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A Prescription for Improving National Health Care
Bylined article for Fred Hassan, Chairman and CEO, Schering-Plough
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One need only look at statistics to be impressed (and humbled) by the great work done by cardiologists over the years. Last summer, for instance, New York Times writer Gina Kolata reported on research about Union Army health records during the Civil War. Most soldiers, it turned out, were small and sickly, and those still alive in their forties were often chronically ill. By age 60, nearly 80 percent of that male population suffered from heart disease.

Today, largely through major advances in cardiology and better overall healthcare, less than 50 percent of U.S. males suffer from heart disease by age 60.

It's encouraging to take stock of the progress we've made as a society and how much healthier people are today than 150 years ago. But as remarkable as this progress is, the public health challenges we continue to face remain enormous. And sadly, a number of figures are trending in the wrong direction.

Metabolic syndrome, for example, currently affects one in four Americans - and it is growing, along with a corresponding upsurge in obesity. Just 16 years ago in 1991, every state in the nation showed obesity prevalence rates of below 20 percent, according to the Centers for Disease Control. By 2005, however, all but four states had obesity prevalence rates of at least 20 percent. And 17 states had prevalence rates of 25 percent or more.

Another worrying statistic concerns adherence to treatment plans, which is relatively poor. According to a recent study, a month after leaving the hospital, 1 in 8 heart attack patients stopped taking their prescribed medication, with predictable consequences. Patients who went off aspirin, beta-blockers and LDL-lowering treatments were three times more likely to die during the next year than the patients who stayed on their medications.

Complicating the problem, our health delivery systems tend to focus on short-term cost containment rather than long-term healthcare. Some of the better-managed care plans, of course, do understand the value of long-term health benefits. They give patients access to education and preventive care, as well as a choice of practitioners. They also recognize that a physician needs the freedom to exercise medical judgment for the good of the patient - which requires adequate time and consideration of each case.

But if we are to reverse the negative health patterns among the population as a whole, then we need a long-term perspective to be the rule rather than the exception among health plans. Such a change in attitude amounts to nothing less than a transformation in healthcare delivery as we know it. However, I believe it is achievable. And the means are not as difficult to implement as they might seem to be.

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First, let's be clear about the goals. Basically, we need to advance healthcare in three critical ways: enhanced prevention, improved intervention and the advancement of innovation.

In the case of cardiovascular treatment, we all know what enhanced prevention looks like - better diet, exercise, avoidance of smoking, smoking cessation and simple prophylactic treatments such as aspirin.

If we are to get more patients to follow this regimen, however, we must substantially improve health literacy. To be sure, schools, health professionals, employers, and government agencies are all working to educate the public. But if we are to really make progress, we need managed care plans to promote health literacy and behavior that enhances disease prevention.

How do we do that? I suggest that we take a page from other industries. I find it peculiar that consumers can easily compare the fuel efficiencies of automobiles and the annual operating costs of refrigerators, yet they cannot readily compare the quality of health delivery systems.

Such comparisons can be accomplished across the healthcare spectrum by publishing simple, transparent scorecards on important health metrics. With scorecards, individual enrollees and employers can see for themselves how a particular managed care organization is performing on overall health maintenance for the long term. They will also be able to see which plans provide the best value.

Scorecards would rate health systems on a few critical "markers," such as the percentage of enrollees who reach medically endorsed goals on:

- Reducing obesity;
- Avoiding, reducing or quitting smoking;
- Increasing exercise.

With health plans competing for better scores in these categories, we should see an acceleration in health literacy and disease prevention. And with a healthier population, we should also see reductions in healthcare costs, as opposed to the escalating costs we currently face.

What about the second goal - enhancing intervention? Here again the need is critical. More than 90 million people in the U.S. could benefit from cholesterol management, for example, but only around 12 percent are getting effective treatment. And with each passing year, the figures get worse.

Again, the answer is to provide transparent scorecards of health delivery systems. In the area of cardiovascular health, I would propose two metrics on intervention:

- Control of high blood pressure and
- Control of high LDL cholesterol.

As with the previous metrics, these would be based on the percentage of patients enrolled in a managed care plan that achieve medically endorsed goals. The introduction of scorecards on these two metrics - combined with increased patient literacy and enhanced preventive behavior - would go a long way toward improving cardiovascular health in general.

For areas outside of cardiology, scorecards could include metrics on such items as vaccinations and immunizations, controlling blood sugar levels and controlling asthma.

The third dimension of improving healthcare - innovation - requires a more involved approach. As we all know, there are enormous opportunities for innovation in new diagnostics, new devices, new delivery systems and new medicines. At my own company, we are developing an important new treatment for thrombosis - our thrombin receptor antagonist compound - and we hope to have it available by 2010 or 2011. Other pharmaceutical and biotech companies also have exciting advances in their pipelines, including the new realm of therapies tailored for individual patients.

As exciting as these advances are, however, there are a number of critical challenges we face in bringing them to market. And one of the greatest challenges is maintaining the momentum of the industry itself. Biopharma has been a wonderful innovation engine over the past several decades, but that engine is now barely keeping up with products going generic. All across our industry important projects are failing, very often at a late stage, and the costs of these failures can run to the hundreds of millions of dollars. Even for successful compounds, the cost of clinical trials is going through the roof. This makes it considerably tougher to fund new projects, and of course, it increases the cost of treatment.

To achieve our third goal - advancement of innovation - we must find ways to make biopharmaceutical discovery and development more efficient. We need to keep working with regulators and academia on important improvements. For example, we urgently need to see advances in regulatory science that keep pace with the advances in medical science, such as modernizing clinical trial designs, more efficient execution of trials and more efficient subsequent reviews of data packages. Biomarkers and adaptive clinical designs are important examples of the kinds of advances needed in regulatory science that can help make these improvements happen.

Essentially, we must crack the code on innovation productivity - and we must do so soon because the need for new treatments is growing rapidly. To a large extent, these requirements are the result of the remarkable success in healthcare I noted at the beginning. More and more people are living beyond the age of 80. But after the age of 80, the odds of contracting Alzheimer’s disease rise to one in two. That’s every other person! As compassionate societies, we do not want to see this population consigned to cities of nursing homes. And from an economic perspective, we cannot afford it.

Today's research holds out hope for remission of Alzheimer's, and perhaps even a cure. But we must build an environment that keeps that research moving full speed ahead.

That leads me to my final suggestion regarding innovation - and it is a message to our political leaders in Washington, D.C., many of whom are newly elected. I would say to them that one of their biggest challenges - and one of their biggest responsibilities - is healthcare. As a nation, and as a society, we are counting on our political leaders to play for the long term.

I would remind them that biomedical research in the U.S. is not only vital to the health of our citizens. It is also vital to the success of our economy. Other countries understand the economic potential of biomedical innovation. Japan, China and India are already implementing long-range plans to improve their competitiveness in biomedical research.

We have seen this scenario before: As a nation we think we have an insurmountable edge in certain markets, such as automobiles and computers, and we are lulled into a sense of complacency, only to see our leadership slip away to Asia. As of today, America is still pre-eminent in biomedical science, but this industry could get away from us as well.

To sustain our biomedical strength, I would urge our lawmakers to give the Food and Drug Administration the resources and independence it needs to do its job well. Benchmark the FDA against other regulators, such as Europe's EMEA, and see where we can improve the innovation, speed and efficiency of the FDA process. And above all, I would call on our U.S. lawmakers to keep the FDA nonpolitical. If we politicize the FDA, we will be damaging not only its authority, but also its science. And we will be damaging a precious innovation engine of our country.

Finally, I would urge our lawmakers to keep just one guiding principle in mind as they address our most important health issues: Do what is right for the patient. If we do what is right for the patient for the long term, then many tough policy questions will be answered in the right way.

In fact, putting the patient first is the key to transforming our overall healthcare delivery system. If we make health literacy a top priority, if we make health plans easily comparable, and if we make the patient's needs the deciding factor in FDA processes and policy decisions, then we will be well along in bringing about a step change in the health of the public. We can take pride in the progress we have made since the Civil War. But we must rise to the challenge of current problems if we want our children and grandchildren to take pride in the work we do today.