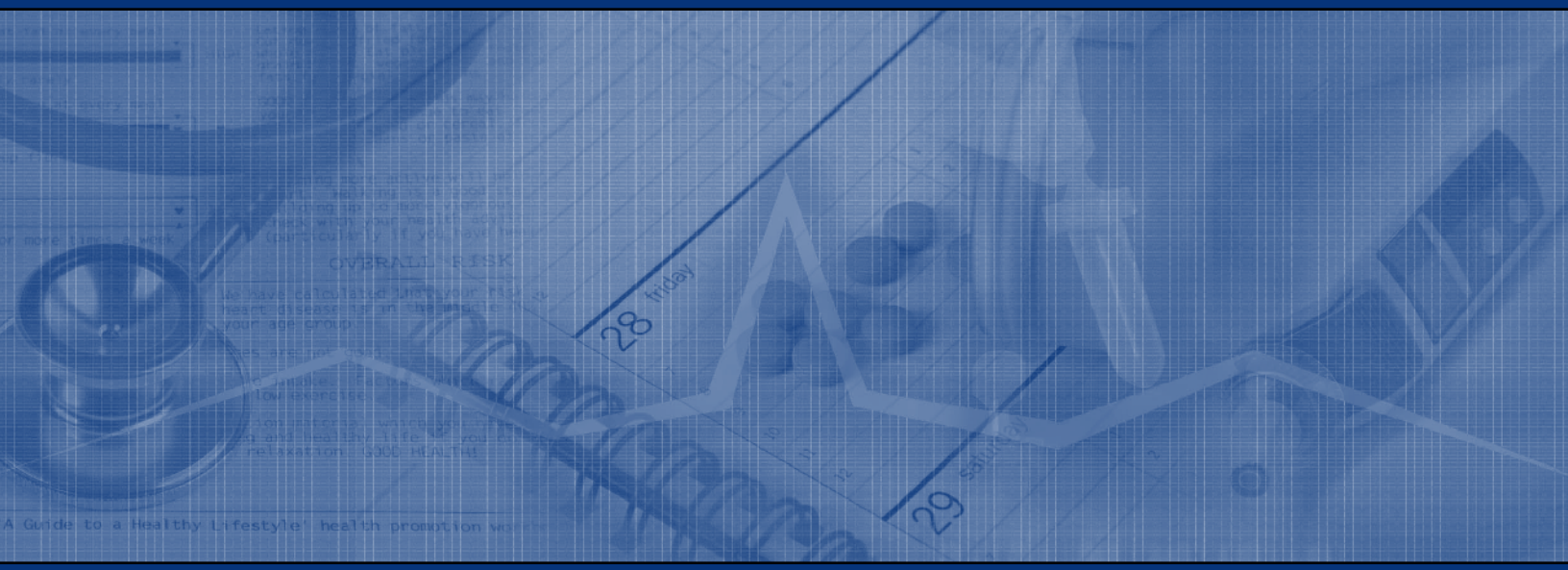
Center for American Progress



Promoting Prevention and Preempting Costs

A New Wellness Trust for the United States

By Jeanne M. Lambrew
and John D. Podesta
Center for American Progress

Center for American Progress

PROMOTING PREVENTION AND PREEMPTING COSTS: A NEW WELLNESS TRUST FOR THE UNITED STATES

Jeanne M. Lambrew, PhD and John D. Podesta, JD
Center for American Progress

October 5, 2006

EXECUTIVE SUMMARY

The U.S. health system has failed to achieve high levels of health for its population. Proven preventive services remain largely unused, and healthy communities and lifestyles are undervalued. This has enormous consequences in unnecessary sickness and lost lives. It also affects our economy because sickness and disability limit individuals' productivity and lowers businesses' bottom lines. These challenges increase as health costs soar and health insurance erodes.

This paper outlines a radical new idea for prevention called the Wellness Trust. Its premise is that disease prevention is more like homeland security than health insurance: everyone needs it, no one notices if it works, and it depends on persistent, strong leadership and systems. It would carve prevention out of health insurance and finance it through a broader delivery system and reward successful practices. Specifically, our proposed Wellness Trust would:

Set national prevention priorities. Beginning with experts' recommendations on clinical preventive services, the Trust would produce an annual list of prevention priorities for the nation. These priorities would be used to design the delivery system, determine financing and payment incentives for providers and individuals, and communicate the importance and value of wellness.

Employ effective delivery systems. The Trust would allow its form to follow its function. Representatives from businesses, public health, medicine, and insurers would help match priorities with effective systems and payment approaches. A multi-layered system would extend prevention activities outside of traditional settings into schools, workplaces, and sites like supermarket and pharmacies.

Develop an information technology backbone. An electronic prevention record would be created for lifelong tracking and integration with the rest of the system to ensure seamless health care.

Drive success through payment policy. The Trust would adapt existing payment systems to align financial incentive with effective practices for prevention. It would use: competitive contracting at the national level; state and regional grants with performance bonuses; a nationwide fee schedule with pay-for-performance systems; and incentives for individuals to use priority services.

Pool resources and authorities. The Trust would be created as a quasi-independent agency with its own Trustees. It would be funded by consolidation of existing federal insurance and public health spending on prevention and as well as new sources of funding (e.g., alcohol or soda taxes or as part of a broader reform plan).

The proposed Wellness Trust would dramatically increase the nation's emphasis on prevention. It would create a broad-based, 21st century system, including population-based interventions outside of the traditional bounds of the health care system. It would use consolidated financing and information technology to expand and coordinate services over a lifetime and across care settings. While elements of the Wellness Trust could be implemented immediately, it should be an essential component of any effort to reform the U.S. health care system.

WHY WE NEED A WELLNESS TRUST

A gap exists between knowledge and implementation of disease prevention activities in the U.S. Disease prevention and health promotion are broadly defined as actions to prevent the onset of disease and detect and treat disease in its early stages. They often include activities that are undertaken as ordinary parts of life. Eating nutritiously and exercising are essential not just for promoting long-term health but effective functioning on a daily basis.

A subset of prevention is generally defined as health care services, called clinical preventive services, such as screening tests for cancer and vaccinations. Over time, a wide range of such services has developed, and scientific commissions have determined which are effective and their comparative impact on both health and costs.[1] As such, we have a good idea of what Americans and their health care system should be doing to promote wellness.

Low Use of Preventive Services

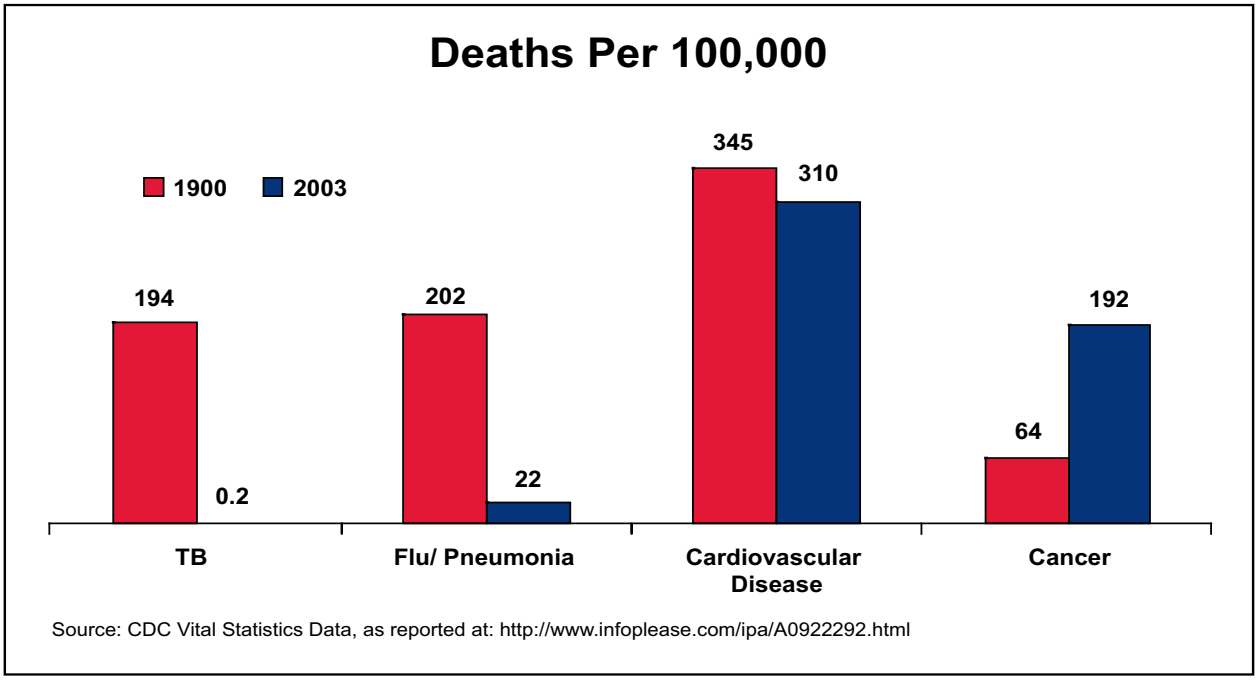
But compared to scientific recommendations, too few Americans receive preventive services. A recent study found that only half of recommended clinical preventive services are provided to adults.[2] While 61 percent of white seniors received a pneumococcal immunization, rates dropped to 28 percent for Hispanics and 40 percent for non-Hispanic blacks.[3] Only 48 percent of U.S. adults had their doctors provide them advice on weight, nutrition, or exercise, compared to 72 percent in the U.K.[4] About 38 percent of participants in one study had colorectal cancer screening.[5] The statistics are similarly grim for most recommended services.

Health Consequences of Low Use of Preventive Services

Lack of effective preventive services has serious health consequences. About 70 percent of deaths and health costs in the U.S. are attributable to chronic diseases (e.g., cardiovascular disease, cancer), some of which may be preventable (Figure 1).[6] A recent comprehensive assessment found that 1.2 million quality-adjusted life years could be saved by achieving 90 percent use of just three services: smoking cessation counseling, use of aspirin to prevent heart attacks, and screening for colorectal cancer (Figure 2).[7] This helps explain what most Americans find shocking: the U.S. ranks 25th globally on high life expectancy.[8]

Figure 1

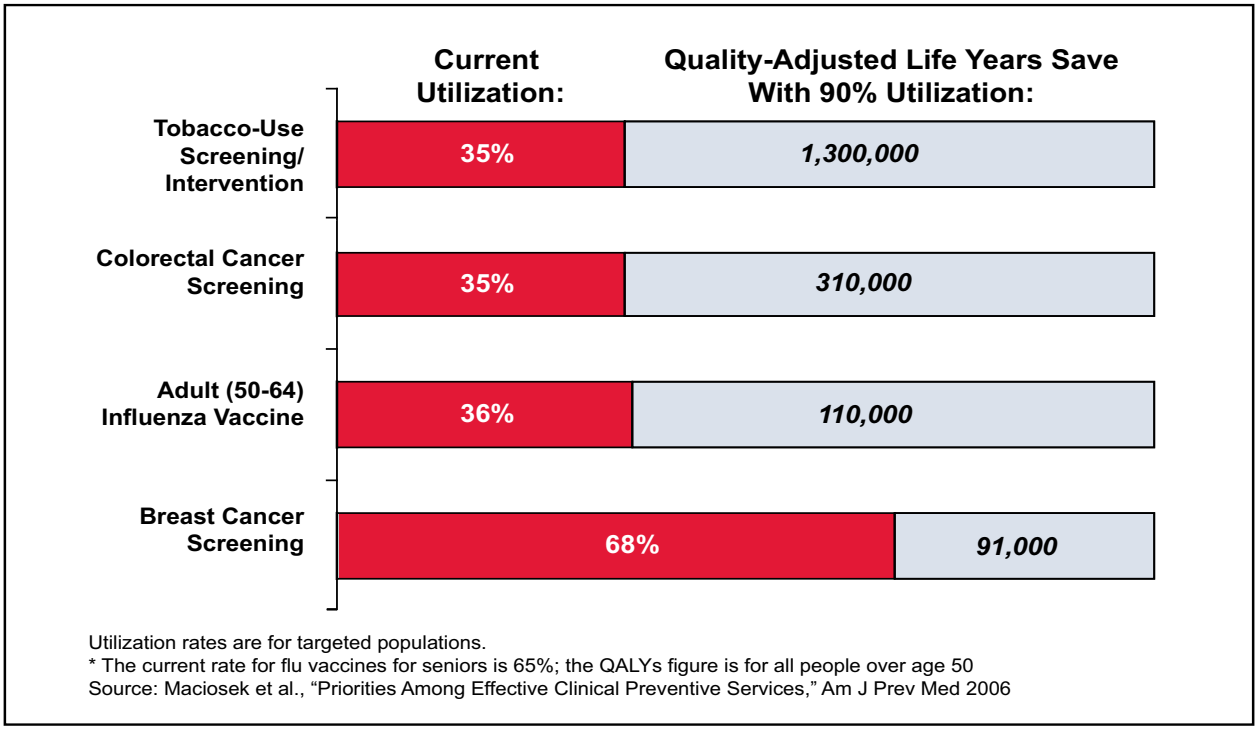
21st Century Problem:Shift Toward Preventable Disease



Source: CDC Vital Statistics Data, as reported at: http://www.infoplease.com/ipa/A0922292.html

Figure 2

Preventive Service Use and Potential Benefits



Utilization rates are for targeted populations.
* The current rate for flu vaccines for seniors is 65%; the QALYs figure is for all people over age 50
Source: Maciosek et al., "Priorities Among Effective Clinical Preventive Services," Am J Prev Med 2006

Economic Consequences of Low Use of Preventive Services

The gap in preventive service use also has economic consequences. Complete, routine childhood vaccination could save up to $40 billion in direct and societal costs over time.[9] Promoting screenings and behavioral modifications in the workplace can lower absenteeism and, in most cases, health costs to firms.[10]

Preventive health care service could reduce government spending on health care. If all elderly received a flu vaccine, health costs could be reduced by nearly $1 billion per year.[11] Over 25 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.[12] Effective prevention could, in some cases, increase direct medical costs as people live longer, such as former smokers. But there is an intrinsic value to improved quality of life for these individuals and their indirect contributions to the economy are generally high.[13]

The gaps in the use of preventive health care service are especially surprising given the level of spending on health care in the U.S. By any measure, the United States has the most expensive health care system in the world. In 2004, we spent nearly $2 trillion on health care, or $6,280 per person.[14] The U.S. spends only an estimated 1 to 3 percent of national health expenditures on preventive health care services and health promotion.[15] This has not increased as much as one might expect since 1929—1.4 percent[16]—despite the development of expensive screenings, early interventions, and the growth of the preventable disease burden.

Reasons for Low Use of Preventive Services

The reasons why preventive services are not used as recommended are complicated, but could be classified into three areas.

Low value placed on prevention. Lack of awareness of the value of prevention and specific recommended services is a major barrier to their widespread use. Generally, individuals do not know about their own specific disease risk profile and the set of recommendations that apply to them. Nearly one in three people with hypertension, for example, are unaware of their condition.[17] The proliferation of information on the internet could help, but often confuses individuals seeking to understand their needs.[18]

Even among those who know what they could do to promote health, the time lag between the action and benefit diminishes the motivation to act. This is especially true for services in areas where behavior modification is needed, like smoking or problematic drinking. People have a limited ability to rationally calculate and compare the immediate cost of prevention (time and money) and long-term benefits of additional healthy and productive years of life. Moreover, some aspects of prevention involve difficult behavioral modifications and significant changes in lifestyle. The benefits may be too abstract to justify immediate and sometimes costly actions.

Similarly, some health care providers, especially specialists, lack awareness of recommended clinical preventive services, or place low value on them. Relative to other countries, the U.S. specialists account for a high proportion of visits and often act as primary care providers, despite their lack of the orientation towards prevention.[19] Even among primary care physicians, 35 percent reported that they did not believe that counseling would lead to a lasting change in patients' physical activity level, despite evidence to the contrary.[20] This lack of consistent, across-the-board value placed on prevention is one of the reasons that providers do not always ask individuals about their use of such services nor do they ensure that they are provided when appropriate.

Delivery system bent toward fixing rather than preventing problems. The health care delivery system is primarily designed to cure existing diseases rather than prevent potential diseases. Training for health care providers is geared to make them action-oriented problem solvers. Their training, and patient expectations, focus on therapies that provide immediate relief rather than screening and counseling that prevents problems perhaps decades later. The culture of medicine also emphasizes individualized, complex treatments.

The doctor as detective is a popular metaphor, in which a smart diagnostician cracks the complicated case or the committed surgeon devises an innovative treatment for the incurable problem. More fundamentally, the health delivery system triages its resources to provide the sickest patients the first and most amount of medical attention.

Generally, this orientation is justified: it would be unethical for a provider to delay resuscitation of a heart attack victim to give an immunization to a child. But it is not always so clear cut: for example, a person with symptoms of a cold, possibly pneumonia, is typically seen in the same day while a person seeking a flu shot could wait for weeks. Given providers' limited time and resources, acute care often comes at the expense of prevention.

These aspects of the delivery system also run counter to what would be ideal in promoting wellness and preventive services. Most services are not individualized and offer neither the provider nor patient instant gratification. Preventive service provision is simple, repetitious, and often applied on a large scale across the population.[21] The mindset as well as practices of most health care providers would need modification.

In addition, radical changes would be required to reallocate resources from the back to the front end of the illness spectrum. An estimated 3 percent of our national health spending is for health promotion, while roughly 20 percent is spent on the last year of life.[22] Trying to improve preventive services in the current medical model has been and will continue to be daunting.

Financial disincentives for prevention. The financing structure of the U.S. health system contributes to its poor performance on prevention. Most health care spending for the non-elderly is financed through employer-based health insurance plans. Generally, people change employers and insurance plans multiple times over the course of their lifetimes. Consequently, the financial benefit of aggressive prevention is not returned to the same employer and/or insurer that makes the initial investment.[23]

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 realized in future periods.

It should come as no surprise, then, that an employer survey found only 20 percent of insurers cover tobacco cessation services and only 18 percent cover alcohol problem prevention.[24] Focus groups with employers found that costs, employee turnover, and low use of services accounted for their unwillingness to cover prevention.[25]

In addition, insurers reimburse health care providers more for caring for a sick person than preventing illness in the first place. Surgical specialists earn nearly twice as much, on average, as primary care physicians.[26] Primary care providers receive higher payments for procedures than counseling.

Moreover, pressures for clinical efficiency and productivity in medical practice have compressed the average length of time available for physician-patient interaction during office visits. Quantity is generally valued higher 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.

The public health system, as much as the medical system, has a responsibility to promote prevention, but inadequate funding has limited its reach. State and local public health departments have a broad set of responsibilities, ranging from monitoring communities for infectious disease outbreaks to providing prenatal care. A recent report found that funding for public health to fulfill its obligations is both unevenly distributed across states and insufficient—requiring an additional $2.6 billion to fill the shortfall.[27] Public health departments have been innovators in developing community-based prevention, but implementing and sustaining them on a wide-spread basis has been a fiscal challenge.[28]

When it comes to coverage in insurance, there is no national coverage policy for prevention – or any other health benefit. Some states, through regulation, ensure coverage of specific preventive benefits like breast cancer screening. However, several of the recommended clinical preventive services are required by none of the states and screenings for high cholesterol and blood pressure, for example, are required by fewer than five states.[29]

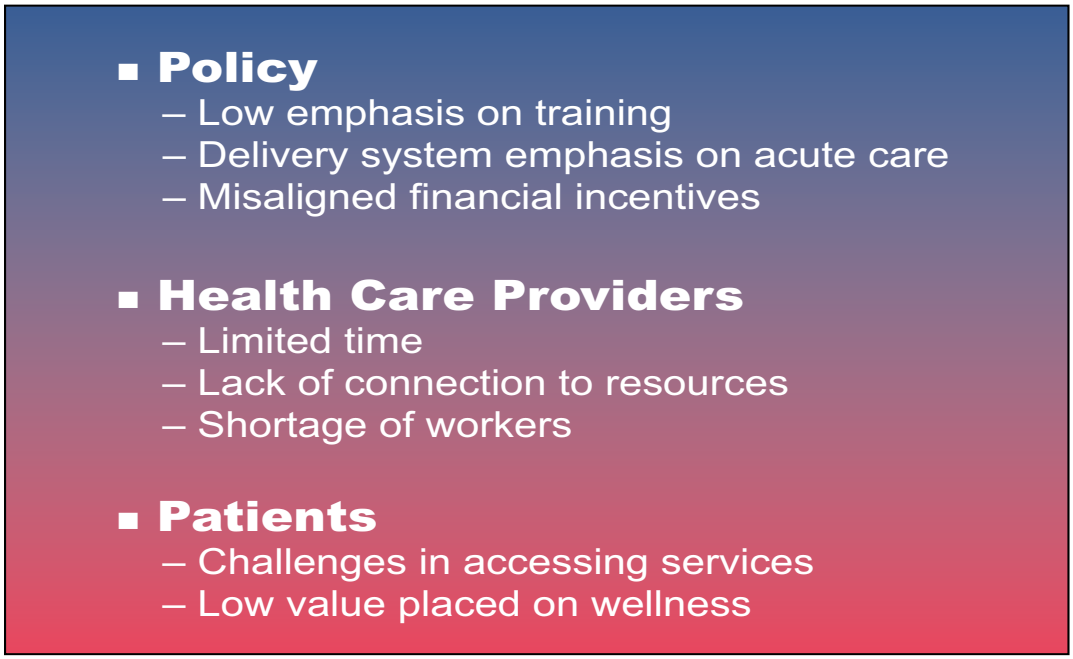
Similarly, Medicaid coverage of influenza, pneumococcal, and other immunizations varies across states, with two states failing to cover them at all for adults.[30] Medicare policy is equally weak: while it has recently expanded its coverage, some recommended services are not covered. This reflects a problem across federal health programs—the challenge in getting Congressional changes to ensure that needed services are covered.

Cost sharing matters as well. Research shows that people generally use less health care if cost sharing is increased.[31] This may be especially true for preventive services given their lack of immediate benefit. One study found cost sharing had significant negative effects on the use of Pap smears, mammography, and counseling services.[32] One employer, in designing its workers' health benefits, found that eliminating cost sharing on services related to asthma and diabetes prevention and control improved workers' health.[33] Yet neither public nor private insurers consistently lower cost sharing for preventive services to encourage their use.

Most troubling, many people lack health insurance coverage altogether. Without coverage, the cost of services often constrains their use. For example, less than half—48 percent—of uninsured women ages 50 to 63 had mammograms in the past two years, compared with 75 percent of women who were insured all year. Only 18 percent of uninsured adults ages 50 to 64 had a colon cancer screen in the past 5 years, compared with 56 percent of adults insured all years.[34]

Success in the use of preventive services—like accomplishing many of the goals we have for our health system—will remain unlikely so long as a large and growing fraction of the U.S. population is uninsured (Figure 3).[35]

Figure 3
Preventive Service Use and Potential Benefits



PROPOSED WELLNESS TRUST SYSTEM

The U.S. needs a policy initiative aimed at improving the use of preventive services and, more broadly, increasing health promotion in the U.S. The motivating principle is that disease prevention is more analogous to homeland security than health insurance: everyone needs it, no one notices if it works, and it depends on persistent, strong leadership and systems.

As former surgeon general C. Everett Koop is famous for saying, "Health care is vital to all of us some of the time, but public health is vital to all of us all of the time." Our failure to think of prevention this way has led to inadequate attention and resources as well as misaligned systems. A new model is needed.

A 21st century prevention system should broaden the preventive services workforce and delivery system, use financing to leverage change, and integrate the new system through information technology with the existing medical and public health systems. Its priorities, financial incentives, and funding itself would be based on research on the most important and effective preventive services and methods of ensuring their full use. This idea was originally sketched out as part of a comprehensive health reform plan proposed by the Center for American Progress and ideally would be implemented as part of such a plan.[36]

A new Wellness Trust would be created to run and finance this new system. Specifically, it would have five functions (Figure 4):

1. Set national prevention priorities
2. Employ effective delivery systems
3. Develop an information technology backbone
4. Create incentive-based payment policy
5. Pool resources and authorities

This Trust and its five major functions are described below. Please note that these proposals are intended to serve as a framework for an ideal system; some elements require further policy development, and its impact on costs are not assessed in detail.[37]

1. Setting national prevention priorities. A lack of clear priorities has plagued public and private actors interested in investing in health promotion. Prevention is a broad term that could include policies that range from air standards that reduce asthma to chronic disease management that prevents uncontrolled diabetes. The proposed system would focus on clinical preventive services to start.

Such services already have been the subject of review through the U.S. Preventive Services Task Force. This Task Force, first created in 1984, is an independent scientific panel that reviews the evidence to develop guidelines for providers and payers on what services have proven to be effective.[38] Its list of recommended services would serve as the starting point for the Trust, since meeting targets for this subset of prevention activities would result in a meaningful reduction in illness and costs.

Additional research would be needed to include the range of services, such as immunizations, and strengthen the evidence behind the existing recommendations. Over time, the scope of prevention covered by the Trust would expand. In particular, community-based interventions are particularly important for prevention that requires significant behavioral change. Given its enormous implications, childhood obesity would be an immediate focus. The work done by the Centers for Disease Control and Prevention's *Community Guide* and Healthy People 2010 projects would be integrated into the new system.[39]

Beyond their efficacy, preventive services would also be prioritized based on their potential impact on health and reduction in costs. The Partnership for Prevention sponsored a National Commission on Prevention Priorities that issued a report ranking preventive services on their health and cost effects.[40] 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.

The Trust would not only identify services which are both recommended and cost effective, but would determine which services should not be covered due to evidence of ineffectiveness or potential harm. It is important to note that prioritization would be difficult due to lack of evidence and natural gray areas in medicine. That said, insurers and providers make such decisions in the current system with less concentrated information in a less transparent way. Each year, the Trust would report its priorities and their rationale to the president and Congress.

The proposed Trust would use this prioritization in several ways. First, it would be used to determine what preventive services are 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.

In addition, these priorities would be reflected in payment policy described below. Incentives for individuals and providers would be developed around these priorities, recognizing that their attainment will have the largest long-run rewards. The priorities would also be used in communication efforts, also described below. Shifting emphasis from sickness to wellness involves more than just systems—it is about culture. Having a clear goal, priority list of services, and targets could help in the Trust's effort to increase the value placed by Americans on wellness activities.

2. Employing effective delivery systems. The heart of this proposal is its ability to build systems around best practices, 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. It would do this in collaboration with the individuals and organizations that currently deliver preventive services.

Primary care doctors and nurses would continue to be central to promoting wellness, gaining new tools and partners and more certain reimbursement for their time and care. Insurers have extensive experience in designing systems for prevention. Kaiser Permanente in Ohio, for example, uses computer-generated reminders to physicians to recommend aspirin for patients with heart disease; as a result, compliance increased from 56 to 84 percent, with outcomes improving as well.[41]

Businesses also have increasingly engaged in worksite health promotion efforts that include clinical preventive services. For example, Union Pacific's aggressive anti-smoking counseling and medication program led to a 29 percent quit time after 6 months.[42] Representatives from these groups would help the Trust determine how priorities get matched with systems and ultimately payments. From a list of delivery system ideas, the Trust would determine whether this activity is best delivered nationally, regionally, through traditional health care providers, and/or through a new health promotion workforce.

The Trust would have its own delivery system role in areas where there are efficiencies and advantages in conducting an activity ***nationwide***. The Trust would be the natural home for central, up-to-date, accurate, and effective information through a website on preventive services. This would be a resource for individuals and providers that offers clinical information, access to nationally-sponsored services, and links to local resources.

The Trust could also operate toll-free telephone services with counselors for quitting smoking and other behavioral interventions. Experience suggests that highly-trained operators on such lines have the motivational skills, time, and knowledge to effectively counsel individuals who prefer this type of contact.[43]

Another activity that would best be conducted nationally is a communications campaign about the importance of wellness. The Trust could 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. It would also be responsibility for the system connectivity—essential given its scope.

Another potential, and more controversial, national function for the Trust relates to prevention screening tests. The cost of recommended screenings is variable, with a low-cost mammogram costing $50 and a high-cost colonoscopy costing $1,000. Research also shows that adequate volume matters in preventing false positive results. Vermont and Connecticut, for example, have used a health planning process to prevent overuse and ensure adequate local access to technology like these screening machines. The Trust could assume this role, since standards now vary by state.

The Trust could also, if it were paying for the tests, 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. This could have the benefit of reducing the costs and improving quality in addition to ensuring access to preventive screening services.

Some preventive services are best organized ***regionally or locally***. Lessons from projects such as the Robert Wood Johnson's Turning Point demonstrations suggest that locally-designed initiatives that engage communities can be effective at increasing health promotion.[44] Group counseling, school-based activities and mobile screening, among other activities, may be best organized at the state or local level.

Delaware's Screening for Life program, for example, provides educational activities in high-risk communities, such as having a health educator offer information at schools and churches and following such sessions with screenings in a state-owned mobile mammography van. States generally have the infrastructure for such services, but this proposal would encourage small and rural states to work together in regions to share resources.

Similarly, large metropolitan areas might be considered their own regions, as they are for certain CDC grants, given their unique needs. In either case, they would be organized to work with local public health departments, state agencies, schools, businesses, insurers, and health systems to promote preventive services in the region.

As the primary source of preventive services today, individual ***health care providers*** would also be central to the system. The Trust would develop payment systems that replace private and public insurance payments to health care providers for specific covered services. Support and reimbursement would be available to health care providers for preventive services for any patient, irrespective of insurance coverage.

The Trust would also collaborate with Medicare on training. Medicare now is the primary source of funding for medical education. New modules to train medical students as well as other health care professionals would be created by the Trust and implemented with the leverage of Medicare medical education funding to ensure that clinicians learn not just about the services but about the preventive system that will evolve over the course of their careers. New continuing education requirements would be implemented as well.[45]

Lastly, a ***prevention workforce*** could be trained and engaged beyond the traditional scope of medicine and public health. Primary care providers would continue to be the organizing force across the spectrum of care. Their work would be supplemented by a broader, credentialed prevention workforce.

A new, national system would be created to train workers to deliver preventive services, possibly as part of a broader effort to promote core competencies for public health professionals.[46] 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 resource personnel in large businesses. In addition, training modules could be built into high school curriculums and volunteer services like AmeriCorps for preventive services that require less skills.

This multi-layered 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.[47]

The Trust would assess these potential overlaps as a way to reduce duplication of efforts and promote efficiency, integration, and simplicity in the system. It would also work in collaboration with the Centers for Disease Control and Prevention, Agency for Healthcare Research and Quality, and other agencies that finance preventive services research and evaluation. Data monitoring and evaluation would be essential not just to determine whether a particular delivery system idea should be included or continued but prioritized through financial incentives.

3. Developing an information technology backbone. A lifelong system for tracking the use of preventive service is essential for monitoring and promoting health. An electronic medical or health record would be ideal in a system that provides preventive services through multiple settings at different intervals over an individual's lifetime. This should be an essential part of any major health reform plan.[48] Short of a fully-developed electronic health record—an "electronic prevention record," like the drug discount cards used prior to the Medicare drug benefit implementation—could be used to track and facilitation payment for recommended services.

The development of such a record would be a significant undertaking, requiring interoperable standards, private protections, and full integration with other information technology efforts. An electronic prevention record, as either a stand-alone record or a component of a full electronic health record, would include the set of recommended services for each individual, based on his or her age, gender, and health history. This would ensure that, no matter where or when an individual enters the system, a qualified provider could access information on what services that individual needs.

Since service use would also be noted in the record, duplication of the service could 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.[49]

Given that preventive services would be delivered in non-clinical 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 a flu vaccine or mammogram. The public health system needs to know if there are geographic clusters of children who have low immunization rates. And the Trust would need this information to design and administer individual financial incentives to encourage preventive service use.

4. Creating incentive-based payment policy. Under the proposed Trust, a new set of payment policies would be developed for preventive services. The **national services** provided by the Trust,—such as quit lines for smokers—would be delivered through competitive contracts with private entities. A large wellness "industry" would emerge as evidence of returns on investment increases. Many of these companies would import expertise from sectors such as information technology, marketing and engineering. Such companies would be part of the Trust through its use of competitive bidding for central functions.

The ***state and regional activitie***s would be financed through grants. States and regions would have the ability to target resources to local needs, such as inner-city schools or mobile services in rural areas. They would be able to test local systems for prevention at, for example, a local HMO-designed obesity reduction program. Most of the grant funding would be allocated based on need, but part would be awarded competitively—on best ideas and performance. The system would build in performance standards and funding rewards to ensure effective use of scarce resources.

At the ***provider level***, a new, national payment system would be created. It would develop a national fee schedule, with adjustments for geographic price variation and different input costs based on existing payments for each service. The typical concerns about a fee-for-service system providing incentives for over-utilization are not relevant in this case because the goal is 100 percent utilization; payments would be prohibited for more than the recommended usage.

Payment incentives could also be used for high-priority services. 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 delivery systems and balance rewards for prevention versus acute-care and chronic-care interventions.

The Trust would work with Medicare to pay health care providers. Since Medicare already has existing relationship with the majority of health care providers in the U.S., the Trust would piggyback on Medicare to transfer payments to health care providers. Medicare's payment rules and fiscal integrity systems would also apply, among them limits on balance billing and kickbacks.

Through Medicare, the new Trust would also pay the new, accredited prevention workforce. The Trust would reimburse Medicare for additional administrative costs. By having a centralized system, the Trust could ensure that no duplicative services are provided and that the first qualified person that administers the services gets paid.

The Trust would also use ***individual incentives*** to encourage uptake of preventive services. Since the goal is to encourage full use of preventive services, there would be no cost sharing for those services with the highest value. Research suggests that any cost sharing is a barrier, even for higher-income people.[50] Other incentives would be explored as well. Some companies have implemented "reward" programs like those for frequent fliers to give people who use appropriate services a dividend.[51] Research shows some short-term improvements in service use such as immunizations resulting from economic incentives.[52]

5. Pooling resources and authorities. The Trust would be created as an independent agency, modeled on the Social Security Administration. Its sole job would be to administer the functions described above. The Trust would be part of the executive branch and subject to its rules and oversight.

Several safeguards would be constructed to help it effectively conduct its work, among them Senate confirmation of the Trust's leadership, and long-term appointment limits. The Trust would also have Trustees, as do Social Security and Medicare. Like other Trustees, they would produce an annual report that assesses the effectiveness of the payments and delivery system and the balance of spending and revenue sources for the system described later.

Since the Wellness Trust would have greater decision-making authority than Medicare, its Trustees would be responsible for ensuring that decisions are based on rigorous and science-based information and reflect a wide range of views, from those of consumers to specialists. This structure would allow for some immunity from changing political agendas, accountability to both the Administration and Congress, and strong leadership.

The Wellness Trust Fund would have dedicated sources of funds. The amount of funds sought would cover the costs of delivery as well as an "investment fund," with any savings from prevention accruing to the system automatically. Since the fragmentation of the U.S. health care system makes it difficult to identify and capture savings from prevention, the Trust would have to quantify its prevention "dividend,"or the amount of savings achieved by its investments. Although difficult to determine, experts would calculate the dividend annually to serve as a guidepost for securing funding.[53] This dividend could be invested in infrastructure, research, and other system architecture to improve its functioning. It would have the side effect of creating a positive feedback loop for the prevention investment.

The Trust Fund could be financed by three major sources. First, it would consolidate existing federal government funding for prevention. This includes funding from the Public Health Service as well as public insurance programs such as Medicare, Medicaid, and the Veterans' Administration. The new Trust Fund would tap Medicare's Trust Funds in an amount equal to the baseline spending on prevention, plus perhaps some amount of estimated savings accruing to the program as a result of the success of the new system.

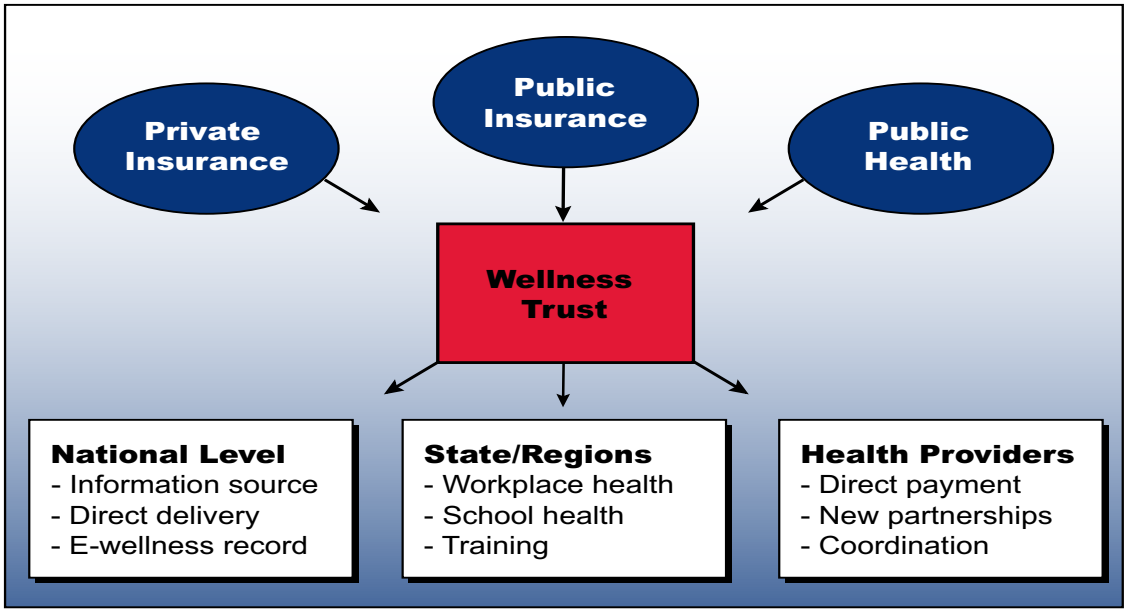
Second, the Trust Fund could be financed by taxes on behaviors that contribute toward health problems. This includes additional tobacco taxes, increased alcohol taxes, possible taxes on sodas and other foods contributing to obesity and related items. According to the Congressional Budget Office, about $13 billion per year could be generated through higher cigarette and alcohol taxes.[54] Some states have implemented soda taxes to finance health benefits, and some physicians have suggested a tax on saturated fats, given their contribution to obesity.

If enacted, these policies would act more as prevention intervention than a steady revenue source, since their revenue would decline with lower use of unhealthy products. At the same time, their revenue could significantly increase what is now available to fund prevention.

Third, and ideally, the Wellness Trust would be created as part of a comprehensive health plan that provides affordable health coverage to all Americans. Most plans, such as the one proposed by the Center for American Progress, would included dedicated financing such as a three to four percent value-added tax. This would finance the wellness system, an information technology investment, research, and subsidies to make coverage affordable for all, including low and high-income Americans.

Short of this, other financing ideas could be used. Some of the prevention spending now paid by employers and individuals through insurance could perhaps be offset by adjusting the tax benefit for employer-sponsored health insurance and health savings accounts by an amount roughly equal to estimated spending under the current system. Alternatively, a small private insurance recoupment fee in the amount of some of the expected insurance savings from the new system could generate funding. Both of these approaches, however, open the risk of costs being shifted back to workers and employers, undermining the goal of broad-based financing for the health system in general.

Figure 4
The Wellness Trust



CONCLUSION

The new Wellness Trust just outlined would dramatically increase the nation's emphasis on disease prevention. This emphasis is needed since health is essential to all other activities. Sickness, mental illness, and disability limit individuals' potential to engage in work, family, and social life. Studies have found positive links between health promotion and school attendance, work attendance, and in some cases productivity. As such, the indirect benefits of a healthy population are large if difficult to quantify and capture. These benefits are needed now more than ever. As health costs soar, the health of the nation lags, with gaps in services widening as health insurance erodes.

Due to the Trust's potential effectiveness and broad financing base, the current payers of care—federal, state and local governments, businesses, and individuals—stand to benefit from the proposal. It would simplify the administration of federal health programs, each of which covers different preventive services. And it would consolidate and expand public health funding through the states and new regions, eliminating the widely-criticized "stovepipe" effect of the current structure of funding.[55]

States would be relieved from enacting and enforcing benefit mandates on insurers to provide preventive benefits like 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 participate in providing prevention and be reimbursed for doing so. And for individuals, current financial, geographic, and time barriers would be removed. Unlike coverage through insurance, the Trust would follow individuals across jobs and over their lifetime, facilitating full use of effective preventive services.

Health care providers, especially those in primary care, would benefit in three ways. First, the preventive care that they currently provide would be more highly valued. The Trust would aim to remunerate providers for the delivery of prioritized prevention. This payment would occur irrespective of the patient's insurance status.

Second, the pressure on doctors to deliver prevention in acute-care visits would be lessened as more patients receive such services in schools, workplaces, and other alternative settings. And third and most importantly, an effective prevention system would contribute to providers' ultimate goal: healthier individuals and populations.

The role for health insurers in promoting wellness would change under this proposal. Insurers could still have a major role in the new system. They could, through the regional authorities, compete for contracts to participate in the new system. They also could supplement the Trust's payments.

A well-organized system might actually reduce administrative costs for health insurers since it would replace the numerous decisions by payers on what to cover. Given its mandated reliance on evidence, the Trust would likely be more immune to pressure to cover ineffective therapies like fad diets. Information technology would provide the connective tissue needed to ensure integration of the prevention system with the health insurance and public health systems.

The proposed system has some elements in common with most consumer-directed care models. Both place a high premium on information and engaging individuals in their own health. Both consider financial incentives 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 making prevention at the point of service fully insured, consumer-directed care would provide no insurance coverage, with 100 percent of the cost coming from individuals' accounts, potentially discouraging use. As such, the Wellness Trust may be more effective at promoting shared responsibility in health promotion.

Major legislation would be required to create the Wellness Trust. It is more radical than the recommendations from the Institute of Medicine's vision for Public Health in the 21st century and Healthy People 2010.[56] But it can be argued that the health system has done as well as it can in prevention given intrinsic barriers to further progress. The medical and public health systems already have large responsibilities without the additional demand of a higher priority placed on preventive services.

The Wellness Trust could have an upfront cost in terms of federal spending as well as time and capital since it involves major changes. Yet we cannot afford to ignore the preventable health crisis that is emerging. The obesity epidemic is putting the nation at risk of having children's life span be shorter than that of their parents.[57] The cost of diabetes is skyrocketing despite known interventions that can reduce costs and improve the quality of life. This emerging crisis requires bold change, new ideas, and a high priority placed on preventing illness—essential to strengthening our nation's health.

That said, a number of elements of the plan could be enacted incrementally. For example, a cross-agency council could be created to improve prevention for people in federal health programs and lay the foundation for the Trust. The development of a new health promotion workforce and payment system could begin immediately. And, probably most importantly, an investment in research should be made to lessen the uncertainty around prevention priorities (see Appendix).

However, even if the Wellness Trust were enacted immediately, it would still operate within a deeply flawed health care system. It would still face the problem of uninsured people who, though screened, cannot afford expensive treatment for disease. The high cost of medical care and relatively low quality of it will persist without fundamental health reform as well. This is why the proposed wellness system should be part of a larger reform plan that ensures access to affordable coverage for all.

APPENDIX: IMMEDIATE STEPS TOWARD A WELLNESS TRUST

Organization

- Create the Wellness Trust as an independent agency
- Define and establish states and regions for Trust activities
- Establish a Trust Fund, with sources of funds including:
  - Consolidation of Public Health Service grants
  - Funding from Medicare, Medicaid and other federal insurance programs

Immediate Activities

- Establish national delivery system functions such as:
  - Website
  - Help lines
  - Social marketing campaign
- Require federal programs to cover prevention priorities

Preparation

- Fund and consolidate research on delivery system options and priorities
- Develop electronic prevention record (as a stand-alone or part of an electronic health record)
- Develop payment systems in cooperation with Medicare
- Develop and train new prevention workforce

Endnotes

[1] Michael V. Maciosek, Ashley B. Coffield, Nichol M. Edwards, Thomas J. Flottemesch, Michael J. Goodman, and Leif I. Solberg, "Priorities Among Effective Clinical Preventive Services: Results of a Systematic Review and Analysis," *American Journal of Preventive Medicine*, 2006, available at: http://www.prevent.org/images/stories/clinicalprevention/article%201669p.pdf

[2] Elizabeth A. McGlynn, Steven M. Asch, John Adams, Joan Kessey, Jennifer Hicks, Alison DeChristfaro and Eve Kerr, "The quality of health care delivered to adults in the United States," *New England Journal of Medicine*, vol. 348, no. 26 (Jun 26, 2003), pp. 2635-2645, available at: http://content.nejm.org/cgi/content/abstract/348/26/2635

[3] National Center for Health Statistics, *Early Release of Selected Estimates Based on Data from the 2005 National Health Interview Survey*, June 2006, U.S. Department of Health and Human Services, Center for Disease Control and Prevention, available at: http://www.cdc.gov/nchs/data/nhis/earlyrelease/200606_05.pdf

[4] Cathy Schoen and Robin Osborne. (2004). "The Commonwealth Fund 2004 International Health Policy Survey of Primary Care in Five Countries." New York: The Commonwealth Fund, available at: http://www.cmwf.org/usr_doc/2004_survey_charts.ppt

[5] Elizabeth A. McGlynn, Steven M. Asch, John Adams, Joan Kessey, Jennifer Hicks, Alison DeChristfaro and Eve Kerr, "The quality of health care delivered to adults in the United States," *New England Journal of Medicine*, vol. 348, no. 26 (Jun 26, 2003), pp. 2635-2645, available at: http://content.nejm.org/cgi/content/abstract/348/26/2635

[6] Centers for Disease Control and Prevention, "Indicators for Chronic Disease Surveillance," *Morbidity and Mortality Weekly Review,* vol. 53, no. RR11 (Sept. 10, 2004), pp. 1-6.

[7] Michael V. Maciosek, Ashley B. Coffield, Nichol M. Edwards, Thomas J. Flottemesch, Michael J. Goodman, and Leif I. Solberg, "Priorities Among Effective Clinical Preventive Services: Results of a Systematic Review and Analysis," *American Journal of Preventive Medicine*, 2006, available at: http://www.prevent.org/images/stories/clinicalprevention/article%201669p.pdf

[8] National Center for Health Statistics, *Health United States*, 2005. Washington, DC: Centers for Disease Control, 2005.

[9] Fangjun Zhou, Jeanne Santoli, Mark L. Messonnier, Hussain R. Yusuf, Abigail Shefer, Susan Y. Chu, Lance Rodewald, and Rafael Harpaz, "Economic Evaluation of the 7-Vaccine Routine Childhood Immunization Schedule of the United States, 2001," *Archives of Pediatrics and Adolescent Medicine*, December 2005, 159(12): 1136-44, Available at: http://archpedi.ama-assn.org/cgi/content/short/159/12/1136

[10] Steven G. Aldana, "Financial Impact of Health Promotion Programs: A Comprehensive Review of the Literature," *American Journal of Health Promotion*, vol. 15, no. 5 (2001), pp. 296-320.

[11] Richard Hillestad, James Bigelow, Anthony Bower, Federico Girosi, Robin Meili, Richard Scoville and Roger Taylor "Can Electronic Medical Record Systems Transform Health Care? Potential Health Benefits, Savings and Costs," *Health Affairs*. September-October 2005; 24: 1103-1117 Available at: http://content.healthaffairs.org/cgi/reprint/24/5/1103?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=Hillestad+&andorexactfulltext=and&searchid=1141251587662_3907&FIRSTINDEX=0&resourcetype=1&journalcode=healthaff

[12] Dana P. Goldman, David M. Cutler, Baoping Shang, Geoffrey A. Joyce, "The Value of Elderly Disease Prevention," *Forum for Health Economics & Policy*, Forum: Biomedical Research and the Economy: Article 1. Available at: http://www.bepress.com/fhep/biomedical_research/1/

[13] For a discussion of the broader economic benefits of investments in health care, see David M. Cutler, *Your Money or Your Life* (Oxford: Oxford University Press, 2004).

[14] Centers for Medicare and Medicaid Services, National Health Accounts, 2004, available at: http://www.cms.hhs.gov/NationalHealthExpendData/.

[15] R. Brown, J Corea, B Luce, A Elixhauser, and S Sheingold, "Effectiveness in Disease and Injury Prevention Estimated National Spending on Prevention – United States, 1988," *Morbidity and Mortality Weekly*, vol. 41, no. 29 (July 24, 1992), pp. 529-531.

[16] I.S. Falk, C. Rufus Rorem, and Martha D. Ring, *The Costs of Medical Care: A Summary of Investigations on The Economic Aspects of the Prevention and Care of Illness* (Chicago: University of Chicago Press, 1933).

[17] David J. Hyman and Valory N. Pavlik, "Characteristics of Patients with Uncontrolled Hypertension in the United States," *New England Journal of Medicine*, vol. 345, no. 7 (2001), pp: 479-486.

[18] Institute of Medicine. *Health Literacy: A Prescription to End Confusion*. Washington, DC: National Academy of Sciences, 2004.

[19] Barbara Starfield, Leiyu Shi, Atul Grover, and James Macino., "The Effects of Specialist Supply on Populations' Health: Assessing the Evidence," *Health Affairs*, Web Exclusive (March 15, 2005).

[20] Christina C. Wee, "Physical Activity Counseling in Primary Care: The Challenge of Effecting Behavioral Change," *JAMA*, vol. 286 (2001), pp. 717-719.

[21] Yaneer Bar-Yam, "Improving the Effectiveness of Health Care and Public Health: A Multiscale Complex System Analysis," *American Journal of Public Health*, vol. 96, no. 3 (March 2006). pp. 459-466.

[22] R. Brown, J Corea, B Luce, A Elixhauser, and S Sheingold, "Effectiveness in Disease and Injury Prevention Estimated National Spending on Prevention – United States, 1988," Morbidity and Mortality Weekly, vol. 41, no. 29 (July 24, 1992), pp. 529-531; Donald R. Hoover, Stephen Crystal, Rizie Kumar, Usha Sambamoorthi, and Joel C. Cantor, "Medical Expenditures during the Last Year of Life: Findings from the 1992–1996 Medicare Current Beneficiary Survey," *Health Services Research*, 2002 December; 37(6): 1625–1642.

[23] National Institute of Health Care Management, *Accelerating the Adoption of Preventive Health Services* (Washington, DC: NIHMC, 2003).
[24] Maris.A. Bondi, Jeffrey R. Harris, David Atkins, Molly E. French, and Beth Umland, "Employer Coverage of Clinical Preventive Services in the United States," *American Journal of Health Promotion*, vol. 20, no. 3 (Jan-Feb 2006), pp. 214-222.
[25] Partnership for Prevention, *Preventive Services: Helping Employers Expand Coverage* (Washington, DC: Partnership for Prevention).
[26] Ha T. Tu, Paul B. Ginsburg, Losing Ground: Physician Income, 1995-2003, Tracking Report No. 15. June 2006.
[27] Jeffrey Levi and Chrissie Juliano, *Shortchanging America's Health, 2006; A State-by-State Look at How Public Health Dollars are Being Spent* (Washington, DC: Trust for America's Health, 2006).
[28] Meredith L. King, *Community Solutions to Health Care Inequality: The Role of Prevention in Rducing Racial and Ethnic Health Disparities*, Washington, DC: The Center for American Progress, October 2006.
[29] Partnership for Prevention, P*reventive Services: Helping States Improve Mandates* (Washington, DC: Partnership for Prevention, 2002).
[30] Sara Rosenbaum, Alexandra Steward, Marisa Cox and Alexis Lee. *The Epidemiology of U.S. Immunization Law: Medicaid Coverage of Immunizations for Non-Institutionalized Adults*, (Washington, DC: The George Washington University Center for Health Services Research and Policy, November 2003).
[31] Joseph P. Newhouse. *Free for All: Lessons from the RAND Health Insurance Experiment*. Cambridge: Harvard University Press, 1996.
[32] Geetesh Solanki, Helan H. Schauffler, and Leonard S. Miller, "The Direct and Indirect Effects of Cost-Sharing on the Use of Preventive Services," Health Services Research, vol. 34, no. 6 (2000), pp. 1331-1350.
[33] Vanessa Fuhrmans, "A Radical Prescription. While Most Companies Look to Slash Health Costs by Shifting More Expenses to Employees, Pitney Bowes Took A Different Path. The Results Were Surprising," *The Wall Street Journal*, May 10, 2004, p. R3.
[34] Sara R. Collins, Karen Davis, Michelle M. Doty, Jennifer L. Kriss, and Alyssa L. Holmgren. Gaps in Health Insurance: An All-American Problem. New York, The Commonwealth Fund, April 2006 http://www.cmwf.org/usr_doc/Collins_gapshltins_920.pdf
[35] Institute of Medicine, *The Future of the Public's Health in the 21st Century* (Washington, DC: National Academy of Sciences, 2003).
[36] Jeanne M. Lambrew, John D. Podesta, and Teresa L. Shaw, "Change in Challenging Times: A Plan for Extending and Improving Health Coverage," *Health Affairs*, Web Exclusive (March 23, 2005), pp. W5-119-132.
[37] A more indepth examination of the financing and implications of this proposal is forthcoming as part of the Hamilton Project; http://www1.hamiltonproject.org/es/hamilton/hamilton_hp.htm
[38] For information on the Task Force, see: http://www.ahrq.gov/clinic/uspstfab.htm; Steven H. Woolf and David Atkins, "The Evolving Role of Prevention in Health Care: Contributions of the U.S. Preventive Services Task Force," *American Journal of Preventive Medicine,* vol. 20, no. 3s (2001), pp: 13-20.
[39] Centers for Disease Control and Prevention, *The Guide to Community Preventive Services: What Works to Promote Health?* Atlanta, GA: U.S. DHHS, CDC, available at: http://www.thecommunityguide.org/; U.S. Department of Health and Human Services, *Healthy People 2010. 2nd ed. With Understanding and Improving Health and Objectives for Improving Health*. Washington, DC: U.S. Government Printing Office, November 2000.
[40] Michael V. Maciosek, Ashley B. Coffield, Nichol M. Edwards, Thomas J. Flottemesch, Michael J. Goodman, and Leif I. Solberg, "Priorities Among Effective Clinical Preventive Services: Results of a Systematic Review and Analysis," *American Journal of Preventive Medicine*, 2006, available at: http://www.prevent.org/images/stories/clinicalprevention/article%201669p.pdf
[41] "Improvement of Cardiac Outcomes in Kaiser Permanente of Ohio," *The Permanente Journal*, 4(2), Spring 2000, available at http://xnet.kp.org/permanentejournal/spring00pj/cad.html
[42] Joseph A. Leutzinger Chris Harter, and Bill Craynor. "Smoking Cessation for Blue-Collar Workers Using One-on-one Counseling and Bupropion HCI, A Pilot Study," *Worksite Health*, Vol 7, no. 4 (2001), pp. 33-39.
[43] Steven H. Woolf, Alex H. Krist and Stephen F. Rothemich. *Joining Hands: Partnerships Between Physicians and the Community in the Delivery of Prevention*. Washington, DC: The Center for American Progress, October 2006.
[44] For example, see Neil E. Hann, "Transforming Public Health Through Community Partnerships," *Preventing Chronic Disease: Public Health Research, Practice, and Policy*, vol. 2, November 2005.
[45] Kristine M. Gebbie and Hugh H. Tilson. The Human Dimension: Strengthening the Prevention Workforce. Washington, DC: The Center for American Progress, October 2006.
[46] See, for example, Council on Linkages Between Academia and Public Health Practice, *Core Competencies for Public Health Professionals*, (Washington, DC: Public Health Foundation and Health Resources and Services Administration, Revised August 2005).
[47] Steven H. Woolf, Alex H. Krist and Stephen F. Rothemich. *Joining Hands: Partnerships Between Physicians and the Community in the Delivery of Prevention*. Washington, DC: The Center for American Progress, October 2006.
[48] Jeanne M. Lambrew, John D. Podesta, and Teresa L. Shaw, "Change in Challenging Times: A Plan for Extending and Improving Health Coverage," *Health Affairs*, Web Exclusive (March 23, 2005), pp. W5-119-132.
[49] National Committee on Vital and Health Statistics. *Privacy and Confidentiality in the Nationwide Health Information Network*. Atlanta: Centers for Disease Control and Prevention, 2006, available at: http://www.ncvhs.hhs.gov/060622lt.htm
[50] Geetesh Solanki, Helan H. Schauffler, and Leonard S. Miller, "The Direct and Indirect Effects of Cost-Sharing on the Use of Preventive Services," *Health Services Research*, vol. 34, no. 6 (2000), pp. 1331-1350.
[51] Steve Case, Revolution Health, 2006, available at: http://www.revolution.com/health/default.asp
[52] Agency for Healthcare Research and Quality, Economic Incentives for Preventive Care, Evidence Report/Technology Assessment No. 101, Rockville, MD: Agency for Healthcare Research and Quality, available at http://www.ahrq.gov/clinic/epcsums/ecincsum.htm

[53] A similar idea for all public health spending was proposed by Lawrence O. Gostin, Jo Ivey Bouffourd, and Rose Marie Martinez, "The Future of the Public's Health: Vision, Values, and Strategies," *Health Affairs*, vol. 23, no. 4 (July/August 2004), pp. 96-107.

[54] Congressional Budget Office, *Budget Options*, February 2005.

[55] Institute of Medicine, *The Future of the Public's Health in the 21st Century* (Washington, DC: National Academy of Sciences, 2003).

[56] Institute of Medicine, *The Future of the Public's Health in the 21st Century* (Washington, DC: National Academy of Sciences, 2003) and U.S. Department of Health and Human Services. Healthy People 2010. 2nd ed. With Understanding and Improving Health and Objectives for Improving Health. 2 vols. Washington, DC: U.S. Government Printing Office, November 2000.

[57] S. Jay Olshansky, Douglas J. Passaro, Ronald C. Hershow, Jennifer Layden, Bruce A. Carnes, Jacob Brody, Leonard Hayflick, Robert N. Butler, David B. Allison, and David S. Ludwig, "A Potential Decline in Life Expectancy in the United States in the 21st Century," *New England Journal of Medicine* 352(11): 1138-1145, March 17, 2005.

ABOUT THE CENTER FOR AMERICAN PROGRESS

The Center for American Progress is a nonpartisan research and educational institute dedicated to promoting a strong, just and free America that ensures opportunity for all. We believe that Americans are bound together by a common commitment to these values and we aspire to ensure that our national policies reflect these values. We work to find progressive and pragmatic solutions to significant domestic and international problems and develop policy proposals that foster a government that is "of the people, by the people, and for the people."

Center for American Progress
1333 H Street, NW, 10th Floor
Washington, DC 20005
Tel: 202.682.1611 • Fax: 202.682.1867
www.americanprogress.org