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Jeanne M. Lambrew

A Wellness Trust to Prioritize Disease Prevention

THE BROOKINGS INSTITUTION

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A Wellness Trust to Prioritize Disease Prevention

Jeanne M. Lambrew, PhD

The George Washington University
and Center for American Progress

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Abstract

A new set of health challenges confronts the United States at the beginning of the twenty-first century. Chronic and preventable diseases now account for most of the deaths and costs in the system, despite relatively low-tech and low-cost services that could limit them. The underuse of preventive services stems from lack of awareness, low perceived value of such services, and a fractured financing system unable to align incentives from sickness toward wellness. This cannot be fixed through private insurance mandates or the public health system alone. Instead, a new system for health promotion and disease prevention in the United States is needed, and one such model is proposed in this paper. It would carve preventive services out of the existing health insurance system and would finance those services through the Wellness Trust, a new agency under the Department of Health and Human Services. This Trust would set national priorities for prevention, employ innovative and effective systems for delivering them, and align payments with priorities. The Trust would be the primary provider of prevention priorities for all Americans, irrespective of insurance status, and would reconnect with the medical system through an electronic health record. While this proposal may not have immediate or, in some cases, overall budget savings, it has the potential to improve and extend lives.

This idea was originally sketched out as part of the Center for American Progress's comprehensive health reform plan and was described in an opinion piece and a shorter paper (Lambrew et al. 2005, Lambrew and Podesta 2006a, Lambrew and Podesta 2006b). This paper describes the idea of a Wellness Trust in greater depth and includes a discussion of its cost implications.

Contents

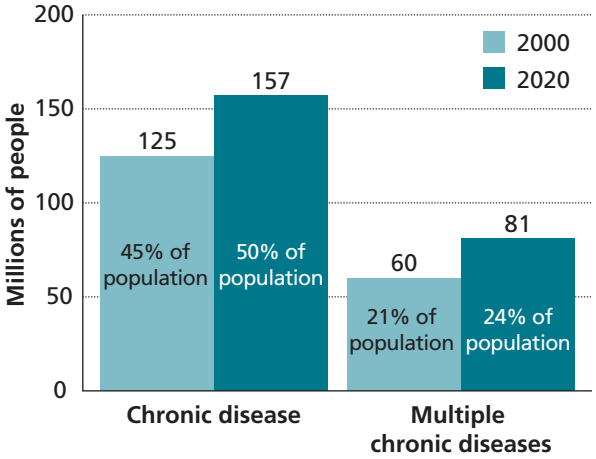
I. Growing Preventable Disease Burden

The health challenges faced at the beginning of the twenty-first century are different from and, in some ways, more daunting than those at the turn of the twentieth century. There were considerable gains made over the last century: for example, life expectancy has lengthened by thirty years and infant mortality has dropped by 90 percent (CDC 1999). Public health and medicine combined to reduce infectious disease. No longer are diseases like tuberculosis, influenza, and pneumonia the major killers that they were in 1900 (see Figure 1). In addition, rapid scientific advances have largely converted diseases like HIV/AIDS from acute and deadly illnesses into chronic ones in the United States.

Chronic diseases are this century's epidemic. Five chronic diseases—cardiovascular disease, stroke, cancer, chronic obstructive pulmonary disease, and diabetes—account for two-thirds of all deaths in the United States (CDC 2004b). An estimated 45 percent of Americans (125 million) had a chronic illness in 2000. This is projected to rise to 50 percent (157 million) by 2020 (Wu and Green 2000; see Figure 2). The elderly are particularly prone to chronic illness: an estimated 87 percent of Medicare beneficiaries have at least one chronic illness (Kaiser Family Foundation 2006). One study found that virtually all of the spending growth in Medicare over the past fifteen years resulted from increased spending on people with multiple chronic conditions (Thorpe and Howard 2006).

FIGURE 2

Projected Prevalence of Chronic Disease, 2000 and 2020

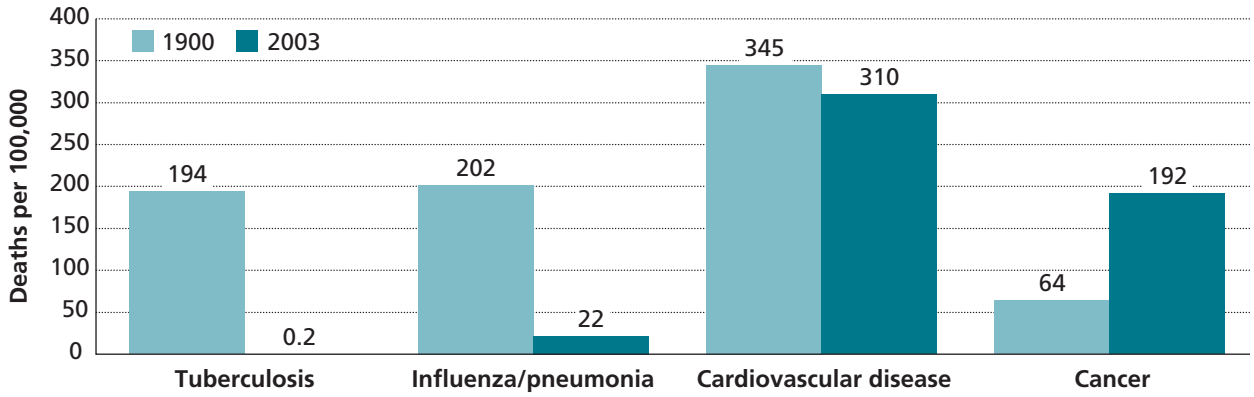


Source: Wu and Green 2000.

While cardiovascular disease has been a long-standing cause of death, a particularly troubling trend has been the increase in diabetes. The number of

FIGURE 1

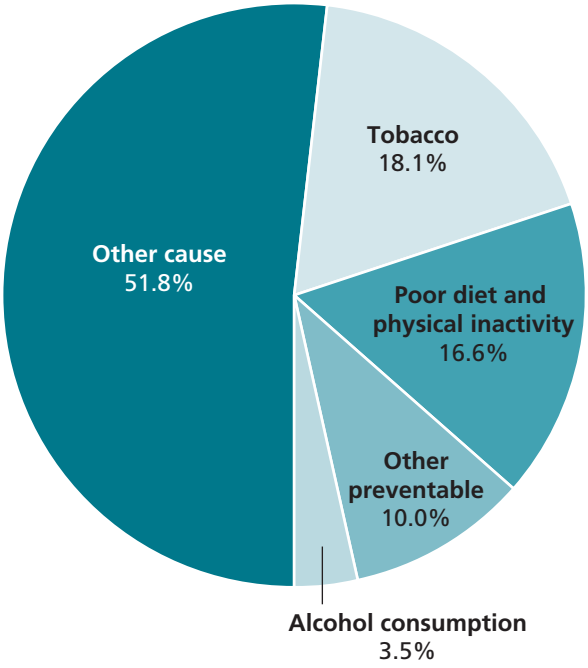
Shift Toward Chronic Disease, 1900 and 2003



Source: CDC 2007.

FIGURE 3

Causes of Death in the United States, 2000



Source: Mokdad et al. 2004.

people with diabetes has doubled in the past fifteen years, and one in three persons born in 2000 can expect to have diabetes in her lifetime (CDC 2006a). Certain racial and ethnic minorities are particularly vulnerable: the rate of diabetes is 50 to 80 percent higher among African-Americans than it is among non-Hispanic Whites.

Much of the morbidity—in some cases, mortality—associated with this growing chronic disease burden is preventable. The CDC estimates that tobacco use remains the leading risk factor leading to deadly disease (Mokdad et al. 2004; see Figure 3). Compared to nonsmokers, smokers are twelve to twenty-four times more likely to develop lung cancer, ten times more likely to die from chronic obstructive pulmonary disease, and two to four times more likely to develop coronary heart disease (CDC 2004a). However, poor diet and physical inactivity have risen as causes of death and could surpass tobacco use in the next decade. About 24 percent of Americans were obese in 2005, up from 15 percent in 1995 (CDC 2006c). Obesity contributes to a wide range of chronic conditions, from diabetes to stroke to cancer. One study estimates that, as a result of obesity, a twenty-year-old man could experience a 17 percent reduction in life expectancy (Fontaine et al. 2003). If trends continue, children's life spans may be shorter than those of their parents for the first time in about a century (Olshansky et al. 2005).

Unlike some health-care challenges, knowledge exists about ways to curtail chronic illness as well as some of the lingering infectious diseases. Disease prevention and health promotion are broadly defined as actions to prevent the onset of disease (primary prevention) and to detect and treat disease in its early stages (secondary prevention). Prevention delivered through the health-care system is categorized as clinical preventive services and includes services such as screening tests for cancer. Over time, a wide range of such services has developed. The U.S. Preventive Services Task Force, an independent scientific commission, is tasked with reviewing the evidence for clinical preventive services and making recommendations as to its strength (Woolf and Atkins 2001), as does the Advisory Committee on Immunization Practices. In addition, the CDC-sponsored Community Guide provides updated, evidence-based recommendations on programs and policies to promote health at the population level (Task Force for Community Preventive Services 2006).

As with all medical research, some ambiguity exists with regard to the effectiveness of preventive services and their application. Specialty societies sometimes disagree with the recommendations, and gaps exist in the research. That said, prevention is unique among health services in having a decades-old, independent review group (the U.S. Preventive Services Task Force) that has spearheaded not just evidence reviews but also cross-service comparisons of services' impacts on health and costs. As a result, we have a good idea of what Americans and their health-care system should be doing to promote health and wellness.

Low Use of Preventive Services

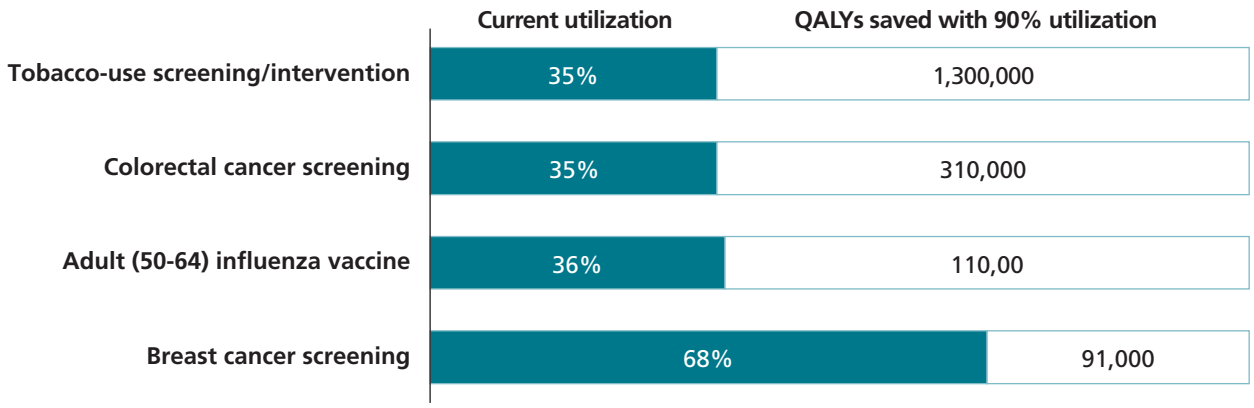
Despite clear health problems and known solutions, the U.S. health system has failed to promote prevention, according to a number of measures. One way to assess this prevention gap is relative to scientific recommendations. A recent study found that only half of recommended clinical preventive services are provided to adults (McGlynn et al. 2003). Only 38 percent of adults receive recommended colorectal cancer screening, according to the same study. The government reports that about 20 percent of children do not receive recommended immunizations, with higher rates in certain areas (e.g., 41 percent in Birmingham, Alabama; see CDC 2006b). One of the major contributors to disease—high blood pressure—has become rampant: about 90 percent of middle-aged Americans will develop high blood pressure during their lives, although nearly 70 percent of those with this condition do not now control it (American Heart Association 2003). The statistics are similar for most recommended services. There are also differences in use by socioeconomic and demographic status: while 61 percent of non-Hispanic White seniors had received a pneumococcal immunization by 2005, only 28 percent of Hispanic seniors and 40 percent of African-Americans had received it, despite having the same Medicare coverage (NCHS 2006).

An alternative way to assess preventive service use is through international comparisons. The United States' results in this regard are mixed. For certain services, like breast cancer and Pap screening, the U.S. rates exceed those of other developed nations. However, only 49 percent of U.S. adults had their doctors provide them advice or counseling on weight, nutrition, or exercise, compared to 72 percent in the United Kingdom (Schoen et al. 2004). The percent of elderly people who received an influenza vaccine in 2003 was 64.6 percent in the United States, well below Australia (79.1%) and the United Kingdom (71.0%), among others (OECD 2005).

Consequences of Low Use of Preventive Services

Low use of preventive services has a measurable impact on health. A comprehensive assessment found that three services—smoking-cessation counseling, aspirin to prevent heart attacks, and childhood immunizations—could substantially lower the clinical burden of disease (Maciosek et al. 2006). If effective preventive services with low use rates were targeted, the achievement of 90 percent use could yield 1.7 million quality-adjusted life years (QALYs; see Figure 4).

FIGURE 4
Preventive Service Use and Potential Benefits



Source: Maciosek et al. 2006.
Notes: Utilization rates are for targeted populations. The current rate for influenza vaccines for seniors is 65%; the QALYs figure is for all people over age 50.

Similar results have been estimated for individual services. One study estimates that, if effective risk reduction were implemented and sustained by 2015, the death rate due to cancer could drop by 29 percent, which would mean sixty thousand fewer cancer deaths each year (Curry et al. 2003). Improved blood sugar control for people with diabetes could reduce the risk for eye disease, kidney disease, and nerve disease by 40 percent in people with Type 1 or Type 2 diabetes. Similarly, blood pressure control could reduce the risk for heart disease and stroke by 33 to 50 percent (CDC 2006a). A sustained, small reduction in blood pressure could reduce coronary heart disease by 21 percent, strokes by 37 percent, and cardiovascular death rates by 25 percent (He and Whelton 1999). A 10 percent reduction in serum cholesterol levels could reduce the incidence of heart attacks and strokes by about 30 percent (Cohen 1997). Studies have also documented that primary and preventive care can reduce the worsening of health problems that leads to hospitalization (Bindman et al. 1995, Parchman and Culler 1994).

The health impact of the prevention gap has economic consequences as well. One study estimates that 78 percent of all health spending in the United States is attributable to chronic illness, much of which is preventable (Anderson and Horvath 2004). As the prevalence of chronic illness expands, so will its cost implications. According to the CDC, the nation spent $132 billion on people with diabetes in 2002. The average cost per diabetic was more than five times higher than that of a person without diabetes (CDC 2006a). About 30 percent of the aggregate cost of diabetes results from work loss, disability, and premature death. Since the prevalence of chronic illness increases with age, its costs are disproportionately borne by Medicare. Between 1987 and 2002, the proportion of Medicare beneficiaries who were obese doubled, while the share of Medicare spending spent on obese beneficiaries tripled (Thorpe and Howard 2006).

Prevention gaps also contribute to costs for acute illnesses. Preventable influenza presents a major cost to employers in terms of sick days and *presenteeism* (reduced productivity due to illness or other causes). Low rates of aspirin use following a heart attack contribute to subsequent heart attacks and costs. The failure to make prevention and primary care accessible also contributes to high rates of use of emergency rooms for preventable problems. This not only contributes to the direct costs of delayed care through these settings but could also impose additional costs in terms of forgone health resulting from the lack of coverage. One study estimates that the societal loss associated with the uninsured in the United States ranges from $65 to $130 billion each year (IOM 2003b).

II. Barriers to Effective Prevention

The reasons preventive services are not used as recommended can be roughly categorized into four areas: barriers at the individual level, the structure of the health-care delivery system, how prevention is financed, and limitations in public policy.

1. Barriers at the Individual Level

Lack of awareness of the value of prevention and specific recommended services is a major barrier to their widespread use. Generally, individuals neither know their own specific disease risk profile nor the preventive services they should receive. Nearly one in three people with hypertension, for example, is unaware of her condition (Hyman and Pavlik 2001). A similar problem exists among people with diabetes: about one in four of those with the disease does not know it, according to estimates. An additional 41 million adults have elevated blood sugar, putting them at risk for diabetes (CDC 2006a). The proliferation of information on the Internet could help raise awareness, but has equal potential to create confusion about health matters (IOM 2004).

Even among those aware of the need for prevention, the attenuated relationship between actions and results diminishes the motivation to act. People have a limited ability to rationally calculate and compare the immediate time and monetary cost of prevention and the long-term benefits of additional healthy and productive years of life. Even when they appreciate its value, people may view prevention similarly to how they view retirement savings and do too little unless it is made easy and inexpensive. Moreover, some aspects of prevention involve challenging behavioral modifications and significant changes in lifestyle. The benefits may be too abstract to justify immediate and sometimes difficult actions.

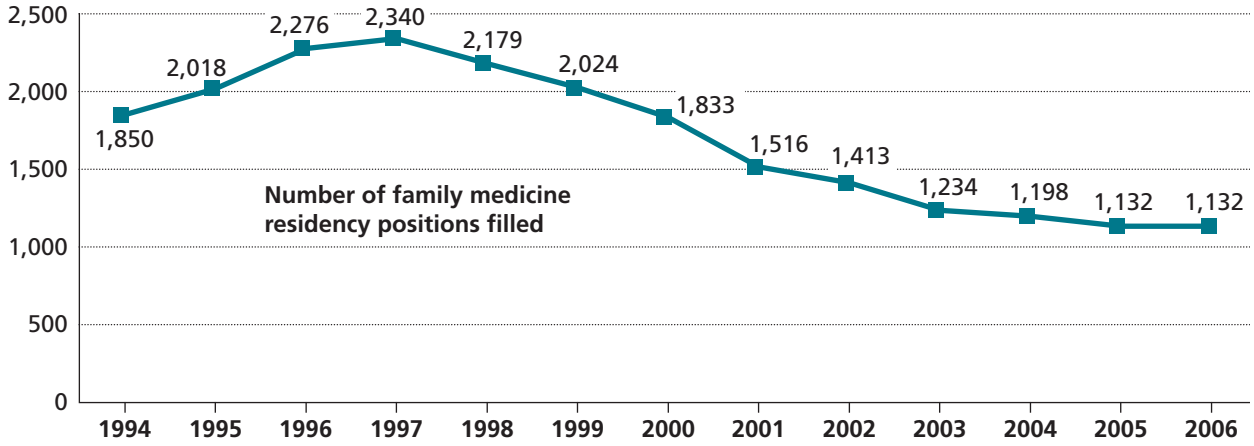
Cost is a concern as well. It costs about $400 to $600 to fully immunize a child (IOM 2003a), and more than $1,000 for certain types of cancer screening. Without coverage, the cost of preventive services often constrains their use. For example, less than half—48 percent—of uninsured women ages fifty to sixty-three had mammograms in the past two years, compared with 75 percent of women in that age group who were insured all year. Only 18 percent of uninsured adults ages fifty to sixty-four had a colon cancer screening in the past five years, compared with 56 percent of adults in that age group who were insured all year (Collins et al. 2006). Even some of those with insurance face financial barriers from either lack of coverage of prevention services or high cost sharing for them. Research suggests that cost sharing has a significant negative effect on the use of Pap smears, mammography, and counseling services (Solanki et al. 2000). Several employers, in designing their workers' health benefits, have found that eliminating cost sharing on preventive services improves use and workers' health without increasing costs (Busch et al. 2006, Vanessa Fuhrmans, "A Radical Prescription," *The Wall Street Journal*, May 10, 2004). Nevertheless, neither public nor private insurers consistently lower cost sharing for preventive services as a way to encourage their use.

2. Structure of the Health-Care Delivery System

Several aspects of the health-care delivery system cut against an effective wellness system. The first is its focus on curing existing disease rather than on preventing it in the first place. Most training for health-care providers is geared toward making them action-oriented diagnosticians. They, along with their patients, often prefer therapies that provide immediate relief rather than screening and counseling that prevent problems perhaps decades later. One study found that, among adults

FIGURE 5

Decline in Family Medicine Residents, 1994–2006



Source: Bodenheimer 2006.
Note: Percent of positions filled went from a high of 72.6% in 1996 to 41.5% in 2006.

that had a doctor visit in the past year but who were not screened for colon cancer, only 6 percent were counseled about the test (Wee et al. 2005). This is not surprising in a system designed around providing the sickest patients with the first and the most medical attention.

A second challenge is workforce. Leadership within medicine has long recognized the importance of prevention and, to that end, has promoted specialties in prevention, family medicine, internal medicine, pediatrics, and gerontology. In addition, the number of physician assistants and nurse practitioners has grown. Nevertheless, the supply of providers who are trained to emphasize prevention is shrinking. Between 1997 and 2005, the number of medical school graduates entering family practice residencies dropped by 50 percent, from 2,340 to 1,132 (Bodenheimer 2006; see Figure 5). Similarly, the percent of internal medicine residents intending to practice general medicine dropped from 54 to 27 percent between 1998 and 2003 (Garibaldi et al. 2005). While the supply of nurse practitioners and physician assistants has grown, many of these professionals are being absorbed into tertiary instead of primary care. In the United States relative to other countries, specialists account for a high proportion of visits and often act as primary care providers, despite their lack of the orientation toward prevention (Starfield et al. 2005).

A third challenge is time: delivering recommended preventive services is time consuming. One study estimates that it would take 1,773 hours per year, or 7.4 hours per work day, to deliver all of the U.S. Preventive Services Task Force–recommended clinical prevention to a typical patient panel of 2,500 (Yarnall et al. 2003). In addition, management of chronic illness that comports to clinical guidelines would take from 3.5 to 10.6 hours per day,[1] depending on whether the chronic illness is stable and managed or is uncontrolled (Ostbye et al. 2005; see Figure 6). It would be a challenge even for a dedicated primary care physician to devote this amount of time to prevention.

There are also two aspects of prevention that differentiate it from other health services. First, there is no diagnosis involved: services are provided to groups of people who have no symptoms of disease. As a result, the decision about whether a service should be provided is made in advance and without

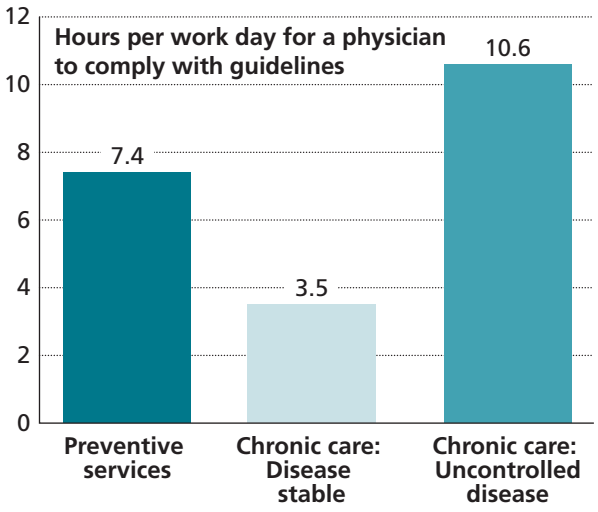
1. For a physician working forty-seven five-day weeks each year.

clinical consultation. Second, there typically is no need for intense medical training to deliver preventive services. Some services such as sigmoidoscopies involve clinicians, but others require skills that can either be taught to nonclinicians (e.g., injections) or are best provided by different types of professionals (e.g., alcohol misuse counseling). These characteristics present challenges in fitting prevention into the traditional medical model.

3. How Prevention Is Financed

One reason for the low emphasis on prevention in the United States is the nature of financing of health care. Not only is there a lack of universal coverage in the United States, but few people—with the exception of those on Medicare—have the same health insurance plan for an extended period of time. The source and duration of health coverage depends on age, work status, marital status in some cases, and where one lives. Most Americans get health insurance as a fringe benefit through employment, which can exacerbate its discontinuities. A recent study found that the average person in her forties has already had eleven jobs (BLS 2006). Thus, insurers have little incentive to invest in preventive services today that will benefit other insurers tomorrow (NIHCM 2003). This is especially true for those preventive services addressing chronic diseases that develop over a period of several years or decades, such as heart disease, hypertension, diabetes, and cancer. In these cases, the costs of prevention are incurred immediately when services are used, but most of the benefits of reduced disease burden and avoided medical care are only realized in the future.

FIGURE 6
Time Cost of Prevention



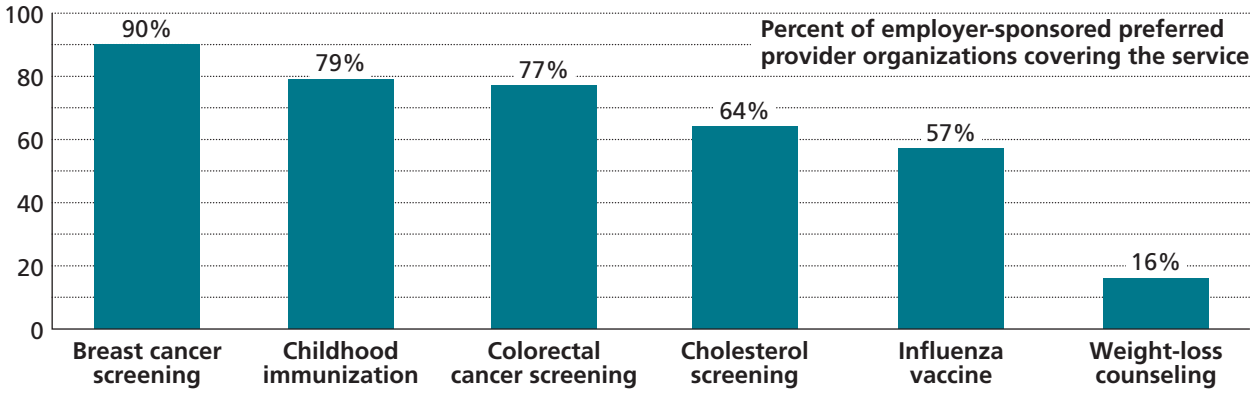
Sources: Yarnall et al. 2003; Ostbye et al. 2005.

The lack of priority placed on prevention by insurers is apparent in both reimbursement and coverage policies. Pressure for clinical efficiency and productivity has compressed the average length of time available for physician-patient interaction during office visits. Quantity is generally valued more highly than quality in reimbursement. This makes it increasingly difficult for physicians to deliver all age-appropriate clinical preventive services, especially when they involve counseling, during a typical visit. One study found that high-volume primary care physicians were one-third less likely to schedule patients for well care and less likely to have high rates of preventive service use compared to low-volume primary care doctors (Zyzanski et al. 1998). In addition, reimbursement for a diagnostic, surgical, or imaging procedure often pays three times as much as a thirty-minute patient visit that involves management and counseling (Bodenheimer 2006). Surgical specialists earn nearly twice as much, on average, as primary care physicians (Tu and Ginsburg 2006).

Insurers also do not uniformly cover preventive services. An employer survey found that only 64 percent of insurers cover cholesterol screening and only 16 percent cover weight-loss counseling (Bondi et al. 2006; see Figure 7). Focus groups with employers found that costs, employee turnover, and low use of services accounted for their unwillingness to cover prevention (Partnership for Prevention 2002a). Public health insurance programs also have gaps in coverage of prevention. Medicaid coverage of immunizations for influenza, pneumococcal disease, and other diseases varies across states, with two states failing to cover them at all for adults (Rosenbaum et al. 2003). Medicare policy also has gaps: it fails to cover some recommended services

FIGURE 7

Insurance Coverage of Preventive Services, 2001



Source: Bondi et al. 2006.

(e.g., screening for alcohol misuse); requires deductibles and cost sharing for others (e.g., colorectal and prostate cancer screening); and covers some that is not recommended (e.g., an electrocardiogram in the "Welcome to Medicare" physical).

4. Limitations in Public Policy

Public policy could, and in some cases does, promote prevention. The system for identifying effective preventive services, described earlier, is government financed. Periodically, governments at the federal and state levels launch awareness campaigns (e.g., National Breast Cancer Awareness Month and smoking cessation services). Demonstration projects in Medicaid and public health have added to the knowledge of what works with regard to prevention, and the public insurance programs have made some progress in covering prevention. For example, the U.S. Department of Defense has been a leader in incorporating prevention into its health system, recognizing its benefits for a prepared military.

However, there is no uniformity among federal health insurance programs and no national regulation of private coverage for preventive services—or any other health benefit. Health insurance regulation is largely in the states' purview. Some states ensure coverage of specific preventive benefits, such as breast cancer screening, but several of the recommended clinical preventive services are required by none of the states. Screenings for high cholesterol and blood pressure, for example, are required by fewer than five states (Partnership for Prevention 2002b). While experts suggest that national benefit mandates be considered for high-priority services such as immunizations (IOM 2003a), little progress has been made in moving this from theory into practice.

The public health system, as much as the medical system, is responsible for health promotion. State and local public health departments have a broad set of responsibilities, ranging from monitoring communities for infectious disease outbreaks to providing prenatal care. Nevertheless, despite repeated reports about the disarray of public health, few policies have been implemented to strengthen its systems (IOM 2003c). Inadequate funding remains a concern. A recent report found that funding for public health is both unevenly distributed across states and insufficient, requiring an additional $2.6 billion to fill the shortfall (Levi and Juliano 2006). One study estimates that the CDC's National Breast and Cervical Cancer Early Detection Program serves only 15 percent of eligible women, due to funding limits (Curry et al. 2003). In addition, a tension exists between supporting the often expensive delivery of clinical preventive services and using population-based interventions.

III. The Wellness Trust: Design and Rationale

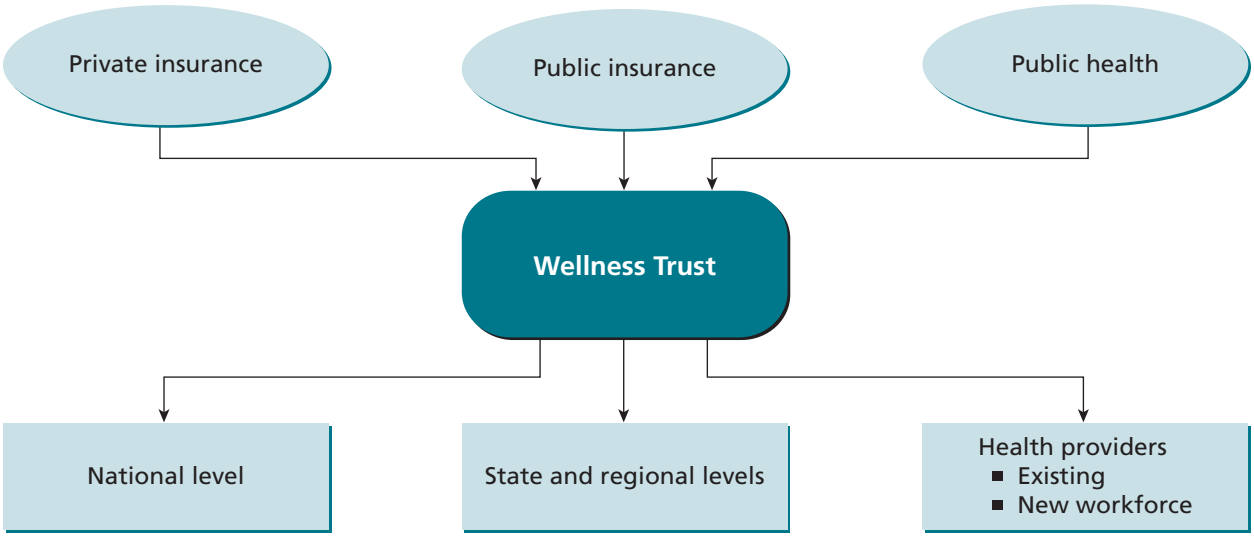
The gravity of the problem of preventable disease, coupled with the inadequacy of the existing system, suggests that a new model is needed to prioritize wellness. To be effective, it should strive to make preventive services perceived as being valuable, available, and affordable. It should elevate wellness within the health system and complement it with new delivery systems. Payment for prevention should be designed to leverage change and widespread use. Finally, it should be universal, providing recommended prevention services irrespective of individuals' insurance status.

A Wellness Trust is one idea of how to structure an effective prevention system. Under this model, preventive services would be carved out of the health insurance system and financed through a new agency. This Wellness Trust would set national priorities for prevention, employ innovative and unconventional systems for delivering services, use payment policy to drive success, and integrate prevention with the health-care system through information technology (see Figure 8). The structure of the Trust and its five major functions are described below.

Structure of the Trust

To concentrate and coordinate national wellness efforts, the Trust would be established as an agency within the Department of Health and Human Services (DHHS). Its director would be nominated by the president and confirmed by the Senate. The term of the director would be at least four years, beyond any single presidential term. While the director would manage the Trust, its trustees would make major policy decisions, similar to the process used by the Federal Reserve. The trustees would be chosen by the president, with Senate confirmation, from among the nation's foremost experts on disease prevention science, delivery, and financing. There would be a sufficient number to ensure balanced decision making, but not so many as to deter the development of a consensus. Decisions would be based on rigorously researched, scientifically-based information and reflect a wide range of views, from those of consumers to those of specialists. This structure would allow for some immunity from changing political agendas and the pressures of special interest groups.

FIGURE 8
Structure of the Proposed Wellness Trust



To maintain flexibility and agility in operating the system, the Wellness Trust would be given the authority to make decisions on specific delivery systems and payment methodologies. What the Trust would do and how it would do it would be determined by the trustees; thus, the ideas outlined in this paper are intended to be illustrative only. The creation and functioning of such a trust would require a significant delegation of power from Congress and the administration. However, the history of Medicare and other public health insurance programs highlight the challenges in creating, updating, and overhauling policies: in many respects, being set in legislation is equivalent to being set in stone. That said, were the Trust to overcome these hurdles, it would be part of the executive branch and subject to its rules as well as to congressional oversight.

The major decisions of the trustees would be issued in an annual report in which the Trust would announce the prevention priorities for the coming one, five, and ten years and its plan for an effective delivery system for those priorities; present a description of its payment incentives; and announce the results of special studies it commissions. It would also release periodic reports and updates to ensure that the relevant information needed to guide the system is available. In the first several years of its operation, before assuming the role of primary payer of selected preventive services, its main job would be to commission and review studies to help it create the necessary infrastructure and decision-support systems. Ideas for how this could work are described in this paper. In practice, these policies would be established through regulation rather than legislation.

Function 1. Setting National Prevention Priorities

A major challenge in prevention is focusing on what works. Prevention can encompass a range of activities, from promoting smoke-free environments, to undertaking highly clinical services, to ensuring access to medications to prevent uncontrolled diabetes. The breadth of services is compounded by the emerging, multibillion dollar wellness industry. The widespread use of some services may be less an indicator of what works than an indicator of what is convenient or popular. For example, the diet and weight-loss industry, which has few standards, is three times the size of the fitness industry, and both are significantly larger than the corporate or school-based wellness industries (TripleTree 2005).

The proposed system would begin by focusing on a subset of clinical preventive services that have strong evidence on their effectiveness. Unlike most areas in health care, prevention has an organization dedicated to reviewing its research. The recommendations of the U.S. Preventive Services Task Force, described earlier, have been widely used by providers and payers (Woolf and Atkins 2001). These recommendations would ground the nation's prevention priorities.[2] In addition, in 2006 the Partnership for Prevention sponsored a National Commission on Prevention Priorities that issued a report ranking preventive services on their health and cost effects (Maciosek et al. 2006; see Figure 9). Such cost-effectiveness analysis is critical to determining the value of health-care services and would play a major role in shaping the proposed prevention system.

Over time, the Wellness Trust would also consider for its list of priorities certain community-based preventive services. Such interventions, which are usually less medical and more behavioral, focus on populations rather than on individuals and are especially important to tackling obesity and tobacco use. The work done by the CDC's Community Guide and Healthy People 2010 projects would be integrated into the new system (CDC 2006d, DHHS 2000). Similarly, to the extent that there is overlap, the primary prevention focus of the Wellness Trust would be linked with secondary prevention (e.g., chronic disease management).

2. Note that the Advisory Committee on Immunization Practices has the responsibility for developing recommendations for immunizations. This proposal assumes that this group would be folded into the U.S. Preventive Services Task Force.

FIGURE 9

Prevention Priorities

Clinical prevention	QALY saved	Cost per QALY saved
Preventive aspirin use	360,000	None / Reduces costs
Childhood immunization series	360,000	None / Reduces costs
Tobacco-use screening and brief intervention	360,000	None / Reduces costs
Colorectal cancer screening	185,000 – 300,000	$0 – $14,000
Hypertension screening	360,000	$14,000 – $35,000
Influenza vaccine	185,000 – 300,000	$0 – $14,000
Pneumococcal vaccine	40,000 – 185,000	None / Reduces costs
Problem-drinking screening and brief intervention	185,000 – 300,000	$0 – $14,000
Adult vision screening	40,000 – 185,000	None / Reduces costs
Cervical cancer screening	185,000 – 300,000	$14,000 – $35,000
Cholesterol screening	360,000	$35,000 – $165,000

Source: Maciosek et al. 2006.
Note: Ranked by cost-benefit and effectiveness

Each year, the Trust would determine and report on a list of prevention priorities to the president and Congress. Its trustees would review the recommendations from the U.S. Preventive Services Task Force and ensure that the list and its ranking reflect what is feasible as well as what is ideal. It is important to note that the evidence base for preventives services, like that of most health services, has gaps and gray areas. The Trust would work with the research agencies across DHHS to develop and support the type of research necessary to determine priorities.

The proposed Trust would use this prioritization in several ways. First, the list would be used to determine which preventive services should be financed by the Trust. If financing for the Trust is insufficient to cover all recommended preventive services, then the Trust would limit its coverage to services with the highest priorities and allow the remaining services to be financed and delivered by the current system. The priorities would also be used in its communication function. Shifting emphasis from sickness to wellness involves more than just systems—it requires a change in culture. Having a clear goal, a priority list of services, and targets would help in the Trust's effort to increase the value that Americans place on wellness. In addition, these priorities would guide payment policy. Incentives for individuals and providers would be developed around these priorities, since their attainment would have the largest long-term rewards.

Function 2. Employing Effective Delivery Systems

This proposal would build systems around best practices in prevention, to allow form to follow function. One of the central functions of the Wellness Trust would be to match the prevention priorities with systems that would increase their use to 100 percent for targeted groups. It would do this in collaboration with the individuals and organizations that currently deliver preventive services, as well as with national and international experts. In the same way that its priorities would be based on evidence, so would its preferred modes of delivering them. While the trustees would determine the specific outline of the delivery system, some ideas for its shape are described here.

FIGURE 10
Prevention Delivery System

	Infrastructure for national priorities	Broadened prevention workforce	Restructured grants to states and regions
Immunizations and clinical prevention	Marketing* Electronic health record* Training*	Trained workers in schools, workplaces, pharmacies, etc.	Developing programs for children, seniors
Screening	Standards to improve quality Planning to: • ensure access • prevent overuse	Traditional health-care providers for invasive procedures, imaging screening Trained workers in schools, workplaces, drug stores, etc.	Mobile technology Remote services
Counseling	National toll-free numbers National Web site for resources	Broad-based workforce including public health, mental health, etc.	Tailoring to vulnerable groups*

Source: Author.
* These activities would be conducted for all types of services

Preventive services can be roughly divided into three categories: (1) immunizations and preventive medicine, (2) screening tests, and (3) counseling (Salinsky 2005). Immunizations and preventive medicine use biological material or chemical compounds to prevent the onset of a disease (e.g., influenza vaccine or the use of aspirin to prevent heart disease). Screening identifies risk factors or diseases in early stages, allowing for early and potentially successful intervention. Some of the screening tests are administered by physicians, involving invasive procedures or imaging technology (e.g., colonoscopy). Others require simple lab tests or exams (e.g., cholesterol checks, vision screening). Finally, counseling consists of activities to try to change behaviors that themselves are risk factors for diseases (e.g., quit lines for smokers). Despite their differences, these preventive services require the same conditions for effective delivery to their target populations: awareness of need by individuals and providers; accessible, affordable services; and catalysts to connect the two. The Wellness Trust would create these conditions through (1) building infrastructure to support services, (2) engaging and training a prevention workforce, and (3) targeting state grant programs for health promotion (see Figure 10).

1. Building Infrastructure to Support Services. Infrastructure for a twenty-first-century prevention system would primarily consist of an information architecture. The Trust would develop and implement an electronic prevention record system (described below under Function 4) to ensure system connectivity, which is essential given its scope. In addition to identifying priorities, the Trust would be responsible for providing information on them. It would maintain a central, up-to-date, accurate, and effective information dissemination system, including a Web site on preventive services. It could build on efforts such as Cancer Control P.L.A.N.E.T., which provides breadth and depth of information on cancer, options for prevention and control, and resources that are accessible in communities. The Trust would also operate toll-free telephone services with counselors for behavioral interventions such as smoking cessation. Experience suggests that highly trained operators on such "quit lines" have the motivational skills, time, and knowledge to effectively counsel individuals who prefer this type of contact (Woolf et al. 2006).

Another information-oriented activity of the Trust would be a communications campaign about the importance of wellness. The Trust would contract

with social marketing experts to lay the groundwork for the shift in emphasis necessary to overcome inertia and barriers to engaging in health promotion and disease prevention. In addition to direct marketing to the public, the Trust could encourage promotion through wholesale distribution partners (e.g., employers, school boards, local government, and food manufacturers) who in turn could affect retail distribution partners (e.g., worksites, schools, built environment, and retail outlets; Maibach et al. 2006). It could also enhance the work of the new CDC National Center for Health Marketing, which helps federal, state, and local programs build in design features that improve their customer research, packaging, and distribution channels.

A more traditional infrastructure role for the Trust would be workforce development. The Wellness Trust would coordinate training for a prevention workforce. New modules to train medical students and nurses would be created and implemented with the leverage of Medicare medical education funding, and new continuing education requirements would be implemented (Gebbie and Tilson 2006). In addition, the Trust would train a new workforce to help run the proposed system. Certification programs would be developed around immunization, screening, and counseling, possibly as part of a broader effort to promote core competencies for public health professionals, community health workers, or both (Council on Linkages Between Academia and Public Health Practice 2005, May et al. 2005). Standards would be set and grants would be given to state and local educational organizations to provide this training. Certain groups of people would be targeted to become certified prevention workers, such as pharmacists, school nurses, and human resources personnel in large businesses. In addition, the idea of training and recertifying a prevention workforce over the Internet would be explored.

In addition to the "software," or human capital, the Trust would ensure an adequate supply of the "hardware" of prevention: imaging technology and immunizations, for example. Wide variation exists in both the price and quality of such services. To address this variation, some states like Vermont and Connecticut have used a health planning process to prevent overuse and to ensure adequate local access to technology, such as imaging machines. The Trust would consider assuming this role, since diffusion as well as quality standards currently vary by state. Also, if it were paying for screening tests, the Trust could competitively contract for such tests in urban areas, create loan funds to ensure access in underserved areas, and promote standards for excellence to limit false positives and retesting. This could reduce costs and improve quality in addition to ensuring access to preventive screening services. Similarly, the supply of certain vaccines has proven unstable. The Trust would explore options for ensuring adequate supplies, including innovative purchasing arrangements or the promotion of a nonprofit drug industry (Pauly 2005, Hale et al. 2005).

2. Engaging and Training a Prevention Workforce. Most prevention supported by the Trust would be delivered through its prevention workforce. Primary care physicians would continue to provide preventive services as part of the continuum of health care that is the hallmark of their profession. Generalists and specialists alike would be encouraged to provide opportunistic prevention as add-on services in acute-care visits. One study found a large percentage of elderly patients could receive recommended immunizations during chronic care visits (Nowalk et al. 2004). Physicians would also continue to be responsible for services such as cancer screening that require imaging and invasive tests. Similarly, the public health system has an infrastructure to deliver immunizations and community-based interventions; such an infrastructure is essential to the current and proposed systems.

However, new participants are needed to carry out the necessary functions to promote health beyond the traditional scope of medicine and public health. Most preventive services could be provided by trained individuals in sites more conve-

nient to target populations, such as supermarkets, pharmacies, schools, and the workplace. Some of this exists today with the growth in retail-based health-care centers that provide screenings, immunizations, and basic primary care. The workplace is also a growing and prime target for wellness activities. The proportion of workers with access to employer-sponsored wellness programs rose from 17 to 23 percent between 1999 and 2005, with a similar rise in the proportion who are offered discounts to fitness centers (9 to 13 percent; see Stoltzfus 2006). Selected results are promising. For example, Union Pacific's aggressive antismoking counseling and medication program led to 29 percent of participants quitting smoking after six months (Leutzinger et al. 2001). Finally, school-based wellness is critical since the trajectory of preventable diseases begins at an early age. The proposed system would train and help fund providers in all of these settings.

3. Targeting the State Grant Programs for Health Promotion. A third level of intervention supported by the Wellness Trust is regional and state grants. State and local governments have a long history of fostering effective, community-based health promotion programs. In this proposal, that role would continue, allowing top prevention priorities to be met with interventions targeted at difficult-to-reach populations through community-based interventions. For example, the demonstrations from the Robert Wood Johnson Foundation's Turning Point Initiative suggest that locally designed initiatives that engage communities can be effective at changing obesity prevalence and reducing substance abuse in communities (Hann 2005). Group counseling, school-based activities, and mobile screening are examples of services that may be best organized at the state or local levels. Delaware's Screening for Life program, for example, provides educational activities in high-risk communities. Its activities include having health educators offer information at schools and churches and following those sessions with screenings in a state-owned mobile mammography van (Mitchell et al. 2006). The Trust would foster this level of intervention by working with the secretary of DHHS and the director of CDC to ensure that prevention priorities are reflected in existing grants. These grants would complement the work done by the Trust at the national level and by the prevention workforce at the individual level.

This multilayered delivery system for prevention would be designed to maximize its cost effectiveness. To that end, the best practices for an individual preventive service would be compared to those of other preventive, acute, chronic, and long-term care services to identify any overlap. For example, the infrastructure needed to promote primary prevention could also be used for chronic disease management, and vice versa (Woolf et al. 2006). Similarly, linking hypertension and diabetes screening could improve the latter's cost effectiveness (Hoerger et al. 2004). The Trust would assess these potential overlaps as a way to reduce duplication of efforts and promote efficiency, integration, and simplicity in the system.

Each level of intervention would also be the subject of evaluation. The Trust would work in collaboration with the CDC, the federal Agency for Healthcare Research and Quality (AHRQ), and other agencies that finance preventive services research and evaluation. Data monitoring and evaluation would be essential to determine whether a particular delivery system idea should be included or continued, as well as if it should be prioritized through financial incentives.

Function 3. Creating Incentive-Based Payment Policy

Under the proposed Trust, a new set of payment policies would be developed for preventive services. These policies would aim to align the payment incentives with the nature of the service and ideal outcome. The Trust's policies would be developed by its trustees. Ideas on how those policies could be structured, based on their level of intervention, are described below.

The national information services provided by the Trust—such as quit lines for smokers and social marketing campaigns—would be delivered through competitive contracts with private entities. Innovative marketing approaches that encourage millions of people to switch products could also help change behavior toward healthier lifestyles. Competitive contracting would also be used for some of the vaccines and imaging technology should the Trust decide that efficiency and accessibility require that it take a greater role in their delivery. The use of competitive contracting would also limit the staff size of the Trust and provide it with flexibility over time to redeploy resources toward different approaches.

At the provider level, the payment approach adopted would depend on the nature of the service. For immunizations and simple screenings, the goal is to encourage high volume in low-cost settings. As a result, payments could be linked to achievement of performance goals (e.g., bonuses for immunizing a certain number of children, or stepped payments that increase with volume). This would potentially improve quality as well since there is a well-documented relationship between volume and quality for services such as these.

A different type of incentive might be needed for complex screenings that occur in clinical settings. To convince busy providers to deliver such services, the payment for these preventive services needs to be on a par with payments for other types of services offered. To ensure that their provision occurs and is of a high quality, performance incentives could be built into their payments, or prevention performance could be built into larger quality systems, as is typically the case today.

In the case of counseling, quality rather than quantity is the priority. It may take intensive counseling to affect a person's smoking, eating, or drinking habits. As a result, case-based reimbursement linked to outcomes might best ensure that services are available and effective. Certified individuals or organizations could be paid a fixed amount per person, with an upward adjustment for additional time only if it has been shown to yield a successful change in behavior. Proven performance over time would merit either higher annual rate increases or other incentives to sustain high performance.

These different approaches would share common features in the payment design. Within the incentive structure, each approach would have some base payment schedule, with adjustments for geographic price variation and different input costs based on existing payments for each service. These payment levels could also be calibrated for the specific service's rank in the priority list. For example, bonuses could be given to providers for low-use but high-value services, or for high-risk populations. Special attention would be given to payment systems for physicians to align incentives with optimal preventive service delivery methods and to balance rewards for prevention versus acute-care and chronic-care interventions. The typical concerns about a fee-for-service system providing incentives for overutilization would not be relevant in this case because the goal would be 100 percent utilization, and payments would be prohibited for more than the recommended usage or for provision to people other than those in the target group. It would not prohibit screenings or other interventions that are not on the priority list, but it would not pay for them. The Trust would also consider contracting with managed care plans, public programs, or states for delivering prioritized preventive services if such programs demonstrate that doing so is cost effective.

The Trust would piggyback on the Medicare payment system to transfer payments to prevention providers. Medicare already has relationships with the majority of health-care providers in the United States. Through Medicare, the new Trust would also pay the new, accredited prevention workforce. The Trust would reimburse Medicare for additional administrative costs. Medicare's payment rules and fiscal integrity systems would also apply. By having a centralized system and electronic prevention record, the Trust would ensure that no duplicative services are provided and that the first qualified person that administers a service is paid for it.

The Trust would also use individual incentives to encourage take-up of preventive services. To facilitate the goal of full use of preventive services, there would be little to no cost sharing for those services with the highest value, as research suggests that cost sharing may be a barrier to use for many preventive services (Solanki et al. 2000). Other incentives would be explored as well. Some companies have implemented reward programs similar to those for frequent fliers to give people who use appropriate services a dividend. One hospital that gave employees $250 to $325 for meeting goals on prevention reported a 28 percent reduction in health-care utilization during the first four years of its implementation (Wellness Councils of America 2006). The research on such incentives is sparse, but some suggest that short-term improvements in service use, such as immunizations, result from economic incentives (AHRQ 2004).

Function 4. Developing an Information Technology Backbone

The Wellness Trust would develop and implement an electronic prevention record. This would ideally be part of a larger electronic health record that runs the gamut of health-care services. Short of this, an electronic prevention record would serve three purposes.

First, an electronic prevention record would provide a lifelong system for tracking the use of preventive service and would include the set of recommended services for each individual based on age, gender, and health history. This would ensure that, no matter where or when an individual entered the system, a qualified provider could access information on what services that individual needed.

Second, an electronic prevention record would be used to promote wellness. At the provider level, the Trust could build on the Electronic Prevention Services Selector recently launched by the DHHS. This tool allows providers to enter basic patient data to determine what services are recommended and access information for both providers and patients on actions to be taken (AHRQ 2006). Kaiser Permanente in Ohio, for example, uses computer-generated reminders to physicians to recommend aspirin for patients with heart disease; as a result, compliance has increased from 56 to 84 percent, with outcomes also improving (Kaiser Permanente 2000). Online tools have grown in popularity, and most major insurers offer them to members. This technology is also being integrated into coaching models, whereby individuals receive technology-enabled reminders, tracking, and other information to educate and motivate them.

Third, an electronic prevention record would be important for ensuring accountability and integration in a system that uses multiple settings. Since preventive services would be delivered in nonclinical settings, an electronic prevention record would ensure that this distinct system is connected to both the medical and the public health systems: physicians need to know whether a patient has received an influenza vaccine or mammogram; the public health system needs to know, for example, if there are geographic clusters of children who have low immunization rates; and the Trust needs to know how financial incentives to encourage preventive service work and whether increasing such incentives has a corresponding effect (i.e., whether there is a dose-response relationship). Since service use would also be noted in the record, duplication of services would be prevented. If linked to billing systems, this would also facilitate payment in multiple settings, and because the prevention workforce would be large, systems to protect medical privacy would be a priority. The development of such a record would be a significant undertaking, requiring interoperability standards, private protections, and full integration with other information technology efforts. However, such an electronic prevention record is the key to responsibly extending the boundaries of the health-care system.

Function 5. Pooling Resources

The Wellness Trust would have a trust fund to finance priority prevention services. Spending

from this trust fund would be considered mandatory, and it would have several sources of dedicated funding. Its authorizing legislation would create a methodology to carve out the prevention funding from Medicare, Medicaid, and other government programs, redirecting such funds to the trust fund. The trustees would assess what additional funding would be needed to eliminate underuse and to create initial infrastructure. Base-year amounts would be indexed by projected growth in national health expenditures in an effort to create parity with growth in spending on acute care services.

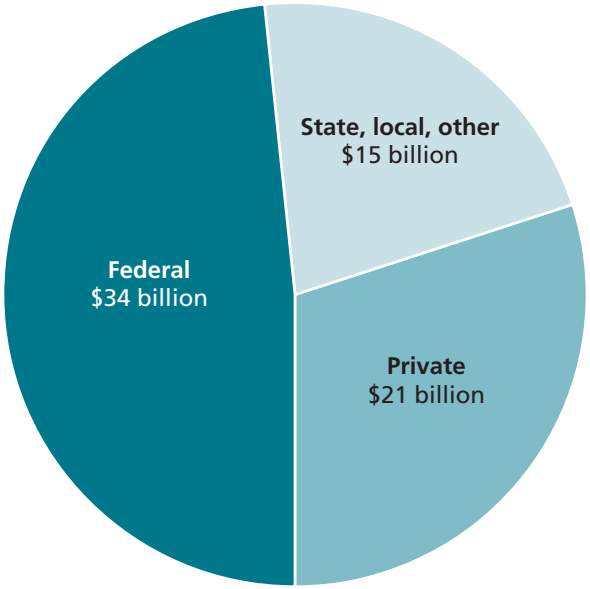
The trustees would also develop a methodology to accomplish a similar consolidation of private insurer spending. In theory, because the Trust would assume primary responsibility for high-priority prevention, it could create a tap on private insurers to help finance it. However, this would be difficult to calculate and administer. Another idea would be to reduce the tax exclusion for employer-sponsored health insurance by an amount estimated to equal the Trust's prevention spending per person. Because the health benefits' tax exclusion value to individuals increases with their tax bracket, this would be a progressive financing method that would be relatively easy to administer. The estimated revenue from this change would be dedicated to the trust fund.

The general revenue dedicated to the Wellness Trust might also be designed to include some type of investment fund. In the same way that venture capitalists are able to pool up-front capital for investments that are likely to have dividends in the future, the Trust could be given a small percent of funding to fund services or infrastructure that could achieve long-term savings (Gostin et al. 2004). If successful, it would not only reduce costs, but it would also create a positive feedback loop for prevention investment.

No solid estimates exist on how much is currently being spent on prevention in the United States. This reflects two challenges relatively unique to prevention. The first challenge is that definitional boundaries are hard to draw (e.g., identifying what component of a physician visit cost is associated with tobacco cessation counseling). The second challenge is that there are multiple sources of payment, including those that typically do not show up in the national health accounts. For example, firms' investments in workplace wellness range from $100 to $150 per employee per year, according to one report (TripleTree 2005). Spending on programs in churches, voluntary health organizations, and other nontraditional sites is also hard to capture. A thorough examination of spending on preventive services, health promotion (i.e., activities influencing behavior), and health protection (i.e., changes in the social and physical environment) estimates that 3 percent of national health spending and 0.7 percent of GNP was spent on wellness activities in 1988 (Brown et al. 1992). This has not increased as much as one might expect since 1929—just 1.4 percent (Falk et al. 1933)—despite the development of expensive screenings, early interventions, and the growth of the preventable disease burden. This is significantly less than the roughly 10–12 percent of

FIGURE 11

Rough Estimates of Spending on Disease Prevention, 2007



Total: $70 billion

Source: Author's calculations based on Brown et al. 1992.

health spending that occurs in the last year of life (Emanuel 1996).

Applying these percentages to projections for 2007 yields an estimated $70 billion of national health expenditures associated with prevention. Almost the same number is achieved by applying the original percent of GNP to the Congressional Budget Office's (CBO's) projected GDP for 2007 (excluding the amount attributable to health protection activities, little of which is counted in the national health accounts). If the proportion financed by public sources has remained the same, then the Wellness Trust might be able to capture $34 billion to $50 billion in public spending (at federal, state, and local levels; see Figure 11). Note that this estimate is imprecise. A number of factors could make the spending higher or lower: the growth in the wellness industry, changes in underlying use patterns, differential price growth in prevention, and the nature and availability of other health services. This estimate is only intended to give a guess of what might be available for the trust fund.

IV. Discussion

The new Wellness Trust outlined here would dramatically increase the nation's emphasis on disease prevention. It would both build on and compensate for the limitations of the current system for delivering preventive services. It would pool existing resources in an effort to redeploy them more effectively. Finally, it would strive to create a truly twenty-first-century infrastructure, where priorities, methods of delivering services, payment incentives, and feedback are based on evidence and information. The model is less like health insurance and more like public health or homeland security: it is needed by all people but not noticed if it works. That said, this proposal raises three major questions: (1) Will it fragment care? (2) Will it reduce health-care spending? and (3) How does it relate to other reform proposals?

1. Will It Fragment Care?

One could argue that taking prevention out of health insurance could fragment the system further. The problems of having multiple insurance systems can be seen in Medicare: employers, Medigap, and Medicaid all supplement it, creating complexity and administrative waste. This model moves away from the integrated "medical home" model that creates teams of physicians and other providers to care for patients (ACP 2006). It also could raise concerns from some health insurers who currently invest and innovate in preventive service delivery and want to keep that role.[3] Putting aside provider concerns, blue-sky approaches typically entail transition costs. And because the Trust would be new, it could acquire the politically damaging label of a big, new bureaucracy.

However, it can be argued that the health system has not done as well as it can in prevention, given trends. From a sheer practical standpoint, the primary care system in the United States is at risk of failing to treat emergent and urgent care; it is hard to imagine it significantly expanding its role in preventive care delivery without substantial changes in structures and incentives. The sharp decline in the supply of primary care doctors, coinciding with the baby boom generation's retirement, suggests that complementary systems must be developed. The same holds true for the public health system that has taken on the task of preparing for potential bioterrorism attacks and pandemics. Its capacity is already stretched thin. Moreover, the employer-based insurance system, through which most Americans are insured, is eroding. Fewer workers are covered, fewer health plans are integrated, and many plans have deductibles that apply to prevention as well as other health-care services. It seems unlikely that we would be able to stop, let alone reverse, these trends.

The nature of preventive services also suggests consideration of a different paradigm. Prevention requires routine, population-wide interventions. Arguably, prevention is more analogous to public health and safety than to an insurable event. Preventive service provision is simple, repetitious, and often applied on a large scale across the population (Bar-Yam 2006). It also involves maintenance of health over time and across jobs. Information technology would provide the connective tissue needed to ensure integration of the prevention system with the health insurance and public health systems. An effective prevention system would also need to work with other social programs. For instance, school lunch and work-site health programs could be more important to reducing obesity than is medicine. The Trust could, with its outreach to new health workers and partners, better achieve well-

3. They could keep this role under the proposal if it were cost effective to do so.

ness than could a traditional, integrated health-care model.

Finally, the Wellness Trust would sidestep two political impediments that might otherwise block effective prevention. The first is regulation. Rather than requiring private insurers and employers to finance and deliver prevention, it would pay directly for prevention. In so doing, it would simplify and prioritize services. This could be more acceptable across the political spectrum in an antiregulatory environment. Second, to be effective, a prevention system must operate in places where asymptomatic people go: work, schools, and shops. The ability to do so would be enhanced by the Trust because it would engage private sector leaders in its own management and create a decision-making framework that is a step removed from the political process, with built-in inclusion of stakeholder input.

2. Will It Reduce Health-Care Spending?

By definition, effective disease prevention and health promotion reduce sickness and death. Healthier or longer lives have prima facie value, irrespective of their net effect on health spending. There also appears to be a positive relationship between health promotion and worker productivity (Aldana 2001). An expanding literature focuses on the health benefits of services as measured in QALYs and disability-adjusted life years (DALYs). These measures capture both the extent to which services lengthen life and the quality of life in those additional years. Cost-effectiveness analysis aims to answer whether the potential health gained from these interventions is worth the marginal cost. Generally, an intervention is considered cost effective if the cost per additional QALY gained is between $50,000 and $100,000, although some experts suggest that this may be too low (see Ubel et al. 2003). Though its methods continue to be refined, such analysis suggests that most prevention services meet this test. In fact, a broad look at the types of interventions that could improve the health of the elderly suggests that prevention stands out as having the potential to improve health and save money (Goldman et al. 2006). The U.S. Preventive Services Task Force takes into account these types of measures when making its recommendations, as would the Wellness Trust.

While this information is persuasive in allocating resources, policy makers typically want to know whether expanded use of prevention will produce savings in the health system. This is a higher test of cost effectiveness whose result largely depends on the specific type of prevention's effect. To oversimplify, prevention that reduces illness without lengthening lives is more likely to produce budget savings than prevention that lengthens lives without reducing illness. Take, for example, tobacco use. Increasing use of screening and interventions from roughly 35 to 90 percent could save 1.3 million QALYs, more than three times that of breast and colorectal cancer screening combined (Maciosek et al. 2006; see Figure 4). However, these extended life years come with different types of health costs, offsetting potential health savings. In contrast, several interventions are so cost effective that they may actually reduce costs. One study estimates that if all elderly received pneumococcal vaccines, health costs could be reduced by nearly $1 billion per year (Hillestad et al. 2005). Over twenty-five years, Medicare could save an estimated $890 billion from effective control of hypertension and $1 trillion from returning to levels of obesity observed in the 1980s (Goldman et al. 2006). The potential for savings also depends on the effectiveness and targeting of the intervention. While their potential for improving health is great, cholesterol and obesity screening are at the low end of the cost-effectiveness scale for these reasons.

An even narrower question about savings is whether the CBO would attribute federal savings to a proposal such as the Wellness Trust. Here, additional variables get included in the equation. The CBO would assess what the potential impact would be on prevention utilization, how fast this would take effect, and whether, in the five- to ten-year bud-

get window, any reductions in utilization of other types of health services might occur (e.g., nursing home use could be reduced by effective reductions in high blood pressure and smoking; see Valiyeva et al. 2006). It would also consider whether consolidation of funding and the payment systems devised by the Trust would increase or reduce prices, what the administrative costs and savings might be, and how immune the Trust would be from funding priorities that are not evidence-based. Last, it would have to parse the costs or savings that would accrue to the federal government versus other payers in the system.

While it is complicated to address each of these questions, the premise of the Trust (to redeploy prevention spending toward highly effective services) should result in some savings—maybe not initially, but in the long run. Studies of similar, private-sector interventions buttress this claim. A review of studies on such programs found that the return on investment is expected to average about three to one, although it takes several years to realize (Goetzel et al. 1999). A longitudinal study of one firm's wellness programs found a slight increase in costs of emergency rooms, but decreases in mental health, outpatient care, and inpatient care, for annual net savings of $225 per employee per year (Ozminkowski et al. 2002). Finally, Freddie Mac, the nation's second-largest home loan financier, opened an on-site clinic at its headquarters where 4,300 people work. It provides on-site preventive services, nutrition counseling, and routine care. Estimated savings due to increased productivity and fewer lost work days are $900,000 per year (Amy Joyce, "A Prescription for Workers' Health," *The Washington Post*, October 9, 2006).

The Wellness Trust could also have other effects on spending. The Trust would consolidate the administration of federal health programs' preventive services, eliminating the widely criticized stovepipe effect of the current structure of funding (IOM 2003c). States would be relieved from enacting and enforcing benefit mandates on insurers to provide preventive services, such as colorectal screening coverage. Employers would benefit in two ways: lower premiums as prevention is implemented and, if it is successful, healthier and more productive workers. They could also choose to participate in providing prevention; if they did so, they would be reimbursed. For individuals, current financial, geographic, and time barriers would be removed. Given its mandated reliance on evidence, the Trust would likely be more insulated from pressure to cover ineffective therapies (e.g., fad diets). It could also limit inappropriate use of prevention (e.g., Pap smears for low-risk women). In short, while some costs would be associated with creating the Trust and its goal of increasing utilization of effective preventive services, the weight of evidence suggests that there could be net, systemwide savings.

3. How Does It Relate to Other Reform Proposals?

The idea of a Wellness Trust could complement both efforts to promote a patient-centered system and to expand health insurance coverage to all Americans. The proposed system has some elements in common with certain consumer-directed care models. Both place a high premium on information and engaging individuals in their own health and consider financial incentives to be an effective tool in motivating desired outcomes. The guiding principle of the Wellness Trust, however, is to make it as easy and simple as possible to connect individuals with effective delivery systems. In contrast, consumer-directed care plans generally expect individuals to take on more responsibility for organizing the system to meet their wellness, acute, and chronic care needs. This is especially true with financing: rather than lowering costs as a financial incentive to use prevention at the point of service, most consumer-directed plans provide no insurance coverage for prevention, with 100 percent of the cost of those services coming from individuals' accounts, potentially discouraging use. As a result, the Wellness Trust may be more effective than consumer-driven models at promoting personal responsibility for wellness.

It also could fit within, and potentially accelerate movement toward, a comprehensive plan to provide quality health coverage to all Americans. The model could conform to any number of health reform plans, from a single-payer plan to an individual market approach that carves out prevention. A number of elements of the plan could also be enacted incrementally in the absence of major reform. For example, a cross-agency council could be created to improve prevention for people in federal health programs and thus lay the foundation for the Trust. The development of a new health promotion workforce and payment system could begin immediately. Probably most importantly, an investment in research could be made to lessen the uncertainty around prevention priorities.

However, even if the Wellness Trust were enacted fully and immediately, it would still operate within a deeply flawed health-care system. Uninsured people who were diagnosed with a disease through the Wellness Trust might not be able to afford its treatment. The high cost and relatively low quality of medical care faced by many will also persist without fundamental health reform. This is why the proposed wellness system should be part of a larger reform plan that ensures access to affordable coverage for all.

In closing, the Wellness Trust represents a major change in the organization and emphasis of preventive care in the United States. It would require new decision-making structures and systems for delivering and financing care. It would also require upfront spending, from both budgetary and political perspectives. Its potential to achieve its goals, like any proposal, is uncertain. Nevertheless, the cost of uncertainty may be smaller than that of the preventable health crisis that is emerging. The burden of preventable disease is escalating, and it will have broad-based implications for the nation, threatening to reverse the steady gains in life expectancy that the nation has experienced for a century. As a result, the changes encompassed within the Wellness Trust proposal are critical.

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Author

JEANNE M. LAMBREW
Associate Professor, The George Washington University and Senior Fellow, Center for American Progress

Jeanne Lambrew teaches health policy at George Washington University and conducts policy-relevant research on the uninsured, Medicaid, Medicare, and long-term care. Lambrew worked on health policy at the White House from 1997 through 2001 as the program associate director for health at the Office of Management and Budget (OMB) and as the senior health analyst at the National Economic Council. In these roles, she helped coordinate health policy development, evaluated legislative proposals, and conducted and managed analyses and cost estimates with OMB, the Department of Health and Human Services, the Treasury Department, the Labor Department and other relevant agencies. She was the White House lead on drafting and implementing the State Children's Health Insurance Program and helped develop the president's Medicare reform plan, initiative on long-term care, and other health care proposals. She also worked at the Department of Health and Human Services during the 1993-1994 health reform efforts and coordinated analyses of budget proposals in 1995. Lambrew received her masters and Ph.D. from the Department of Health Policy, School of Public Health at the University of North Carolina at Chapel Hill and bachelor's degree from Amherst College.

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