THE HAMILTON PROJECT

Advancing Opportunity, Prosperity and Growth

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A Wellness Trust to Prioritize Disease Prevention

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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

> An estimated 78 percent of all health spending in the United States is attributable to chronic illness, much of which is preventable.

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.

The Underuse of Preventive Care

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 demonstrations 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.

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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

Setting National Prevention Priorities

Employing Effective Delivery Systems

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.**

- **Workforce.**

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

- **Regional and State Grants.**

Establishing Incentive-based Payment Policies

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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

Questions and Concerns

Will It Fragment Care?

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?

CONCLUSION

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.

Additional Hamilton Project Proposals

Additional Hamilton Project discussion papers and policy briefs on health care can be found at www.hamiltonproject.org, including:

- **Mending the Medicare Prescription Drug Benefit: Improving Consumer Choices and Restructuring Purchasing**
  The new Medicare Part D provides many important benefits to the elderly in need of prescription drugs. The program suffers from a variety of problems, however, including complexity, inefficiency, and discontinuity in coverage (the "donut hole"). This paper proposes reforms that, by better utilizing the forces of competition, would improve health outcomes, reduce the financial risks faced by the elderly, and provide options for closing the "donut hole".

- **The Promise of Progressive Cost Consciousness in Health-care Reform**
  Health-care cost sharing implemented through health-savings accounts (HSAs) is unlikely to reduce total health care spending significantly, even as it increases the financial and medical risks faced by low- and moderate-income families. This paper shows that more effective forms of cost sharing, such as income-related cost sharing, could restrain health spending, improve the effectiveness of health spending, and insulate families from major financial risks.

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