Executive Summary

Prioritizing Prevention Investments

Better Health Through Informed Policy

Wisconsin Public Health & Health Policy Institute

Department of Population Health Sciences
University of Wisconsin Medical School
Suite 760, 610 Walnut Street • Madison, WI 53726-2397
Phone: (608) 263-6294 • Fax: (608) 262-6404
Prioritizing Prevention Investments

Policymakers must contend not only with limited resources and how to use them, but also with how to justify spending now in order to save money in the future. This issue brief examines this dilemma in the context of healthcare prevention.

We develop one method for using published evidence to determine which disease prevention and health promotion efforts make the best fiscal investments. Specifically, we identify the clinical preventive services for which there is evidence of both clinical and cost effectiveness. We prioritize these services by comparing them with the fifteen most costly diseases and the impact each clinical preventive service could have on those diseases. Then we compare the resulting priorities with the priorities of Healthiest Wisconsin 2010 (the state’s health goals) and prevention strategies in the area of long-term care compiled by the Department of Health and Family Services.

Finally, we explore the implications of using rankings as a way to allocate health spending and we identify policy options that public- and private-sector policymakers may want to consider.

Although we compare the list of prioritized clinical preventive services with state goals and strategies, the evidence behind our analysis and the methodology of prioritizing clinical preventive services are equally valid for private-sector policymakers.

This is a short version of a paper with the same title. The longer version explains the sources and methodology we used to determine our ranking of clinical preventive services and identifies resources available to policymakers. The long version of his paper can be obtained by writing the Wisconsin Public Health and Health Policy Institute, 610 Walnut Street, Room 760, Madison, Wisconsin 53726 or call 608-263-6924, or download at www.medsch.wisc.edu/pophealth/StateForums/.

The Top Clinical Preventive Services

Our ranking of clinical preventive services was based on services that are clinically effective, cost effective when compared with other preventive services, address the diseases that cost the most to treat, and have the ability to address the underlying factors leading to increased costs for those diseases. Using these criteria, the top five clinical preventive measures are:

- Assess adults and adolescents for tobacco use and provide tobacco cessation counseling including advice to quit.
- Screen for hypertension among all persons.
- Screen for high blood cholesterol among men aged 35-65 years and women aged 45-65 years.
- Assess physical activity patterns of all persons aged 2 and above and counsel on increasing activity levels.*

* Note: Investments in physical activity and dietary patterns are included because of their overwhelming cost impact on healthcare purchasers (the cost part of our equation). If demonstrable clinical effectiveness and classical cost-effectiveness (other parts of our equation) are valued more highly then overall economic costs to society, these investments should not be included in the list of top priorities.
• Assess dietary patterns of persons aged 2 and above and provide counseling on: intake of fat/cholesterol; caloric balance; intakes of fruits, vegetables, grains.

Comparing the Top Clinical Preventive Services with Healthiest Wisconsin 2010

*Healthiest Wisconsin 2010* is the state's compilation of health problems, goals, and methods of reaching those goals. The clinical preventive services listed above correspond to four of the eleven health priorities identified in *Healthiest Wisconsin 2010*:

- Adequate and appropriate nutrition.
- Obesity, overweight, and lack of physical activity.
- Social and economic factors that influence health.
- Tobacco use and exposure.

Comparing the Top Clinical Preventive Services with the DHFS’s Long-Term Care Priorities

The state Department of Health and Family Services asked us to compare proven clinical preventive services with the department’s long-term care priorities. These priorities have been compiled by DHFS in a document titled *Long Term Care Reform Prevention/Early Intervention Priorities* that has not been published.

Six of DHFS’s long-term care priorities correspond with the top clinical preventive services:

- Cardiovascular disease.
- Nutritional problems.
- Physical inactivity.
- Tobacco use.
- Chronic lung disease.
- Diabetes.
The Policy Implications of Prioritizing Clinical Preventive Services

Having identified priority clinical preventive services, we issue a caveat to policymakers: the policy implications of prioritizing clinical preventive services and basing spending decisions on those priorities are numerous. This is especially true in a budget-neutral context where additional money will not be allocated, but funding may be shifted from other areas to the priorities determined by policymakers.

Several broad issues of concern to policymakers are implicated by the prioritizing of clinical preventive services. These include:

1. The desire of healthcare purchasers to constrain rising costs.
2. The possibility of implementing, in the present, preventive measures that will delay the need for, and reduce the expenditures that result from, long-term care in the future.
3. The desire of healthcare purchasers to purchase the highest quality care for the most competitive price, using both quality and price as factors instead of only one.
4. The existence of unbiased, nonpartisan, scientifically based information and the extent to which such information will be used by policymakers and, conversely, the extent to which other factors will play a role in decision making.

These policy implications can be framed as a set of questions and answers.

**Question 1** — What are the policy implications of constraining overall health care costs, since constraint will almost surely mean that some people will receive more clinically effective and cost-effective services through their current coverage and others will find themselves paying for or doing without services that were once covered either by government or employer health plans?

**Answer 1** — The group receiving more services may save money for: 1) themselves; 2) government and employer buyers of healthcare; and 3) society, whose taxes pay for government-sponsored programs. The group for whom services were cut will either pay more or go without some services. Arguably, many services appear medically unnecessary, at least to purchasers, and might be healthfully avoided. Nevertheless, for this group, either paying more or going without may result in a shift in users to government assistance programs such as high risk pools or Medicaid. If these programs do not also use similar methods to constrain costs, the net result may not be a savings in healthcare costs but only a shift of those costs to different payers.
Q2 — What are the policy implications of spending money now on preventive clinical services whose payoff, in terms of cost savings, may be many years away?

A2 — This issue reflects an ongoing concern, particularly among private-sector purchasers (employers). From the perspective of an employer, this concern can be stated thus: why should I, as an employer, invest in health prevention when the odds are great that some other employer (a competitor, perhaps) or the government will reap the rewards of those health prevention investments? This concern will only be allayed if all employers expect to contribute to prevention at a level comparable to their peers and the government. It is unlikely this will occur in the absence of action by the government, which can either provide a minimal set of preventive services or use some combination of mandates and incentives so that every employer provides these services.

It is worth noting that some current funding for prevention services may be “wasted” since a percentage of the population will die from non-related causes before they reach an age where long-term care becomes a factor.

Q3 — What are the policy implications of purchasing preventive health services: 1) regardless of cost or quality (i.e., paying whatever is charged); 2) based on cost considerations alone; or 3) based on value — using both cost and quality considerations?

A3 — Alternative one has resulted in a national consensus among those who pay (in both the public and private sectors), that our healthcare costs and their rates of increase are unacceptable. Research over the past 20 years has shown that method two results in lower immediate costs, but that uncontrolled quality issues can greatly increase both near- and far-term expenses. For purchasers to make effective value-based decisions (method 3) they must have objective measures of the healthcare services they are purchasing, which they can use to make and prioritize spending decisions. Within the context of this issue brief, those measures are clinically proven benefit, cost effectiveness, costliness to society of the diseases impacted and related determinants of costliness that seem most policy sensitive.

Q4 — Given budget-neutral assumptions, what is the impact of shifting resources from current programs and services to those that we highlight as priorities? More specifically, assuming that budgeted outlays for purchasing preventive health services do not change, what are the implications of shifting money from current prevention efforts, established through many different priorities, to different prevention services based on measures of effectiveness, efficiency or economic costs?
A4 — Withdrawing funding from one prevention program or service (for example, where there is currently a low prevalence or incidence of a problem, low costs in terms of illness or early death, or a lack of clinically proven effectiveness) may allow the diseases associated with the program or service to once again flourish. In its simplest terms, a change in funding priorities may result in a boomerang effect. (This answer assumes that at one time the prevention program or service was put in place because the associated disease was a problem because of a high incidence, prevalence, or cost.)

A4b — If prevention programs or services were in place as a result of factors other than incidence, prevalence or costs (e.g., political, commercial or societal pressures) then policymakers should expect similar pressures if funding is withdrawn from the programs or services.

Q5 — What are the economic policy implications of shifting state spending priorities?

A5 — Given the assumptions upon which the priorities in this paper were developed, the long term effects might logically include:

- Delays, particularly in the under 50 population, in the need for long-term care services.
- Reductions, in the same populations, in the lifetime healthcare expenditures incurred once long-term care services are engaged.
- Reductions across the population in lifetime healthcare expenditures, through decreases in illness, mortality and level of illness experienced by populations at risk for the diseases associated with the newly prioritized clinical preventive services.

A5b — If funding for low value preventive services is reduced, increased funding could become available for higher value services or for expanding the range of preventive services about which we possess strong value evidence.

A5c — If the methods and assumptions in this issue brief prove useful and effective for the state of Wisconsin, private health purchasers might follow suit by increasing investments in preventive services.
Q6 — What are the policy implications of focusing attention and resource allocation efforts on clinical preventive services and costs rather than on classical public health services such as education and surveillance?

A6 — This question brings up long standing philosophical and practical questions, particularly in areas such as teaching / education, about “if” and “how” we should measure and evaluate the effect of our actions. If we advocate prevention services, how long do we wait, and what measures do we use, to declare the success, or failure, of that advocacy; and how do we separate often complex causes and outcomes? Further, there is no reason that some preventive services (e.g., smoking or nutritional evaluations, warnings and assistance) must occur in a clinical setting. They could just as easily take place in a community setting and perhaps the same questions about efficiency, effectiveness, and costs should be addressed for non-clinical efforts and settings. There is very little research to inform questions such as, “what preventive services are most cost-effectively supplied by public health servants versus medical clinical personnel?” And there is virtually no research comparing a wide variety of policy options such as hiring lay people to work in community settings, providing direct economic incentives or disincentives to individuals, directly paying medical personnel in clinic settings, suing or taxing the commercial interests that contribute to the problems, or buying media ads teaching people how to be healthier and live better lives.
Options for policymakers

Should policymakers decide to prioritize clinical preventive services and make spending decisions based on those priorities, the following courses of action are available for policymakers.

Options for Implementing Clinical Preventive Service Priorities in the Long-Term Care System

If the Legislature and DHFS decide to follow the priorities identified in this paper, the detailed information provided by the U.S. Preventive Services Task Force, together with the department’s own information on the implementation of clinical preventive services, should provide ample basis for the practical work needed to implement these services.

Options for Public- and Private-Sector Healthcare Purchasers

For purchasers of healthcare services, including employers and public sector payers, the priorities identified in this issue brief and the evolving recommendations of the U.S. Preventive Services Task Force can guide efforts regarding preventive care.

The Partnership for Prevention and the National Institute for Health Care Management Foundation make the following recommendations:\(^2,3\):

- Provide financial incentives for health plans to improve delivery rates.
- Eliminate or reduce co-payments on a core set of evidence-based preventive care services.
- Provide incentives for employees to receive these services.
- Measure delivery of these services to hold health plans accountable.
- Reward providers who exhibit strong performance on standardized measures for the delivery of preventive care services.
- Pay physicians for the time they spend counseling patients about lifestyle changes.
- Subsidize the cost of office-based software that helps physicians track the delivery of preventive care services, generate reminder notices, and the like.
- Promote collaboration among competing health plans.

Options for Health Plans and Plan Administrators

The Partnership for Prevention makes the following recommendations for health plans and healthcare administrators:\(^4\):

- Cover high-priority services with minimal or no co-payments.
- Measure the delivery of these services to hold providers accountable.
- Support delivery of these services.
• Provide financial incentives for medical group performance on these services.

• Facilitate collaborative efforts among medical groups to improve delivery rates.

In Wisconsin, efforts along many of these lines have already begun. Healthcare providers and purchasers collaborate on ways of improving and paying for quality healthcare. A successful statewide effort to track and improve diabetes and cardiovascular care is another example of public-private partnerships underway in Wisconsin. The groundwork laid in these efforts could be adapted to take into account the thinking on preventive services presented in this issue brief.

Summary

Building on the best information available we have ranked clinical preventive actions that, relatively, have the most clinical benefit, are most cost effective, impact the disease states that are most costly to healthcare purchasers, and address the factors causing increased costs in treating the most expensive disease states.

We have used one method in this paper to suggest which clinical preventive services could be prioritized by both public- and private-sector policymakers in Wisconsin. Our findings, and the method used to reach them, are meant to guide public, private and individual decision-makers as they determine how and where to commit resources and to spur further discussions between policymakers and researchers about how to improve the body of evidence available to policymakers.
Endnotes

1 We note that no recommendation from the U.S. Preventive Services Task Force corresponds with Healthiest Wisconsin 2010’s priority of mental health and mental disorders. However, the cost of these diseases is such that even without a proven clinical preventive service this priority ranked as highly as those listed above (see Table 5 in the full report - available at www.medsch.wisc.edu/pophealth/StateForums/). In addition, the Task Force on Community Preventive Services is expected to issue recommendations for the treatment of depression in the near future. In light of the high cost and evolving evidence regarding treatment of depression and other mental health disorders, policymakers may want to continue to watch for developments in this area.


5 See, for example, the work of the Wisconsin Collaborative for Healthcare Quality. http://wchq.org/.