly positive policy goal; it promises better health for the individual and lowering of the medical costs that now consume a dangerously high share of our nation’s productivity.

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NOTES


