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Research Insights

Prevention and Health Reform

Summary

Prevention has not played a big part in health reform discussions to date. Polling suggests that the public is generally supportive of prevention, but concerned about affordability. In addition, there is confusion and vagueness in the public's understanding of prevention concepts, in part due to historically modest investments in preventive efforts. Finally, public support suffers because investments in prevention have been siloed across a fragmented funding and delivery system. Proponents argue that prevention should be a key part of health reform discussions because of its potential to control the growth and costs of chronic illnesses, especially obesity. The key policy challenge is to replicate and scale interventions whose effectiveness have been demonstrated. An increased focus on prevention may also be effective in reducing health disparities. In order to do so, community-based efforts that address environmental and social determinants of health must complement an emphasis on clinical preventable services. One health plan's approach to community-based prevention, Kaiser Permanente's Healthy Eating Active Living (HEAL) initiative, provides an important opportunity to learn which interventions work, and to support replication. The Vermont Blueprint for Health represents one state's approach to testing interventions that integrate provider and community interventions to improve the care and prevention of chronic disease.

Introduction

In most discussions of health reform efforts to date, prevention has often been a "footnote in the conversation." To some extent, this is understandable in that much of the conversation takes place around where most current resources are focused: on dealing with sickness and injuries when they happen. The first challenge to elevating prevention's role in the debate is to understand public perception of the value of prevention efforts. Poll statistics suggest that the public is generally supportive of prevention efforts, but also concerned about affordability: in a recent survey, one-third supported increasing spending on prevention efforts, but 55 percent favored keeping spending at current levels. The public support for prevention falls somewhere in between that for Medicaid and protections against bioterrorism; only support for veterans healthcare and the children's health insurance program (SCHIP) ranked higher.[1]

Genesis of This Brief: AcademyHealth's 2009 National Health Policy Conference

At its annual National Health Policy Conference (NHPC) in Washington, D.C. on February 2-3, 2009, AcademyHealth convened a panel of four experts with different perspectives on prevention, particularly primary, community-based prevention efforts, and its role in health reform. Kenneth Thorpe, Ph.D., Emory University, moderated the session and provided some motivation and context for community-based prevention efforts. Ray Baxter, Ph.D., Kaiser Permanente, presented the perspective of a provider, and described the Kaiser Permanente HEAL initiative. Craig Jones, M.D., discussed Vermont's statewide Blueprint for Health initiative and the early results of pilot sites. Marsha Lillie-Blanton, Dr.P.H., George Washington University, concluded the session with an assessment of the barriers and challenges facing community based prevention efforts, and some suggestions for moving the conversation forward. This issue brief summarizes the presentations and discussion from the NHPC session.

A second challenge is a lack of branding, and resulting public confusion and vagueness about what terms such as disease prevention, health promotion, community-level prevention, and community-based prevention mean. The policymaker and research communities are starting to "unpack the black box" of what those terms mean, but the public's understanding lags, in part due to the plethora of terms used. The current lack of investment also inhibits better understanding and support, which in turn could engender greater investment.

A third major challenge to increasing the role of prevention is the problem of collaboration across fragmented systems and funding streams. Any broad, community-based initiative raises issues of who is responsible, who takes leadership, and how the project will be financed. Silos of funding and service delivery exist, and to move forward, policymakers must devise vehicles and mechanism for cross-collaborations to take place. States and local communities may be ahead of the federal government in this regard, because at the federal level the silos are so institutionalized—not only across federal departments, but even within the Department of Health and Human Services (HHS).

Why Should Prevention Be Part of the Health Reform Debate?

Proponents argue that prevention should be a key part of the health reform discussion in part because of its potential role in addressing the growth of chronic disease, of which obesity is a major contributor. Assuming that a considerable portion of chronic disease is preventable, the cost-savings potential of prevention is considerable:

- *Prevention is fundamental to affordability.* Three-quarters of health-care expenditures are linked to chronic conditions. A great deal of discussion in health policy is dedicated to preventing unnecessary use, and the proper design of health insurance in the form of higher co-pays or deductibles to minimize it. But, a different set of policy instruments is needed to refocus priorities toward prevention of chronic disease, and those instruments need to focus on driving supply-side changes.

- *Many cost-driving conditions are preventable.* The World Health Organization data suggest that 80 percent of new cases of stroke, coronary heart disease, and other chronic conditions are potentially preventable. Failure to prevent such conditions imposes considerable suffering on individuals and a large and growing cost burden on payers.

- *The health reform debate should recognize the role of obesity in driving chronic conditions and their resultant costs.* Obesity has doubled since the 1980s, and research suggests that obesity accounts for 15-25 percent of the growth in healthcare spending. Obesity is strongly correlated with a number of chronic conditions: the growth in obesity accounts for nearly all of the increase in diabetes in recent years. Five medical conditions account for much of the cost increases in Medicare: diabetes, arthritis, hyperlipidemia, hypertension, and back problems—and all are linked to obesity.

- *The precursors to Medicare's cost burdens—and opportunities to prevent them—occur long before individuals become eligible for Medicare.* Normal-weight 65-year-olds cost 15-40 percent less over their remaining life than those entering Medicare overweight or obese with one chronic condition. Thus Medicare has an incentive to reach out earlier.[2]

- *Primary and tertiary prevention efforts are target areas for potentially cost-saving intervention.* There is considerable buzz concerning whether prevention works, and whether it is cost-saving. In our current health care system, the vast majority of attention is on secondary prevention: early detection of existing disease. Cost-savings are not the point of secondary prevention: the key advantage of secondary prevention is that earlier intervention affords patients with more and better medical options. Primary prevention—the prevention of disease before it occurs—can be cost-saving. There is a need to demonstrate, replicate, and scale projects that establish the cost-saving potential of primary prevention. Tertiary prevention—efforts to mitigate the impact of established disease—is also an important area for intervention, because that is where the money is—75 percent of healthcare dollars are linked to chronic conditions. Thus tertiary prevention can be cost-saving if it lowers the expense of caring for the most expensive group of patients.

- *The key policy challenge is to replicate and scale the interventions whose effectiveness has been demonstrated by current projects.* The evidence base is building from current and established projects that primary prevention, including community-based efforts, can be effective and cost-effective at preventing chronic disease. The next step is to build on those efforts by scaling up the interventions that have demonstrated success.

Could a Larger Role for Prevention Reduce Health Disparities? Promise and Challenges

An increased focus on prevention may also be effective in reducing health disparities. Even though health outcomes are improving over time, there are still significant gaps in health disparities. Outcomes may be increasing across all groups, but not increasing fast enough among disadvantaged subgroups to erase the disparity. And, while an increased focus on increasing the use of clinical preventive services (CPS) will help, it may not be sufficient to eliminate disparities. Current measures of CPS use document similar use across races, and in some cases, higher utilization by minorities, yet the gaps in health outcomes remain. These findings suggest that clinical preventive service use is part of the answer, but not sufficient, because of the multiple, overlapping social factors behind health disparities. Community-based efforts must complement the emphasis on CPS by addressing environmental and social determinants of health. The social and physical environments in low-income populations and communities of color generally present greater risk in terms of toxic exposure, quality of housing stock, and stressors. As much as 20 percent of differential mortality seen in disadvantaged groups is associated with social and environmental factors, and social environments have the added effect of influencing personal behaviors.[3] For these reasons, finding a way to integrate community level prevention into the framework of health reform will be necessary to make progress in reducing disparities, and funding and financing these efforts may be as important as increasing awareness of these connections. Marsha Lillie-Blanton of George Washington University believes that the biggest challenge going forward is not generating new knowledge, but is coordinating the resources to implement what is already known to shape health disparities.

Blanton shares a quotation from her former colleague Jeanne Lambrew, now deputy director of the HHS Office of Health Reform: "the change we need is to put wellness ahead of sickness in allocating healthcare resources and priorities, and success, like in Homeland Security, is measured by the absence of tragedy." Blanton adds that our goal should be to reduce the need for healthcare, not just insure access when it is needed. If community-level prevention efforts can achieve the goal of reducing the need for healthcare, then that will help sustain whatever health reform strategy is passed.

One Health Plan's Approach to Community-Based Prevention

Kaiser Permanente's community-based prevention efforts are driven by the conviction that access to quality health care is critical but it is not enough, because providers don't shape health. "As a delivery system, we may see you for an hour or two a year. We don't shape your health: where you live, where you play, what you eat shapes your health" says Ray Baxter, Senior Vice President for Community Benefit at Kaiser Permanente. He adds that health choices are not simply a matter of personal responsibility: the environment shapes people's choices for healthy living. People cannot be healthy in toxic environments even with universal coverage.

The Healthy Eating Active Living (HEAL) initiative provides an important opportunity to learn which community-level interventions work, and to support replication. The Healthy Eating Active Living Convergence Partnership is a collaboration that includes the Centers for Disease Control and Prevention, Kaiser Permanente, the Nemours Foundation, the Robert Wood Johnson Foundation, the Kellogg Foundation, and the California Endowment. With the support of other partners, Kaiser Permanente has 39 HEAL sites nationwide to advance policies that improve the food and exercise environments in communities. Such efforts include giving youth the tools to document and mitigate barriers to walking to school, and promoting workplace-based farmers markets.

If health reform efforts are to include a greater emphasis on prevention, they need to build on and incorporate the lessons from community-based prevention efforts such as HEAL. This includes addressing the social determinants of health. Reform efforts need to converge across sectors, with a goal of "health in all policies" by including a public health perspective in other sectors that have important health implications, such as transportation, land use, and agriculture. Funding for community-based prevention and public health should reflect the value of these strategies in reducing healthcare costs and lowering the burden of disease. Currently, prevention only commands a small percentage of health care dollars and research budgets. To support community efforts, funding for those efforts needs to be consistent over time, sustained, and dedicated. According to Baxter, state and local entities should be able to consolidate funding streams in order to rationalize service delivery and increase flexibility and innovation.

Baxter believes that reform should support the role of health care delivery systems in promoting community health. This may include incorporating and sufficiently funding community health centers and public hospitals that support public health. Other delivery-system initiatives should support the development of health information technology and reward the provision of preventive services across all payers. Solutions should be designed with a view to simultaneously address equity, the economy, and environmental sustainability. These priorities needn't be in conflict, and can work together, as in the case of investing in public transit and parks.

Integrating Community-Based Prevention with Improved Chronic Care: One State's Approach to Systematic Reform

The Vermont Blueprint for Health is a state-wide initiative to improve the functioning of the healthcare system for Vermonters. According to Director Craig Jones, the Blueprint began as the state's vision for health reform, and has grown and evolved over the past few years. The Blueprint Communities Act of 2006 focused on community activation and community-based prevention efforts which have been primarily state-funded. The Blueprint Integrated Pilots Act of 2007 and 2008 broadened the funding base to include insurer as well as state funding, and focuses on integrating provider and community efforts to improve the care and prevention of chronic disease.

The Integrated Pilot Programs are currently up and running in two sites—Burlington and St. Johnsbury—and in the planning stages in Bennington. A key aspect of the Integrated Pilot is the integration of two sets of key players: a patient-centered medical home (PCMH) and the community care team (CCT). Jones argues that to be sustainable, delivery system reform must be tied to financial reform. To this end, the pilots include all payers: Medicaid, commercial insurers, and Medicare (the Blueprint program subsidizes the cost of Medicare beneficiaries' participation). Payment to primary care providers is based on the degree to which they meet the National Committee for Quality Assurance's standards for a patient-centered medical home. A key feature of the payment scheme is that provider payment is based on incremental changes in the NCQA score of five points, not just large payment changes in response to a large change in level. A second key financing feature is that all payers share the cost of the CCTs. The CCTs are multidisciplinary care support teams that provide local care support and population management. The teams include nurse practitioners, registered nurses, social workers, dieticians, behavior specialists, community health workers, and a Vermont Department of Health public health specialist. This combination of patient providers and a prevention specialist reconnects healthcare delivery with public health prevention. The CCTs are a shared resource that interacts with primary care providers, patients, and the community to both support patients with chronic conditions and facilitate community health planning.

Health information technology plays a key role in providing patient care, calibrating provider payment, assessing community needs, and evaluating the pilot programs. Components include a web-based clinical tracking system, visit planners and population reports, electronic prescribing, updated electronic medical records to match clinical measures with program goals, and a health information exchange network. Jones acknowledges the challenges of integrating information exchange without getting in the way of clinical care, but reports that it can be done using existing patient health data in unique ways to provide individual patient care and support, to manage and plan for the health of the community, and to effect quality improvement.

Links and Resources

HEAL Initiative at Kaiser Permanente
info.kp.org/communitybenefit/html/our_work/global/our_work_3.html

HEAL Initiative Convergance Partnership
www.convergancepartnership.org

Vermont Blueprint for Health
healthvermont.gov/blueprint.aspx

Partnership to Fight Chronic Disease
www.fightchronicdisease.org

Prevention Institute
www.preventioninstitute.org/healthdis.html

The integrated pilots emphasize community prevention and wellness efforts as well as interventions designed to improve chronic disease care. To that end, prevention specialists are members of the CCTs, and the teams conduct community profiles and risk assessments.

The infrastructure for evaluation is built into the integrated pilot model. Key evaluation tools include NCQA PCMH scores and score changes to evaluate process quality, clinical process measures, health status measures, and the multi-payer claims data base. These tools provide valuable insights into the results of the pilot efforts to improve the health of individual patients and communities, and to evaluate the sustainability of the program.

The eventual plan for the Blueprint model is to expand the programs statewide. Jones notes that the Blueprint is designed to work in different settings. The model anticipates that as Blueprint communities mature, they will add components, or expand existing ones. At the same time, experience from the Integrated Pilot program will be used to refine and target Blueprint Community grants, and build capacity and readiness for more complete healthcare reform.

About the author

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Endnotes

1 Kaiser Family Foundation and Harvard School of Public Health. The wording of the health policy priority is "Public health programs to prevent the spread of disease and improve health"; 34 percent of respondents favored increasing funding for this health policy option. Toplines: The Public's Health Care Agenda for the New President and Congress. January, 2009. Available at www.kff.org/kaiserpolls/upload/7853.pdf. Accessed on June 4, 2009.

2 Finkelstein, Eric, Ian Fiebelkorn, and Guijing Wang, 2003. National Medical Spending Attributable to Overweight and Obesity: How much, and Who's Paying? Health Affairs Web Exclusives W3-219-26.

3 McGinnis, J. Michael, Pamela Williams-Russo, and James Knickman, 2002. The Case for More Active Policy Attention to Health Promotion. Health Affairs, Vol. 21, No. 2, pp. 78-93.