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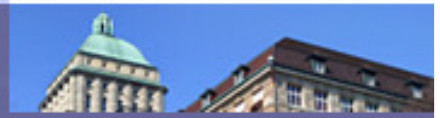


Ökonomie und Medizin – Pflicht oder Kür?

Symposium
Schweizerische Gesellschaft für Innere Medizin
Jahrestagung, Basel
13.5.2009

Prof. Dr. med. Thomas D. Szucs

Institut für Sozial- und Präventivmedizin
Universität Zürich

Der Reigen

1. Einstiege
2. Irrwege
3. Auswege

Was ist Ökonomie?

“Die Lehre, wie Menschen und Gesellschaften letzendlich KNAPPE RESSOURCEN WÄHLEN die eine ANDERWEITIGE VERWENDUNG hätten”

Paul Samuelson,
Nobelpreisträger (1980)

Zentrale Aufgaben der Gesundheitsökonomie

University of Zurich

Deskription

Prediktion

Evaluation

Das Verteilungsproblem

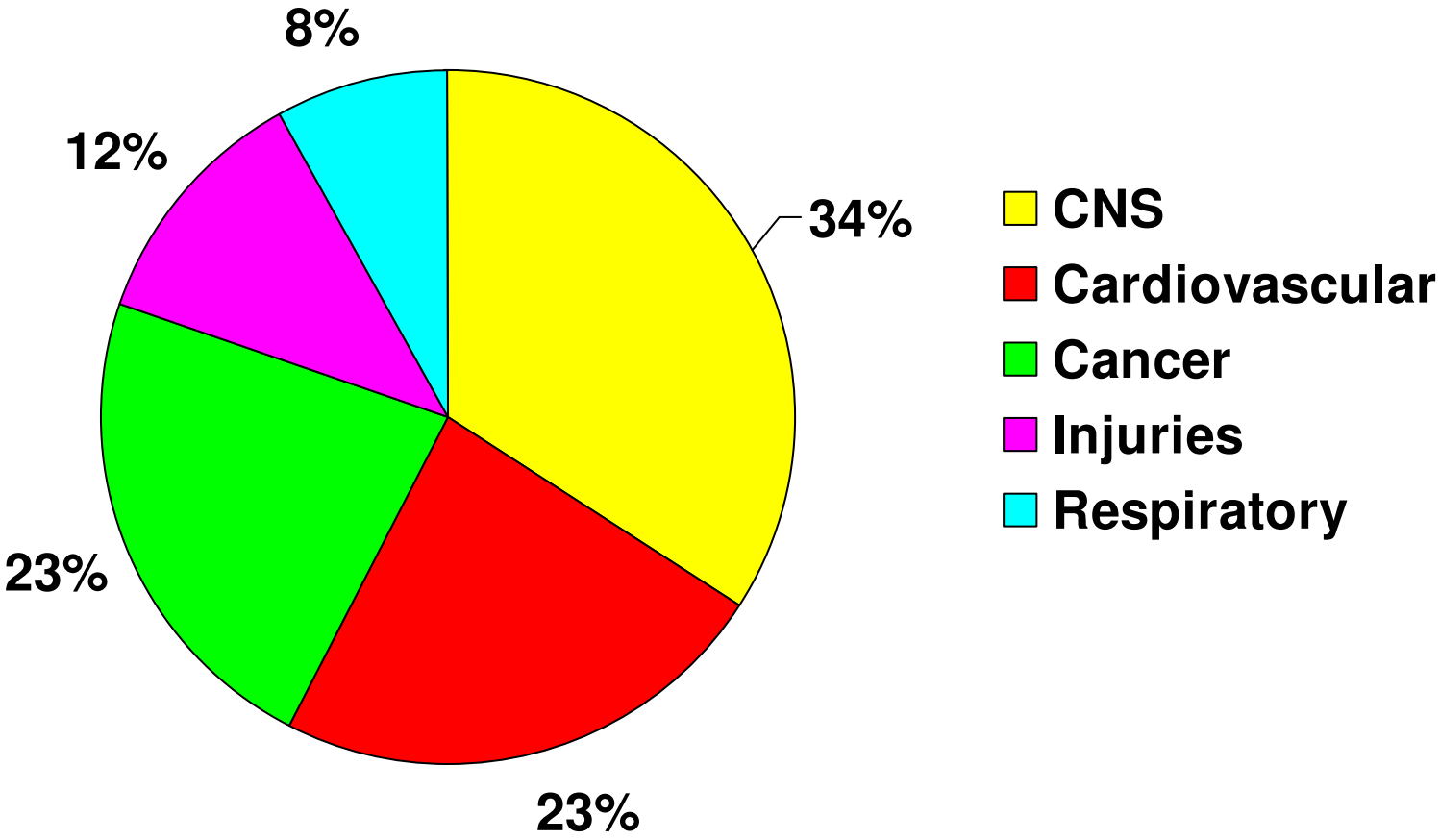
Verteilung der Gesundheitsausgaben

- 1% der teuersten Patienten verursachen 30% der Ausgaben
- Die teuersten 5% der Patienten verursachen 58% der Ausgaben
- Die “billigsten” 50% der Patienten machen nur 3% der Ausgaben aus

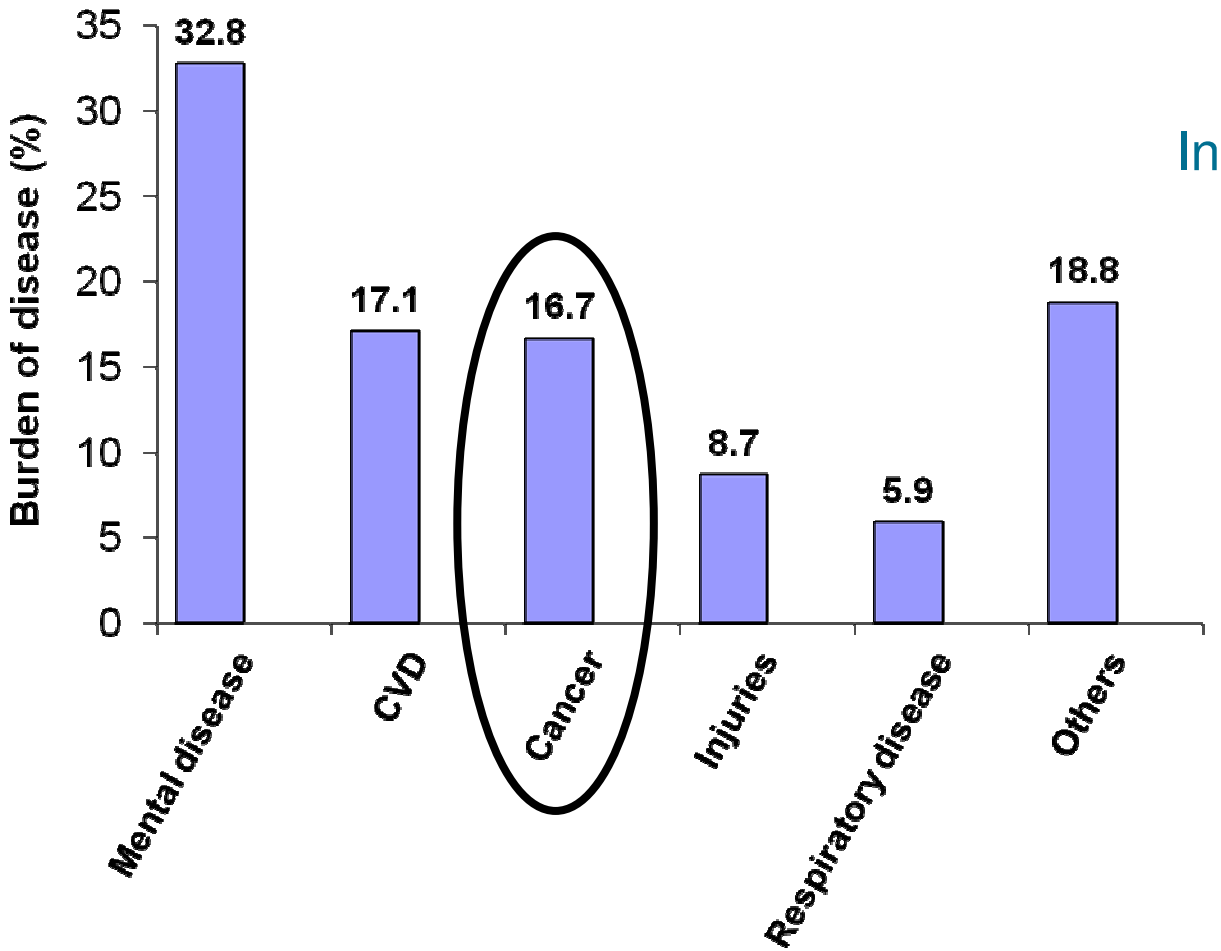
Disease Burden in EU 15 (2002)

University of Zurich

Total: 58.8 mio DALYs (129.7/1000)



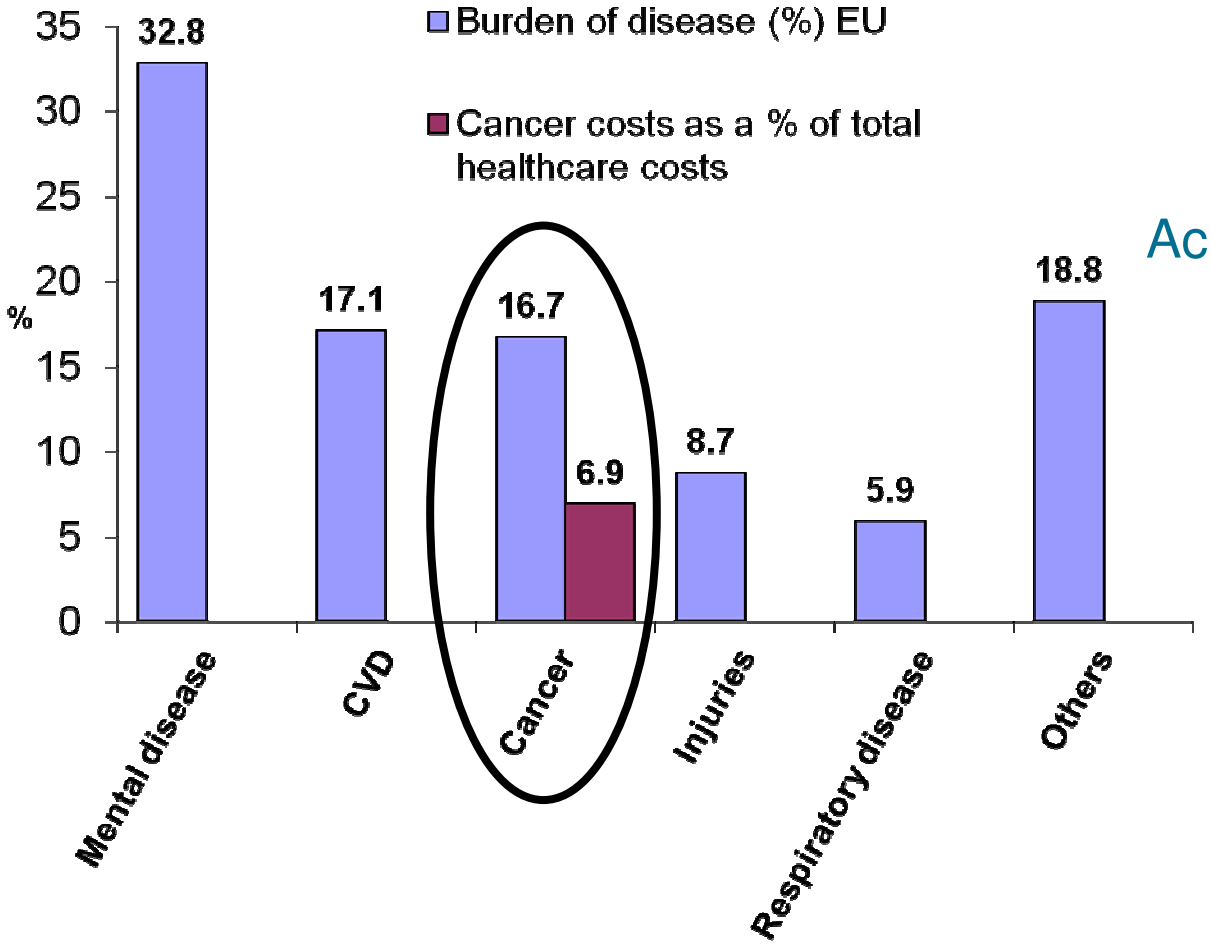
Cancer has a 17% share of the EU 'disease burden'



In 2002 cancer represented 17% of the share of disease burden across the EU

Source: WHO. Priority medicines for Europe and the world. http://mednet3.who.int/prioritymeds/report/index.htm

...but healthcare spending on cancer is not proportionate

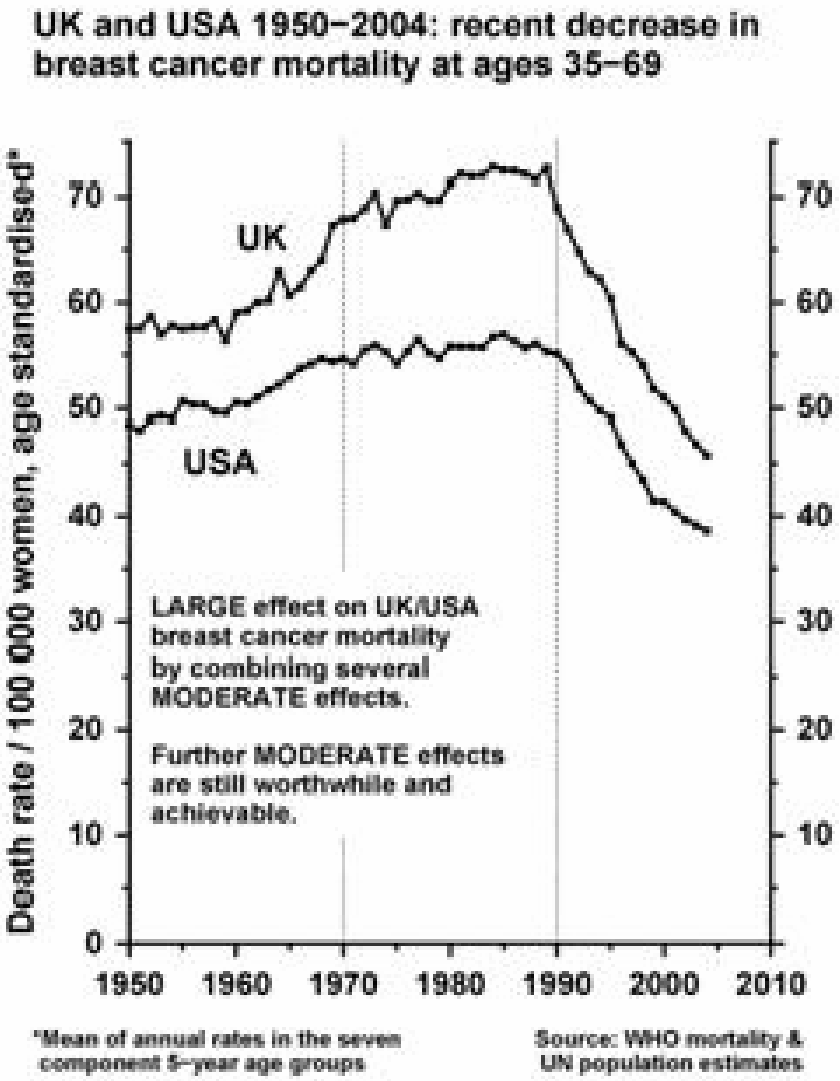


Across the EU cancer accounts for only 6.9% of overall healthcare costs

Source: WHO. Priority medicines for Europe and the world. http://mednet3.who.int/prioritymeds/report/index.htm

What are we getting for it?

- Efficacy
- Quality of life
- Improved survival in developed countries



Peto et al. SABCS 2007.

The Conflict

Human Life is Priceless

To think otherwise is to detract from the dignity of the patient

All Resources Are Finite

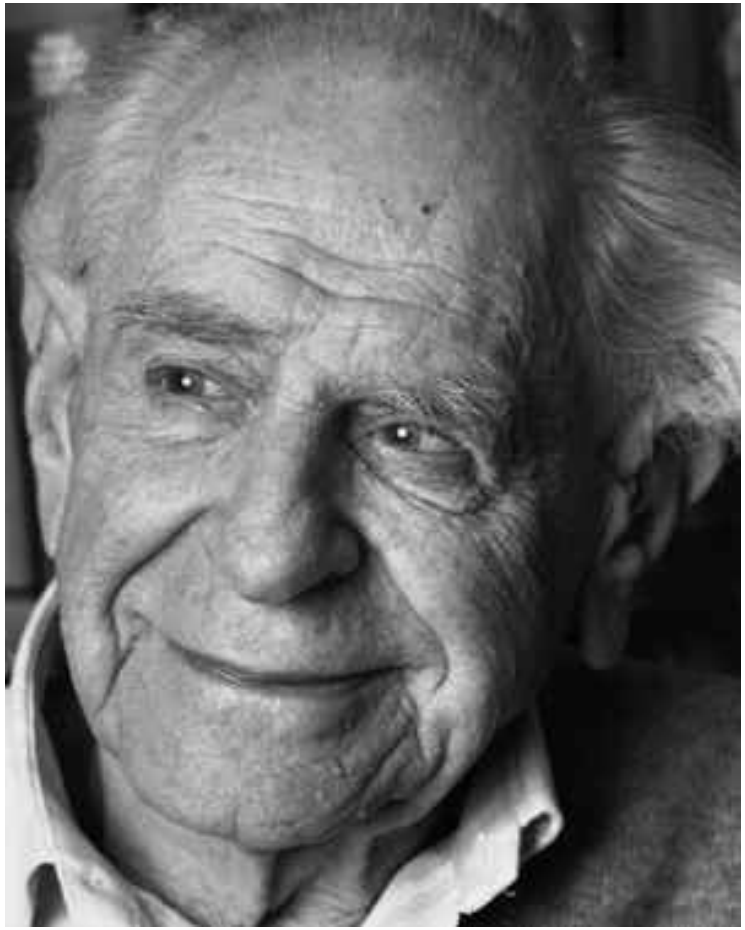
Society must decide how best to distribute health care resources

Sulmasy DP. J Clin Oncol 2007;25:217-22.

Myths and Science

Thus science must begin with myths, and with the criticism of myths; neither with the collection of observations, nor with the invention of experiments, but with critical discussion of myths, and of magical techniques and practices.

- Conjectures and Refutations: The Growth of Scientific Knowledge (1963)



Karl Raimund Popper (1902-1994)

4 myths

University of Zurich

1. There are significant savings at the end of life
2. High costs at the end of life cannot be influenced
3. Reduction in mortality leads to higher costs
4. Health expenditure as a proportion of the domestic product is steadily increasing

Myth 1

There are significant savings at the end of life

Estimated savings from greater use of advance directives, hospice care and less aggressive interventions

University of Zurich

Variable	Total		Medicare
	Age <65 yr	Age ≥65 yr	
No. of patients who died in 1988	0.68 million	1.49 million	1.49 million
Average cost of health care in the last year of life per dying patient	$34,102†	$29,295‡	$13,316
Savings from the use of advance directives, hospice care, and less aggressive interventions by all patients§			
Savings per patient	$9,208	$7,910	$3,595
Total dollar savings	$6.3 billion	$11.8 billion	$5.4 billion
1988 U.S. health care spending	$546 billion		$88.5 billion
Savings in health care spending (%)	3.3		6.1¶

*Expenditures are shown in 1988 U.S. dollars.

†Extrapolated from the estimated $15,346 in Medicare health care expenditures for patients 65 to 79 years old during their last year of life, which constitutes 45 percent of the total health care costs of these patients.[15]

‡Includes $13,316 for Medicare costs and $15,979 for health care costs not covered by Medicare for these dying patients in 1988.[15,40]

§Savings were calculated as 27 percent of the average cost of health care in the last year of life.

¶Percentage shown is of the entire Medicare budget, not of Medicare payments for patients over 65 ($73 billion in 1988).[15]

Emanuel EJ NEJM 1994; 330; 540 - 544

Can we save money on care at the end of life?

- **Advance directives**: do not significantly affect costs of patients‘ terminal hospitalisations (Schneiderman 1992)
- **Hospice care**: saves between 31 and 64% of medical care costs (Kidder 1992; Kane 1984; Spector 1984; Hannan 1984; Mor 1985; Brooks 1984)
- **Reducing futile care at end of life**: no impact (Maksoud 1993)

Myth 2

High costs at the end of life cannot be influenced

ORIGINAL INVESTIGATION

Cardiovascular Risk Profile Earlier in Life and Medicare Costs in the Last Year of Life

Martha L. Daviglus, MD, PhD; Kiang Liu, PhD; Amber Pirzada, MD; Lijing L. Yan, PhD; Daniel B. Garside, BS; Philip Greenland, MD; Larry M. Manheim, PhD; Alan R. Dyer, PhD; Renwei Wang, MD; James Lubitz, MPH; Willard G. Manning, PhD; James F. Fries, MD; Jeremiah Stamler, MD

ARCHIVES OF
INTERNAL MEDICINE

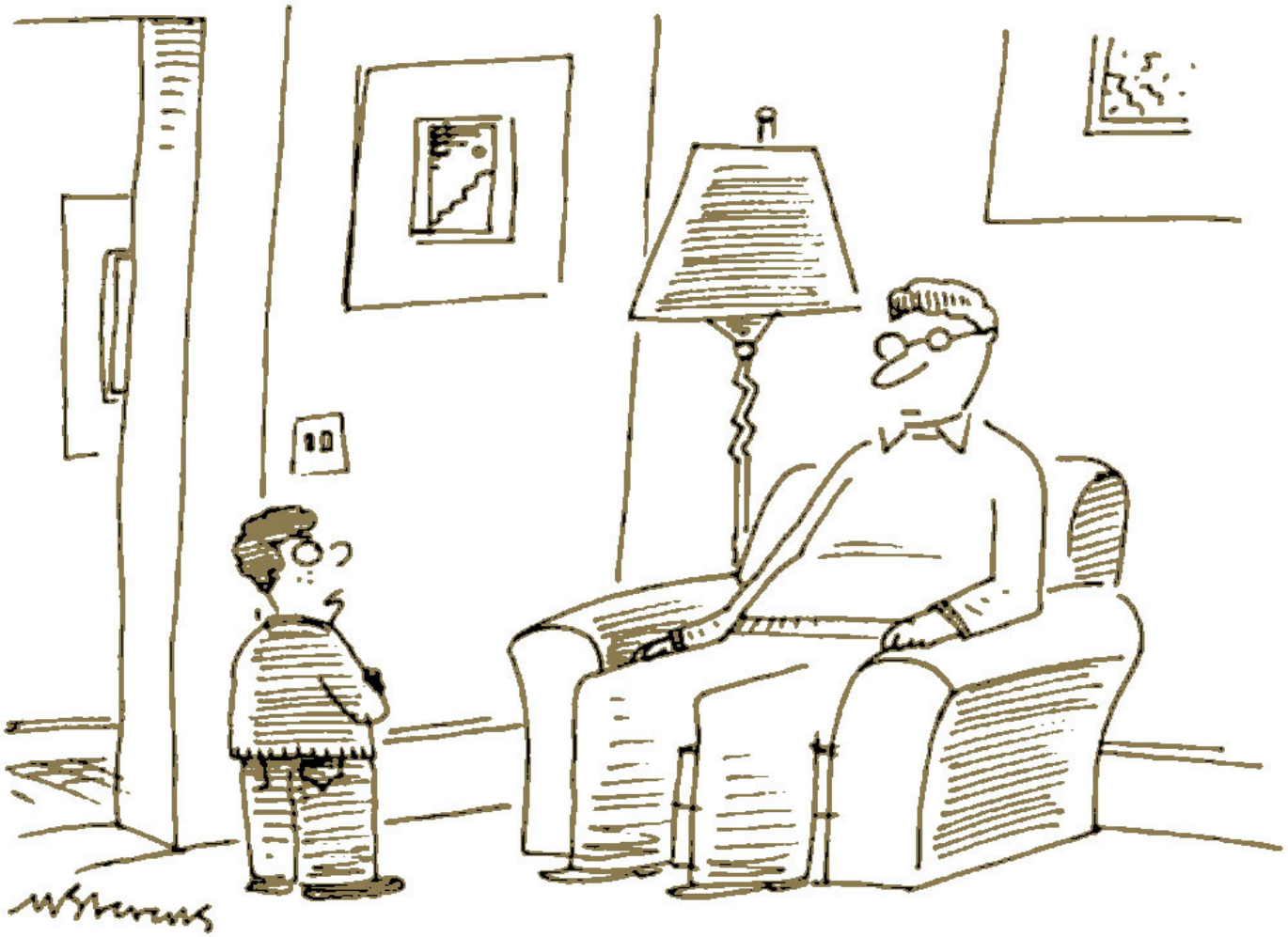
Conclusion: Favorable cardiovascular risk profile earlier in life is associated with lower Medicare charges at the end of life.

Arch Intern Med. 2005;165:1028-1034

Myth 3

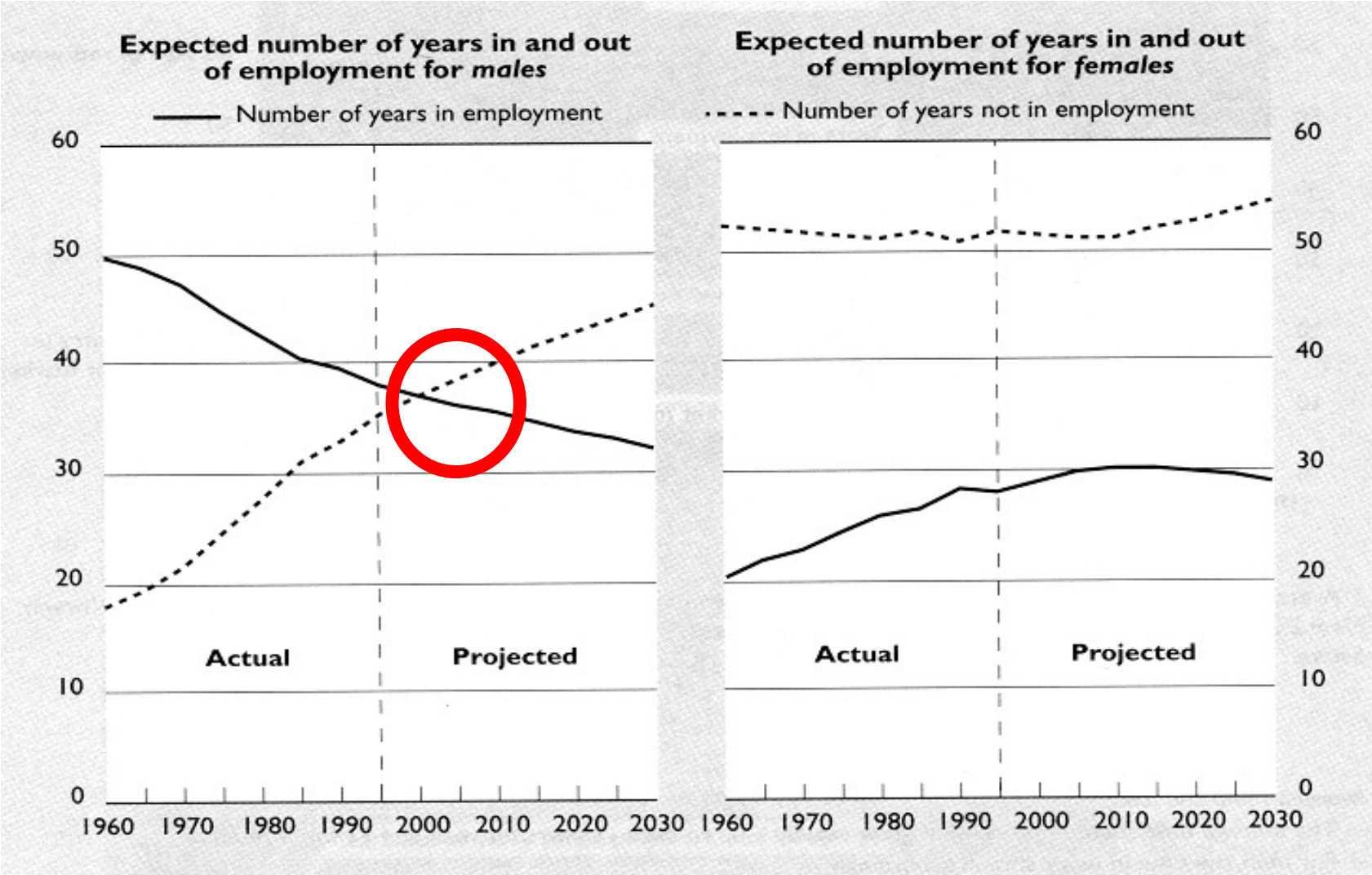
The reduction in mortality leads to higher costs.

"By the way, Sam, as someday you'll be paying for my entitlements, I'd like to thank you in advance."



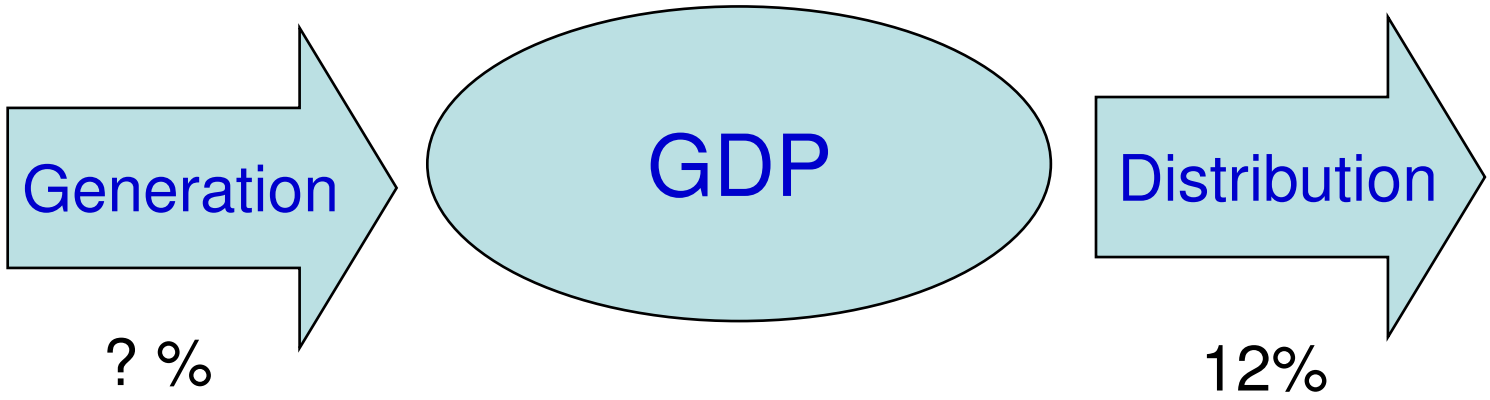
"Just what exactly is your generation going to do about my generation's social security?"

Large changes in the amount of time that individuals can expect to spend in employment



Source: OECD

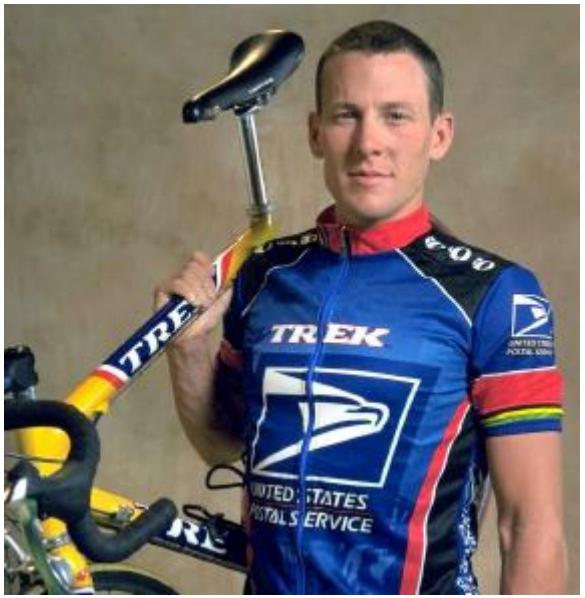
The two sides of the gross domestic product

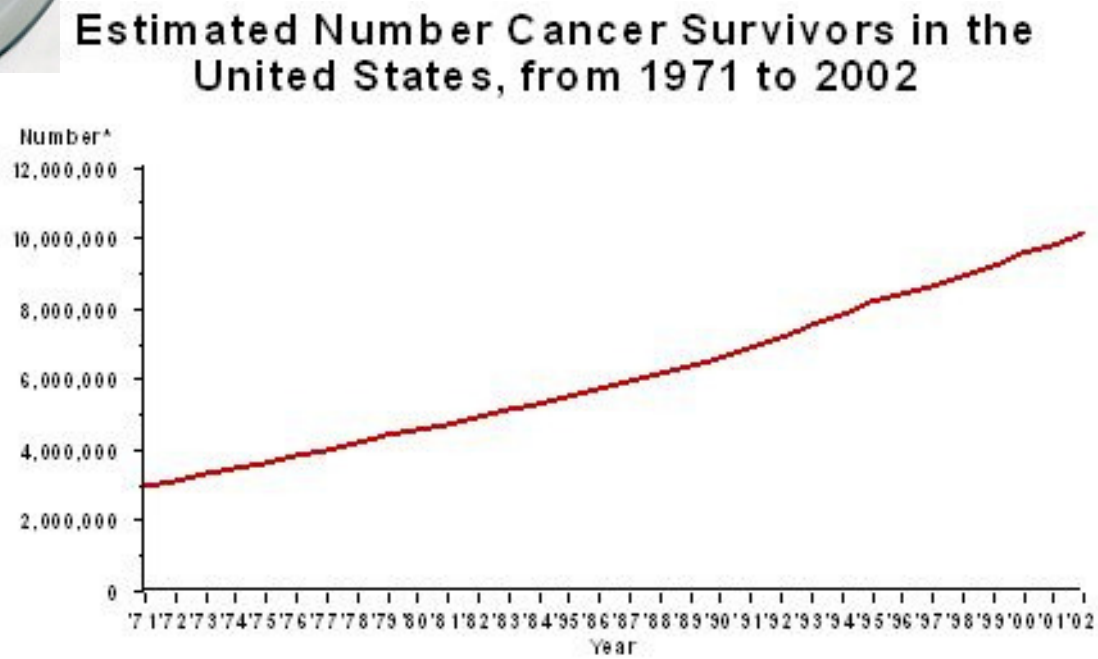


A dead patient is not a cheap patient

Longterm cancer survivors

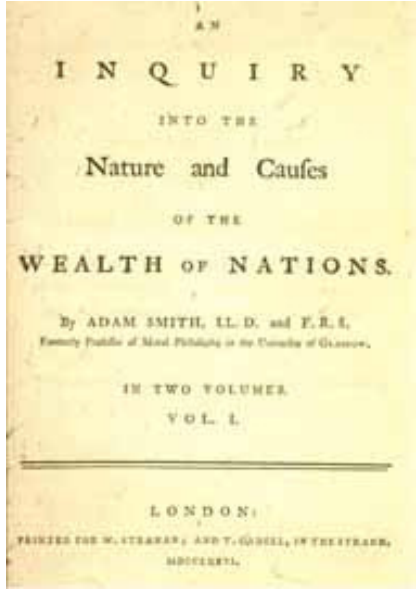
Jose Carreras





Myth 4
Health expenditure as a proportion of the domestic product is steadily increasing

More money ≠ More health


AN

INQUIRY

INTO THE

Nature and Causes

OF THE

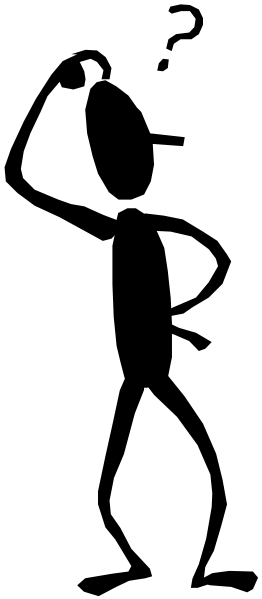
WEALTH OF NATIONS.

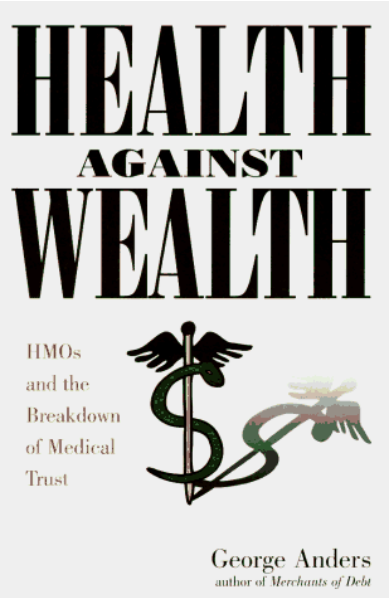
By ADAM SMITH, LL. D. and F. R. S.

IN TWO VOLUMES.

VOL. I.

LONDON:





Study of National Bureau of Economic Research (2001)

University of Zurich

1 additional life year
life expectancy

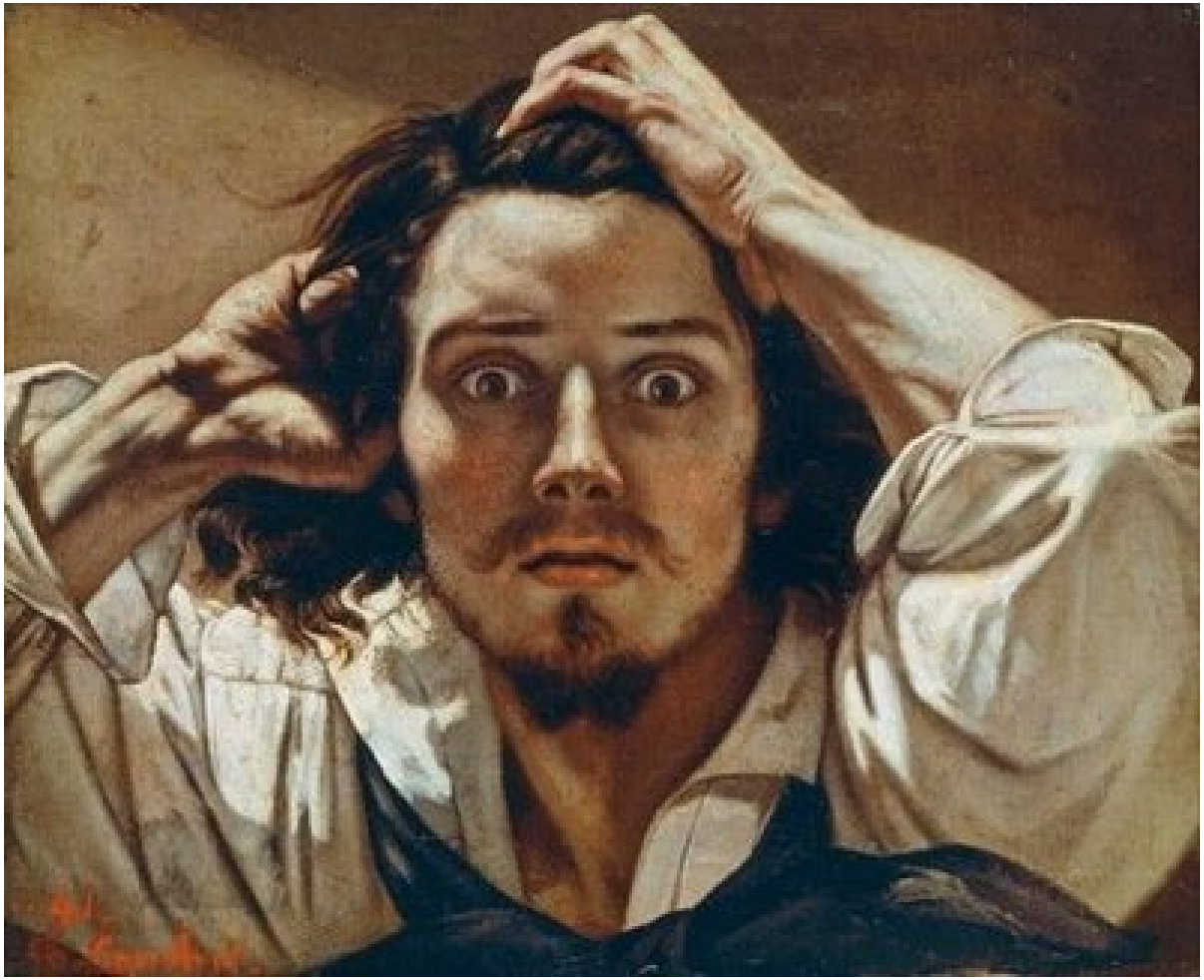
→

4 % increase
In GDP

Deficiencies of the domestic product

1. Considers only products and services which are generated in a market oriented environment and valued in monetary terms. Voluntary and unpaid services are not included.
2. No information in which labour time value creation was produced (leisure time as welfare inducing alternative to market based labour).
3. Lack of market prices for public services, hence these are valued at production cost
4. Informs only on level of population income and not on distribution.

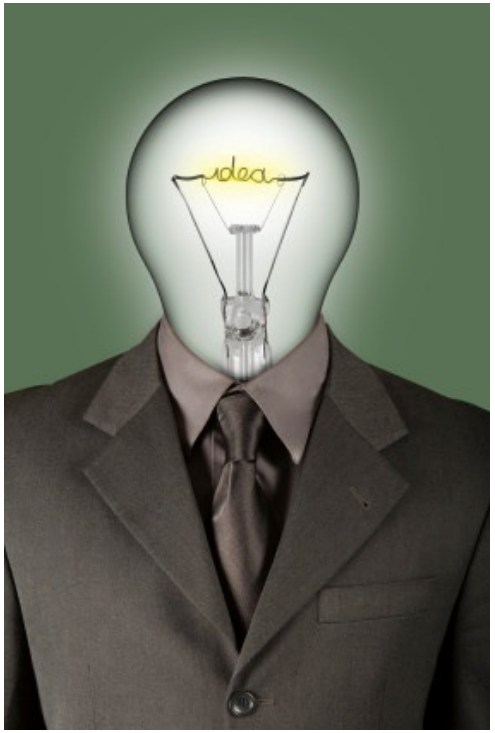
Warum sagt einem das niemand?

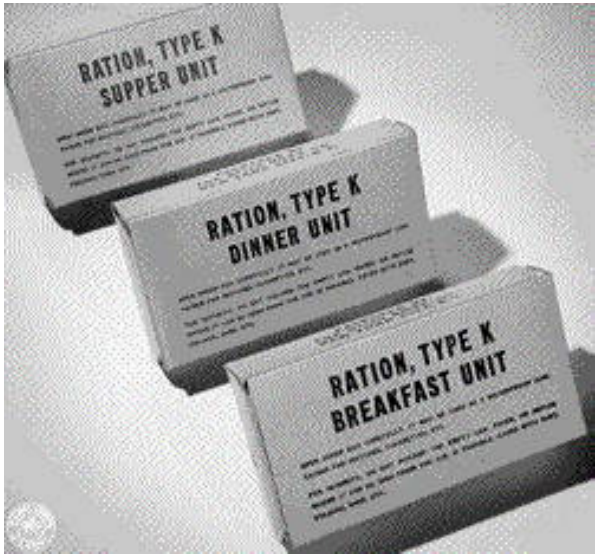


Gustave Courbet (1819-1877): Self Portrait or The Desperate Man

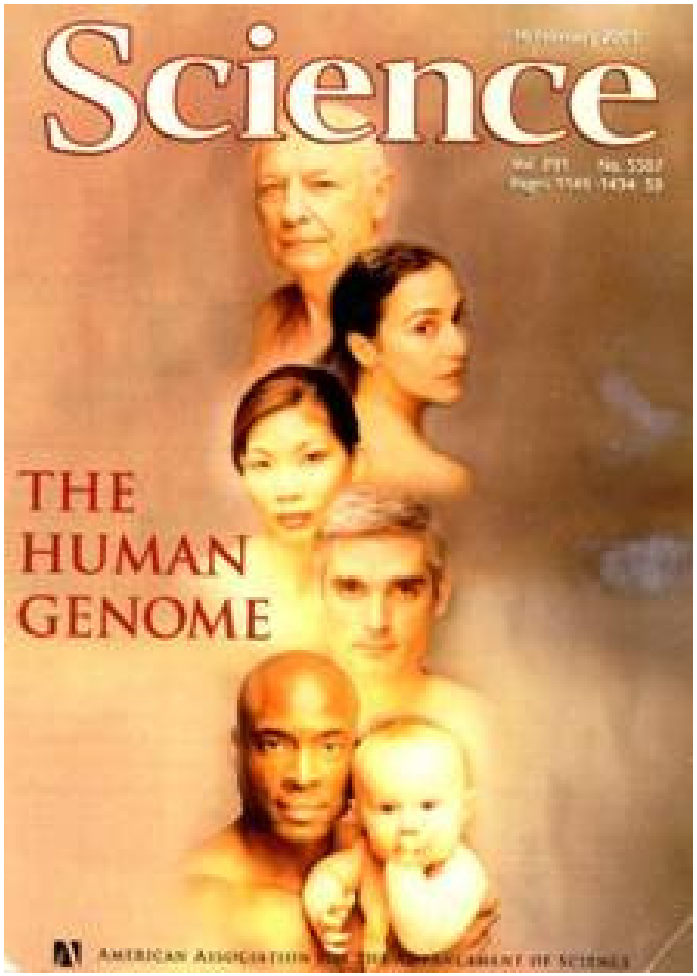
The Road Ahead

Zukunft der Medizin – Eine Frage der Innovation, des Geldes und der Moral

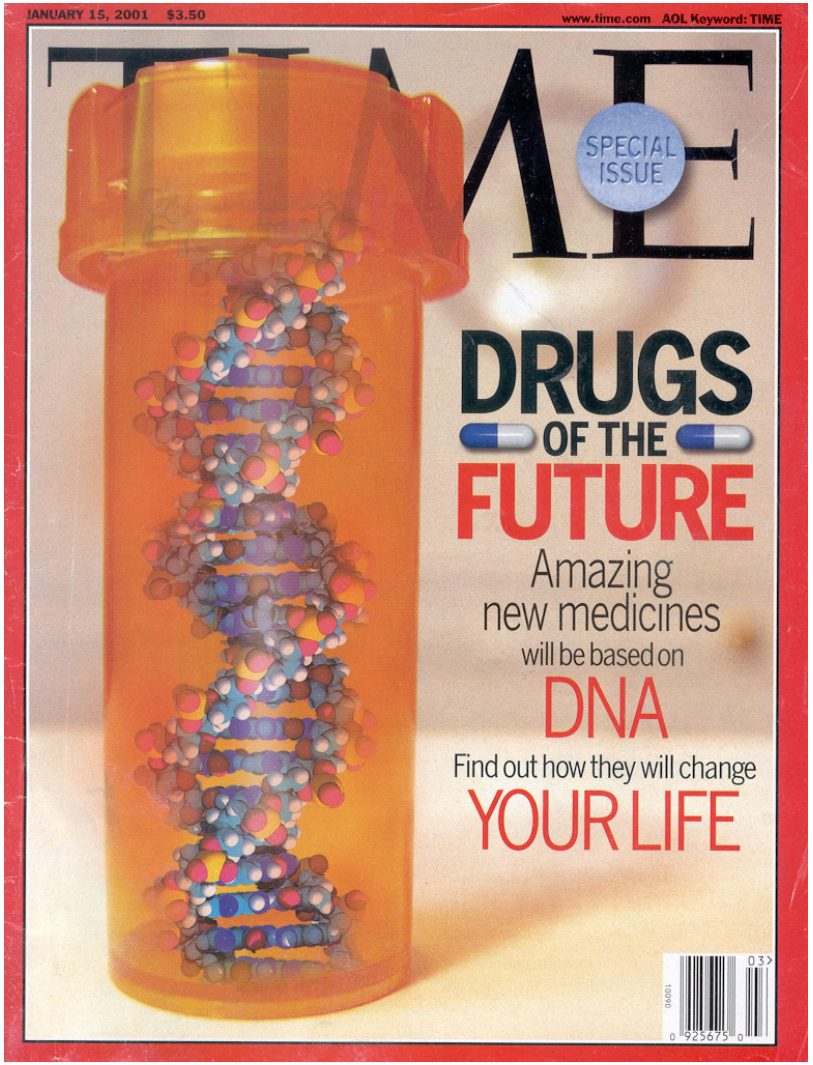




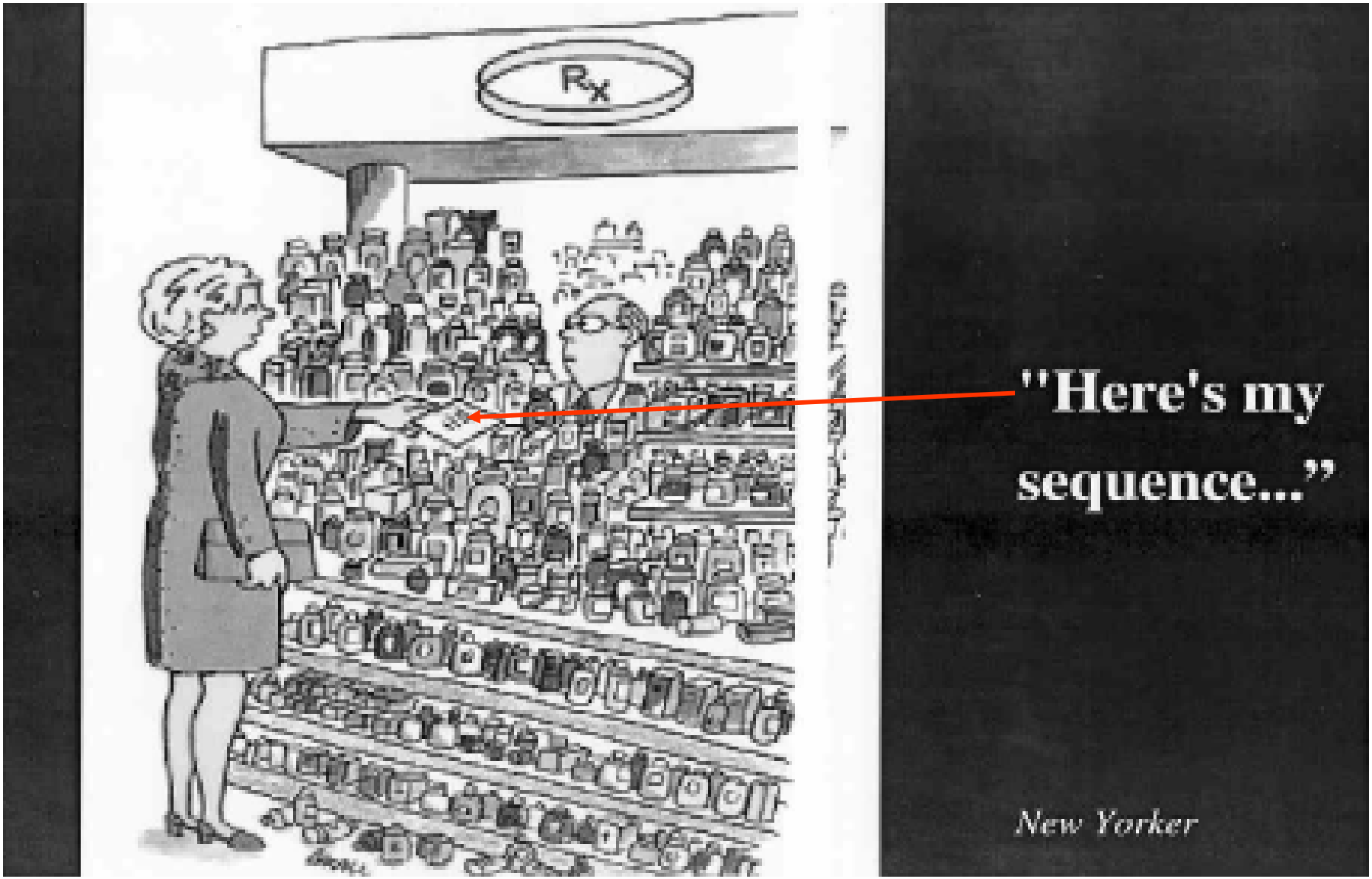
Year 2000: ”The Changing Face of Medicine” - Discovery Genomics and Pharmacogenomics



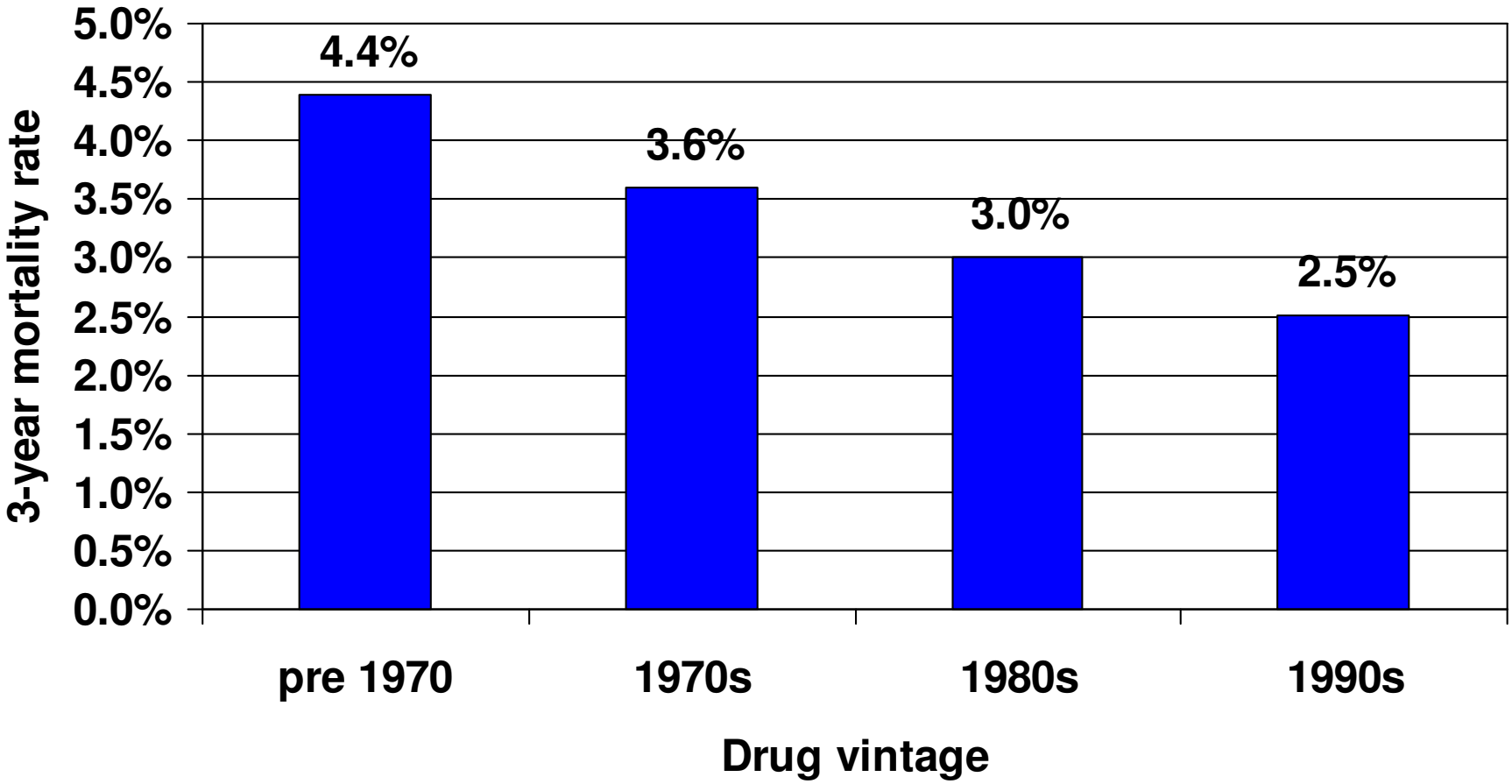
Targeted therapies



The Future ?!

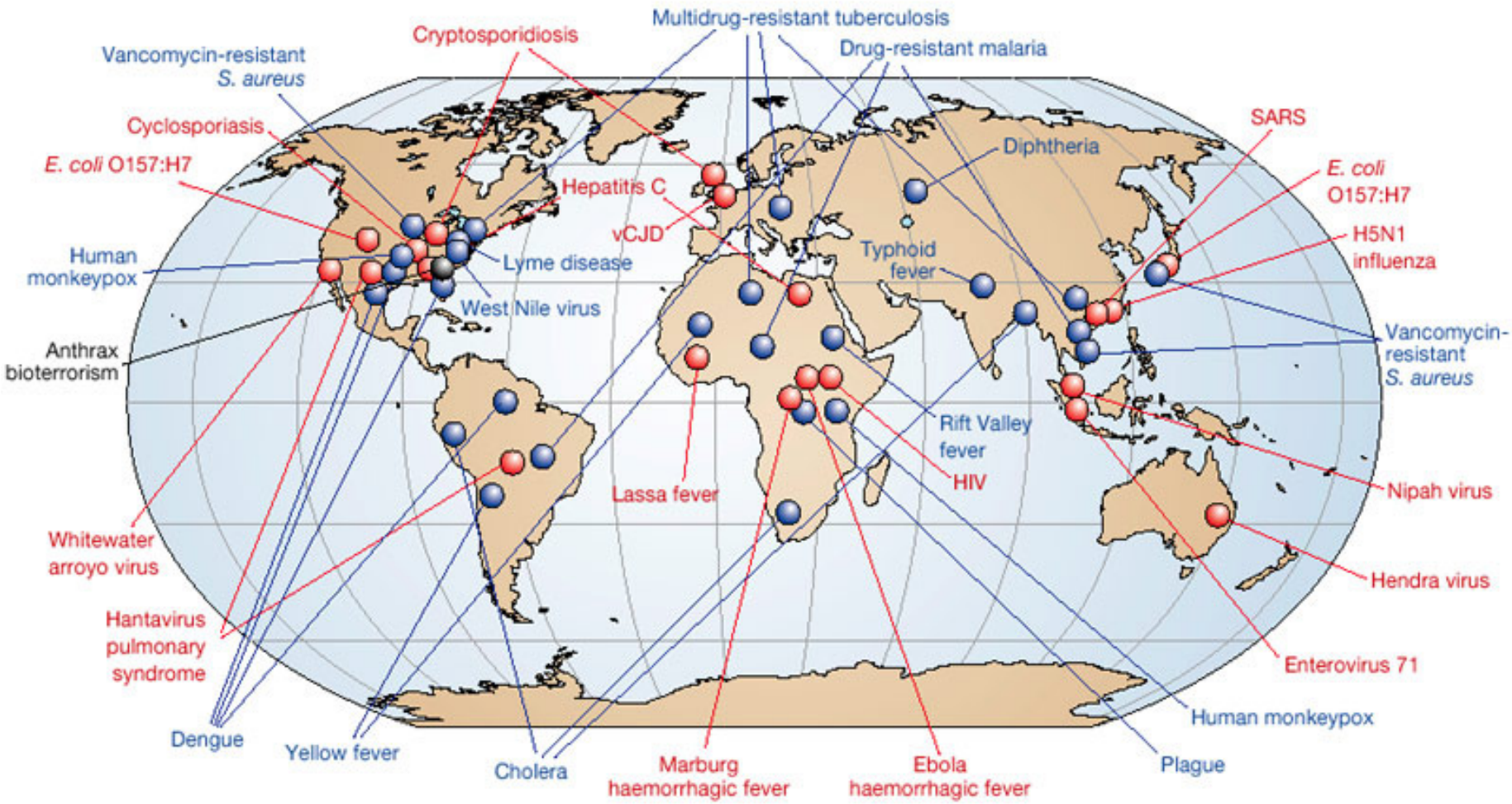


Mortality rate declines as drug vintage increases



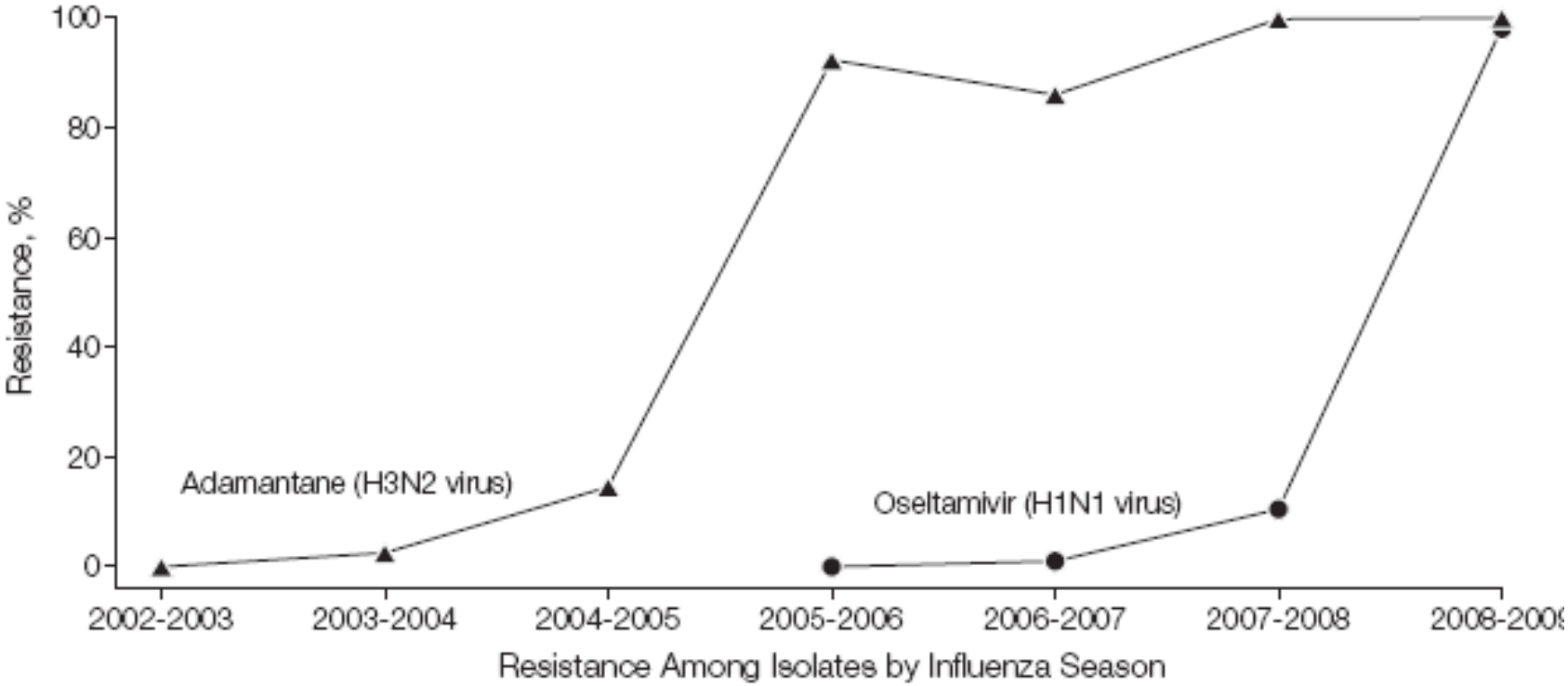
Lichtenberg F. National Bureau of Economic Research, Working Paper

Neu aufkommende Infektionskrankheiten



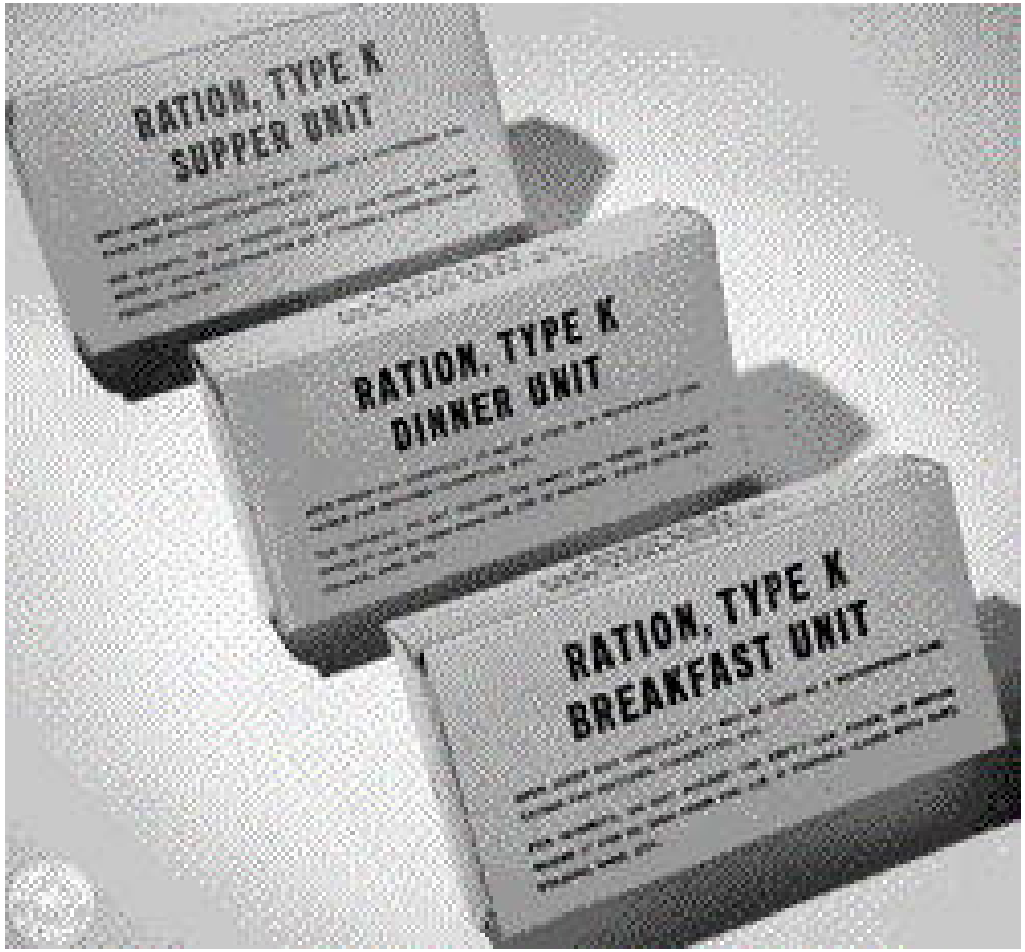
Rot: neu entstehende Krankheiten; Blau: wiederkehrende/wieder auflebende Krankheiten;

Häufigkeit der Resistenz gegen Adamantan bei A(H1N1)-Influenza-Isolaten und gegen Oseltamivir bei A(H3N2)-Influenza-Isolaten

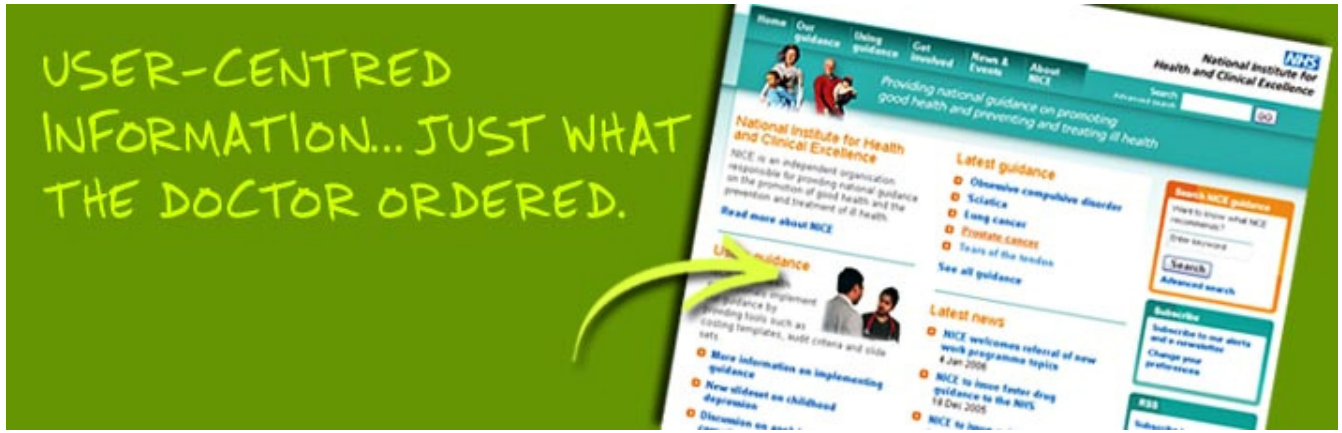


Quelle: Weinstock, JAMA 2009

Eine Frage der Moral?



Findet Rationierung bereits statt?



From The Sunday TimesNovember 9, 2008

Cancer patients sentenced to an early death by bureaucrats

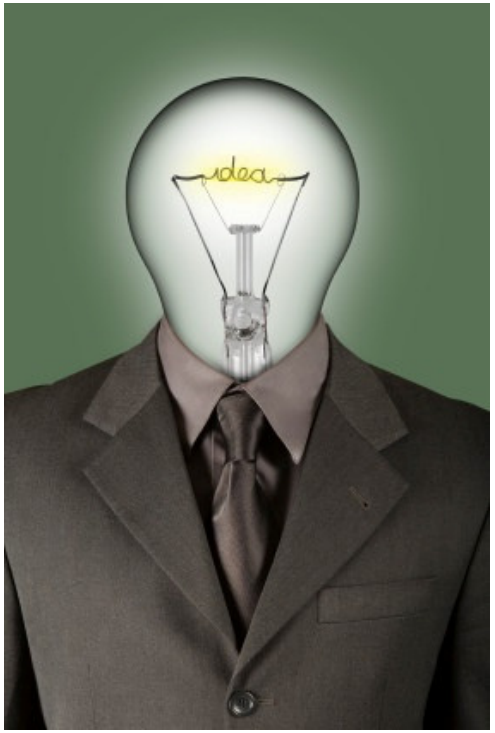
This woman got the life-saving cancer drug she needed. Thousands more have been sentenced to an early death by bureaucrats. Russell Miller investigates. Photographs by Larry Dunstan

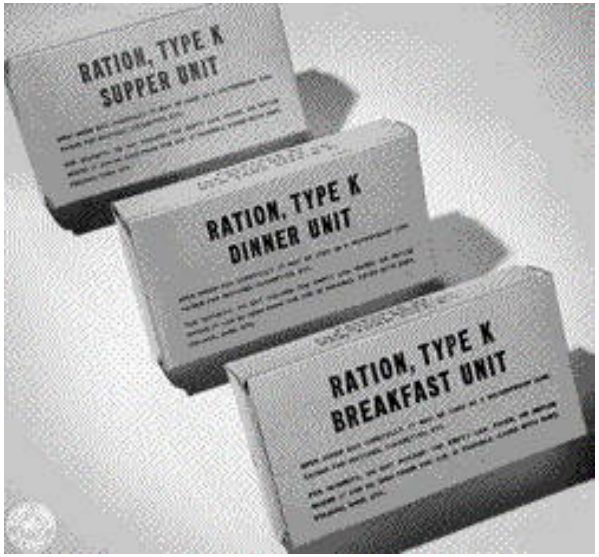
- Das britische National Institute for Health and Clinical Excellence (NICE) räumt seinen Appraisal Committees die Möglichkeit ein, kostspielige, für terminale Krankheiten zugelassene Medikamente zu berücksichtigen.
- Die im Januar 2009 erfolgte Zusatzempfehlung umfasst Medikamente, die bislang für eine kosteneffiziente Nutzung von NHS-Mitteln als zu teuer angesehen wurden.

Welche Krankheiten werden durch die neue NICE-Empfehlung abgedeckt?

- Wirtschaftlichkeit > 30.000 £ pro QALY
- < 7000 neue Patienten pro Jahr
- terminale Krankheit und Lebenserwartung >24 Monaten.
- Beleg wesentliche Lebensverlängerung.
- keine alternativen Therapien vorhanden

Zukunft der Medizin – Eine Frage der Innovation, des Geldes und der Moral





Die Auseinandersetzung mit ökonomischen Themen wird eine zunehmend wichtige Aufgabe des Arztes:

Pflicht und nicht Kür!

Konsequenzen für die Ärzteschaft

- Massnahmen auf Verhältnis zwischen Kosten und Nutzen mit entsprechender Überprüfungsverfahren beurteilen.
- Ressourcen dorthin umverteilen, wo sie den grösstmöglichen Nutzen erzielen.
- Lernen über Kosten und Nutzen nachzudenken und sich auf ergebnisorientierte, pauschalierte Leistungsvergütungen einstellen.
- Ökonomische Terminologie aneignen.

Und dies zum Schluss...

Anstatt zu warten bis Politik, Verwalter, Kassen oder Bundesbehörden entscheiden, welche Leistungen ihr Geld wert sind, sollten Ärzte praktizierende klinische Ökonomen werden. Kliniker müssen ökonomisches Denken in ihr Entscheidungsverhalten einbauen, für eine rationale und nicht eine rationierte Medizin.

Dr. med. John M. Eisenberg († 2002), Ehemaliger Leiter
Agency for Healthcare Quality and Research

"Lieber Freund, bitte entschuldige, dass dieser Brief so lang geworden ist. Weißt Du, ich hatte keine Zeit für einen kurzen."

Johann Wolfgang von Goethe

Danke für Ihre Aufmerksamkeit!