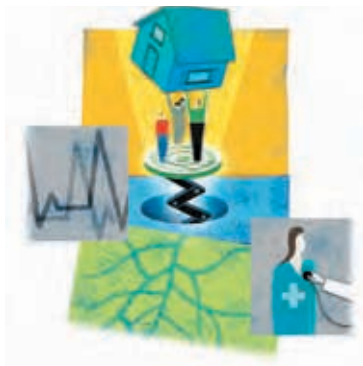


A Wellness Trust to Prioritize Disease Prevention



CHRONIC AND PREVENTABLE DISEASES are a growing challenge confronting the United States. They currently account for most deaths and costs in the health-care system, despite the relatively low-cost and low-tech services that could limit them. Disease prevention and health promotion are crucial for ensuring the health and well-being of Americans in a cost-effective manner, but the current system is ill-suited to

achieve these goals. People often are unaware of preventive services, perceive them as having low value, or are deterred by costs. Moreover, the myopic focus of the health-care system on treating disease crowds out resources and directs incentives away from preventive care that fosters long-term wellness.

In a discussion paper released by The Hamilton Project, Jeanne Lambrew of the Center for American Progress proposes to elevate wellness and prevention on the health agenda by placing them under a new agency: the Wellness Trust. The Trust would be formed by carving preventive services out of disparate pieces of the health-care system and uniting them under a single agency with the appropriate mission, incentives, and tools to deliver those services. Lambrew's proposal aims to provide all Americans with access to preventive care, with the ultimate goals of generating a healthier, longer-lived population and of developing a health system that gets higher value for its spending. Strategies to improve preventive care—like Lambrew's "Wellness Trust"—would be an important part of any health-care reform to ensure high-quality, cost-effective care for all Americans at every stage of the health-care process.

THE CHALLENGE

At the dawn of the twenty-first century, the United States faces very different health challenges than it did a century ago. Considerable gains have been made in extending life expectancy, reducing infant mortality, and combating infectious diseases. The new epidemic facing the United States is chronic disease. Five chronic diseases—cardiovascular disease, stroke, cancer, chronic obstructive pulmonary disease, and diabetes—account for two-thirds of all deaths in the United States and affect an estimated 45 percent of Americans, and that number is continuing to rise.

Much of the incidence and severity of chronic diseases, and the deaths resulting from them, is preventable. Unlike some health-care challenges, there is substantial knowledge on how to curtail chronic diseases and some of the lingering infectious diseases. Over time, a wide range of preventive services has been developed, aimed at either preventing the onset of diseases or detecting and treating diseases in early stages. But despite major problems and clear solutions, the United States falls short of desired prevention targets according to a number of measures. For example, a recent study found that only half of scientifically recommended clinical preventive services are provided to adults. Preventive service usage also varies between socioeconomic and demographic groups:

while 61 percent of non-Hispanic White seniors have received a pneumococcal immunization, only 28 percent of Hispanic and 40 percent of African-American seniors have received it, despite having the same Medicare coverage

Better prevention could have a substantial impact on health. Studies show that adequate use of preventive services could decrease the death rate from cancer by 29 percent and reduce the risk of heart disease and stroke by 33 to 50 percent. Targeting lifestyle changes could also produce major benefits: in recent years, poor diet and physical inactivity have risen as causes of death and could surpass tobacco usage as contributors to mortality in the next decade.

The underuse of prevention also has important economic consequences. An estimated 78 percent of all health spending in the United States is attributable to chronic illness. Medicare must bear the burden of many of these costs because the incidence of chronic illness increases with age. The inaccessibility of preventive services, especially to the uninsured, also contributes to costs, because patients defer treatment until they end up needing much more expensive services. One recent study, for example, found that providing the pneumococcal vaccine to all seniors would reduce health care spending by up to \$10 for every dollar spent on the vaccine. Aside from direct health-care spending, chronic diseases and other illnesses impose an additional cost on the economy in terms of lost productivity. At a minimum, better preventive care and disease management offer the hope of substantial improvements in both life expectancy and quality of life at a relatively low cost. And, in some cases, better preventive care might even save money.

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The Underuse of Preventive Care

Lambrew identifies four main reasons why preventive services are underutilized. First, individuals fail to use recommended preventive services. This often occurs because of gaps in knowledge: individuals may

not be aware of services, may not perceive the value of services, or may not understand their own risk factors. Effective prevention may also require significant changes in behaviors or lifestyles that many individuals find difficult to undertake. Cost is another disincentive: insurers do not uniformly cover preventive services, and when they do, they often impose deductibles or cost sharing that could discourage use. Cost is a particular barrier for the uninsured.

Second, the current health-care system's focus on curing disease can be detrimental to prevention. Health professional training emphasizes treatment and diagnosis rather than screening and counseling, and medical specialization has overshadowed more prevention-oriented general medicine practices. In part, this results from the nature of some preventive services, which are generally simple, large-scale, repetitive, and do not require diagnosis or intensive medical training. These features make many preventive services particularly ill-suited for delivery by highly trained, and highly paid, health providers. Prevention is also time-consuming: one source estimates that providing all of the recommended clinical preventive services to a typical patient population of 2,500 would take over 1,700 hours per year. In a health-care system short on primary care providers, this demand cannot be met by its current workforce.

Third, the financing structure of health care tends to discourage prevention. An increasingly mobile workforce means that fewer people have the same insurance over a long period of time. Insurers thus have little incentive to cover prevention costs, because they are unlikely to reap the benefit of lower future health costs. Reimbursement and coverage policies reflect this reality, valuing short-term clinical complex care over forward-looking preventive care.

Finally, national public policy is not oriented toward encouraging prevention. Though federally supported public awareness campaigns and demon-

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strations in public health programs have advanced the prevention agenda in some cases, federal health insurance programs still lack uniformity on the matter, and no national regulation sets a baseline for private coverage of preventive services. Insufficient funding also constrains the public health system's ability to promote wellness and deliver preventive services.

A NEW APPROACH

Lambrew argues that the gravity of the problem, coupled with the inadequacy of the existing system, requires a new model for prioritizing wellness. Such a model would be designed to shift current perceptions to characterize wellness as being valuable, available, and affordable, and to make access to preventive services universal, regardless of insurance status.

In light of these goals, Lambrew advances an ambitious proposal for an effective prevention system. It would unite prevention elements from the existing health system under the Wellness Trust, a new agency under the Department of Health and Human Services charged with prioritizing a range of preventive services and then delivering them.

Lambrew emphasizes that the Wellness Trust is only one idea for how preventive services could be delivered effectively. Technical questions about how such a system would fit into the rest of the health infrastructure would dictate caution and careful

planning before any dramatic restructuring could be implemented. For example, adopting the Wellness Trust in the absence of universal insurance coverage could result in problematic gaps in health care: free screenings that give people the knowledge that they have a preventable disease do not help if those people cannot afford the corresponding remedy. However, Lambrew takes an important step in focusing on the substantial problems currently facing the provision of preventive services. In addition, she notes that many elements of her proposal could be adopted independently, without full-scale reform, to rectify important shortfalls in the current health-care system.

Key Highlights

The Wellness Trust would:

- **Set national prevention priorities** based on evidence of their impact, cost, and feasibility
- **Employ effective delivery systems** by connecting individuals to accessible and affordable preventive services
 - **Infrastructure.** Build an electronic prevention record system, launch a communications campaign, and strengthen human and physical capital
 - **Workforce.** Reorient health-care providers toward prevention and train new providers to offer accessible services
 - **Regional and state grants.** Incorporate prevention priorities into grants provided to state and local health programs
- **Create incentive-based payment policy** by using payment incentives to encourage appropriate delivery, high standards, and greater take-up of preventive services
- **Pool resources** to fund the Trust by drawing from public (potentially \$34 billion to \$50 billion) and private resources currently spent on prevention

The Wellness Trust

The Trust's initial duties would be limited in scope: it would commission and review studies needed to help it create the necessary infrastructure and decision-support systems for a full-scale preventive services network. Over time, the Trust would take on the role of primary payer of selected preventive services, using public and private funds consolidated from current spending on prevention and operating through the existing Medicare payment infrastructure. The main duties of the Trust would be setting national prevention priorities in the short and long terms, designing and employing effective delivery systems, and creating incentive-based payment policies. The Trust would be led by a politically-appointed director, but major decisions would be made by its trustees, who would be chosen from among the nation's foremost experts on disease prevention science, delivery, and financing. A key duty of the trustees would be to annually determine and publicize prevention priorities and a plan for achieving them.

Setting National Prevention Priorities

A major challenge in prevention is focusing on what works. Prevention activities vary substantially in cost effectiveness and health impact. Therefore, an early role of the Trust would be to prioritize a subset of clinical preventive services that demonstrate strong evidence of clinical and cost effectiveness. The work of the U.S. Preventive Services Task Force, an existing independent scientific commission that reviews evidence on clinical preventive services, would provide the foundation for these decisions. Over time, the Trust would also consider prioritizing nonclinical community-based services, such as school-based nutrition programs.

Employing Effective Delivery Systems

Delivering preventive services effectively to target populations requires two key features: first, awareness of the need for prevention by both individuals and providers; and second, accessible and afford-

able services. The Wellness Trust would facilitate these features by building up the prevention infrastructure, developing the prevention workforce, and leveraging regional and state grant programs. The resulting multilayered delivery system would be structured to maximize cost effectiveness, with an emphasis on identifying best practices and reducing redundancies. Each level of intervention would also be subject to data monitoring and evaluation, enabling policy makers to prioritize delivery-system models based on what works.

■ **Infrastructure.** First, the Trust would create a nationwide information technology architecture, ideally through a comprehensive electronic prevention record system. That system would track patients and their treatment histories and needs, serve as an important source of up-to-date information on the prevention priorities and their delivery, and ensure accountability and integration across the health care system. The system could also promote wellness by flagging preventive services to health-care providers. Second, the Trust would launch a communications campaign in partnership with local, regional, and governmental bodies to provide wellness information and to advocate for preventive services. Finally, the Trust would build up the capabilities of wellness providers by strengthening the training infrastructure and ensuring an adequate supply of prevention “hardware,” including imaging technology and immunizations.

■ **Workforce.** Since primary care physicians and other health-care providers would continue delivering preventive services when cost effective, the Trust would help to reorient health-care providers toward the goal of prevention by coordinating the training of the prevention workforce. In addition, the Trust would expand prevention provision to a new, accredited prevention workforce to include pharmacists, school nurses, and human resources personnel. A crucial role of these new workers would be staffing sites that

The Wellness Trust would use funds carved out of current prevention spending to provide universal access to a set of high-priority preventive services.

are more convenient for target populations, such as supermarkets, pharmacies, schools, and workplaces.

■ **Regional and State Grants.** State and local governments have a long history of fostering effective, community-relevant health promotion programs. The Trust would support state and local prevention programs by encouraging greater attention to prevention priorities in existing grants.

Establishing Incentive-based Payment Policies

While the trustees would determine the eventual payment policies that would be used, Lambrew provides illustrative ideas on how those policies could be structured. The nature of the service provided would be a key determinant of the payment policy. For example, low-cost preventive services where the goal is maximum volume—such as immunizations and simple screenings—could be reimbursed by quantity, with bonuses for reaching performance targets. Because the goal is 100 percent utilization for target populations, there is no danger of fee-for-service provider payments leading to overutilization. Complex screenings and time-intensive preventive services could use performance-incentivized payments, or could be integrated into broader quality systems, to ensure that busy providers deliver those services and do so to a high standard of quality. Time-intensive preventive services may be better served by case-based payments linked to outcomes.

All of the payment approaches would share some base payment schedule with adjustments for geographic

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price variation and different input costs. Payment levels could also be calibrated to reflect the prevention priorities list. The Trust would use Medicare's infrastructure to transfer payments to prevention providers, taking advantage of Medicare's existing relationships with most U.S. health-care providers. The Trust would also devise incentives to encourage individual adoption of preventive services. Minimizing cost sharing would be the first essential step, but the Trust could go even farther and provide economic incentives to individuals to receive preventive care. While evidence is sparse, some data suggest that such incentives can increase preventive services use while decreasing overall health-care use.

Funding the Wellness Trust

The Trust's financing for priority preventive services would come from current public and private funding streams. Public funding would initially come from carving out prevention resources from Medicare, Medicaid, and other government programs. Future allocations would be based on projected growth in national health expenditures and the additional needs of the Trust; it is important to take into account that if the Trust successfully increases preventive service use, prevention costs could be higher than they are now. Lambrew posits that the Trust would also be able to consolidate some of the private funds that would be freed up by its coverage of preventive services, although doing so would be administratively more difficult.

No solid estimates exist on how much is currently spent on prevention in the United States. The task is inherently difficult, given the ambiguity over what constitutes prevention as well as the diversity of payment sources (e.g., employers, churches, and volunteer organizations). By one estimate, about 3 percent of national health spending, or 0.7 percent of GNP, is spent on wellness, which translates into about \$70 billion for 2007. Lambrew estimates that roughly \$34 billion to \$50 billion of this amount comes from public spending (at the federal, state, and local levels) and could be made available to the Trust. The Trust's scope would be tailored to its funding levels: the prevention priorities would determine which services would be financed, balancing potential health impacts with funding and feasibility concerns. Preventive services not covered by the Trust would remain under the umbrella of the rest of the health system.

Questions and Concerns

Lambrew's proposed model for a Wellness Trust could dramatically increase the nation's emphasis on disease prevention, but it also raises at least two key questions.

Will It Fragment Care?

The health-care system is already fragmented among multiple providers and payers. Lambrew notes that creating another health-care payer could further fragment the system, while incurring the transition costs and political risks associated with any major restructuring of public institutions. In addition, the proposal cannot fully resolve the potential disconnect between preventive screenings and curative treatments, though ideally, the Trust would be created as part of a universal coverage system.

Lambrew argues, however, that the health system is not fulfilling its full potential in prevention provision and currently does not have the proper incentives to improve its performance in this area. Lambrew also points out that preventive services operate under a different paradigm, more akin to public health and

safety than to an insurable event. Wellness should be widely dispersed and broadly integrated, moving beyond the standard domains of hospitals and clinics and into people's everyday lives.

Will It Reduce Health-care Spending?

Healthier and longer lives have obvious value. Dozens of studies have identified preventive treatments and public education strategies that extend and improve lives in a cost-effective manner, often costing only a few thousand dollars to add a quality-adjusted life year (valued at between \$50,000 and \$100,000, according to most experts). More broadly, research shows that pneumococcal vaccines, hypertension controls, and certain other preventive treatments provide benefits that make up their costs multiple times over. Lambrew argues that the Trust could produce other benefits by lowering insurance premiums, limiting inappropriate preventive services, and increasing worker productivity.

A more difficult question is whether spending on prevention in the aggregate could save money, either for society generally or for the federal budget. Studies suggest that relatively few preventive treatments save money overall, in part because any prevention that extends life also results in budgetary and societal costs associated with caring for a person over a longer period of time. Nevertheless, Lambrew hypothesizes that prevention spending on select services prioritized in terms of feasibility and cost effectiveness—the Wellness Trust's effective mandate—would result in some savings in the long run.

CONCLUSION

The burden of preventable disease is escalating and has serious implications for the nation. Given the disincentives embedded within the current health infrastructure, preventive services will continue to be underutilized unless there is fundamental change. Lambrew proposes an intriguing strategy to remedy that problem and advance the broader goals of a healthier and more productive America.

Learn More About This Proposal

This policy brief is based on The Hamilton Project discussion paper, *[A Wellness Trust to Prioritize Disease Prevention](#)*, which was authored by:

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Lambrew conducts policy-relevant research on the uninsured, Medicaid, Medicare, and long-term care. A former senior health analyst at the National Economic Council, she has played a central role in the formulation of various health-care policies, including the State Children's Health Insurance Program and Medicare reform.

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