PREVENTION – HOW MUCH BANG FOR THE BUCK?

DR LESLEY RUSSELL
MENZIES CENTRE FOR HEALTH POLICY

7 OCTOBER 2009

INTRODUCTION

It may be surprising to some that there are many common issues driving health care reform in both Australia and the US (and indeed in other developed countries).

While we so often look at the current situation in health care in the US as a keen example of how not to do things, in terms of future directions we can no longer dismiss the US approach.

This is especially true for prevention and public health issues which are the focus of tonight's seminar.

SLIDE

There is much that I could talk about and very little time in which to do it, so I will give you a quick run through of what the prevention initiatives are in the health care reform bills currently under consideration, how cost and cost-effectiveness issues are playing out in this context, and throw out some of the prevention issues that I see as common between the two countries.

Hopefully my fellow speakers will pick up on these and carry some of them forward.

My focus is on primary and secondary prevention and public health, but there is some straying into the realm of tertiary prevention.

SLIDE

What the bills all have in common.

Health insurance reform will mean that for the first time it will be illegal to discriminate or refuse cover to people on the basis of pre-existing conditions.

It will also be illegal to rescind cover if people get sick and start to use their health insurance.

The bills do allow premium ratings on the basis of age and geographic location and the Senate Finance Committee bill allows increased premiums for smokers if tobacco cessation programs are also offered.

The bills all ban out-of-pocket costs and deductibles for approved preventive health services, regardless of whether these are provided by public or private insurance.

Children in lower income families which will receive subsidies to purchase health cover in the private market (hopefully one that has a public health option) will be protected by the requirement that these policies must offer the same Early Periodic Screening, Diagnosis and Treatment services that are currently offered under Medicaid and CHIP (the Children's Health Insurance Program). These services include screening and treatment for dental, eyesight and hearing and behavioural problems.

There are incentives to encourage more health care professionals to go into primary care, especially in under-served areas, to have people linked into medical homes, and to have their care coordinated through Accountable Care Organizations.

Studies from the Commonwealth Fund show that people with a medical home are considerably more likely to get preventive care services, regardless of their race and ethnicity. So this is also an effective way to address health care disparities, especially as these apply to prevention.

The nurse home visiting program for mothers and babies in at-risk families, which OATSIH is piloting here in Indigenous communities, is also expanded in all the bills.

And there is funding for some large scale demonstration programs to reduce preventable hospital readmissions and to bundle reimbursements to ensure that acute care patients get all the post-acute services they require.

There are three bills currently out there – two in the Senate which must be combined to go to the Senate floor and a tri-committee bill which will change only marginally before it goes to the House floor. The two bills must then be conferenced to produce some sort of final compromise that will be passed by both the House and the Senate.

In its approach to health care reform generally, and prevention and public health in particular, the House bill should probably be viewed as the ceiling and the Senate Finance Committee bill as the floor with respect to the negotiations that lie ahead.

SLIDE

The House bill and the Senate Health, Education, Labor and Pensions Committee bill both put some real money on the table for prevention and related issues.

There is $89 billion / 10 years in the House bill. The main focus is on building the needed infrastructure and workforce for prevention and public health. (The equivalent funding in Australian terms would be around $680 million / year over a decade)

$38 billion of this goes to Community Health Centers.

$35 billion goes to a new Prevention and Wellness Trust.

$11 billion is for the needed workforce investment, including a new Public Health Workforce Corps and an Advisory Committee on health workforce needs.

The Senate HELP Committee has $80 billion / 10 years. But in contrast to the House bill, it funds a grab-bag of everybody's favourite prevention initiatives.

It does recognise the whole of government approach that is needed to tackle prevention by requiring the President to establish a National Prevention, Health Promotion and Public Health Council – which will have a huge membership drawn from every possible government agency and more. It remains to be seen how effective such a behemoth can be.

But take you pick – healthy lifestyle programs in the workplace, breast feeding, nutrition labelling, social marketing campaigns – they are all here.

SLIDE

And there's more.

It's hard to object to any of these programs in isolation, but I fear that their lack of cohesiveness will put them all at risk if the Senate is keen to cut back the cost of the final bill.

This is particularly so because the Senate Finance Committee bill manages to almost completely ignore preventive health outside of the issues we have previously discussed.

SLIDE

There is support for some healthy lifestyle programs in Medicare, Medicaid and the private sector, but little else. And while funding of $100 million / 5 years looks like a lot, that doesn't go far when spread among 40 million Medicare beneficiaries and perhaps as many as 60 million people who will be on Medicaid.

SLIDE

There is little in any of these bills to address mental health, dental health, vision and hearing – the same areas always seem to miss out. There is also little on e-health, but that's because most of this has already been agreed to and funded though the economic stimulus package passed earlier this year.

SLIDE

President Obama has had prevention as a key pillar in his proposed health care reforms since his election campaign, and has often spoken out about it.

He has been criticised by some conservative commentators and academics for exaggerating the impact that better prevention might have on health care costs, and it appears that his claim that if the US went back to the obesity rates of the 1980s Medicare would save $1 trillion was an exaggeration. Still, obesity does cost the health care system something like $147 billion a year. That's real money, even in American terms.

SLIDE

The Democrats in Congress, especially those who support greater efforts in prevention, have been frustrated because the independent Congressional Budget Office has refused to assign savings to any of these provisions in the bills.

Obviously successful preventive care can make Americans healthier and save lives. But, as the CBO wrote in this letter to the Congress, the bean counters believe that it will not save money.

However there are other points of view. For example, a recent paper from my colleagues at George Washington University showed that the House bill's investment in community health centers, which furnish comprehensive primary health care access to residents of medically underserved communities will have an important impact on costs, even as it expands access. The $38.8 billion expenditure could result in overall health care savings of $212 billion over the 2010 to 2019 time period, including federal Medicaid savings of $59 billion.

Does prevention save money? Well that's the key question for tonight's seminar. The answer hinges on what sort of prevention programs we are talking about, and the population groups to which they are targeted. And given the outrageous cost of American health care, the answers may be different for Australia and the US.

SLIDE

As an example, a recent American study looked at the cost of caring for people with type-2 diabetes as they progressed from diagnosis to various complications and death. It found that enrolling federally-insured patients in a simple but aggressive program to control the disease once diagnosed would cost the government $1,024 per person per year. This money would be recovered after 25 years through lower spending on dialysis, kidney transplants, amputations and other treatments.

However the problem is that with that timeframe, these additional services would add to the overall health spending, not decrease it for all but the youngest diabetics.

Still, as you can see from this bar graph, it's not as expensive as it looks and if the other social costs were considered, such a program is almost certainly justified.

SLIDE

Perhaps the question as to whether prevention saves money misses the point. Arguably what should matter is whether prevention services provide value for the money spent.

Steven Woolf argues that we should look beyond cost-effectiveness to good economic value.

I should point out that Woolf does make these assertions on the basis of 'well-defined' preventive services that are recognised as effective and delivered in a targeted fashion.

SLIDE

In the US, among the core set of preventive services that offer high economic value, there is a subset (smoking, children's immunisation programs) that yields net savings.

And among the 25 strongly recommended preventive services examined in 2006 by the National Commission on Preventive Priorities, 10 cost less than $14,000 per QALY.

One problem in the US is that there are major health disparities between the racial and ethnic groups, and this shows up particularly in terms of access to preventive health services. In part this is because African Americans and Hispanics are less likely to have a regular doctor or a medical home.

Closing the gap in the use of just five preventative services – use of aspirin, smoking, colorectal cancer screening, annual flu vaccinations, and breast cancer screening – would save more than 100,000 lives each year.

[SLIDES]

As a summary, I'd like to highlight some of the issues of commonality and difference between Australia and the US.

Currently spending on prevention is both countries is very low – around 2% of the total health budget. In the US there is is significant new money on the table, which will hopefully survive into the bill that the President signs into law.

The US already has the Centers for Disease Control and Prevention and the US Preventive Services Task Force at the Agency for Healthcare Research and Quality to drive forward work in prevention and health promotion. Whether or not it will also get a national coordinating agency remains to be seen.

The US also has in use a national preventive health strategy – a document called Healthy People 2010 which is currently being updated for the next decade.

Like Australia, there is some confusion about whether prevention is a public health or a clinical activity but at least the US has set up taskforces in both areas, and does not seemed destined to having prevention seen solely as a health care activity delivered in a medical environment.

The US has barely begun the huge issue of tackling obesity. However there are some very real opportunities to reform national eating habits offered by the large involvement of the federal and state governments in programs such as food stamps, school lunch programs and the Women, Infants and Children program for mothers and children up to five at nutritional risk.

The US is looking to use success in anti-smoking programs, admittedly a long-time coming, as a model for other actions. Alcohol doesn't get much attention, but there's considerable talk about sin taxes for sugary and fatty foods and soda pop.

SLIDE

The Senate Finance Committee has considered a soda tax as one of the options to pay for its bill. The Congressional Budget Office estimates that adding a tax of 3 cents per 12 oz can would generate $24 billion over the next 4 years. At least a dozen states already have some type of taxes on sugary beverages.

SLIDE BACK

Assuming the House provisions are carried forward, the US looks ready to make substantial new investments in the prevention and public health workforces, and will also train primary care doctors to deliver preventive services.

Whether or not these new workforces will ensure that those most in need get better access to preventive health services remains to be seen. However removing the out-of-pocket costs will also remove a major barrier to access.

As in Australia, the US federal government must also link into and effectively harness the roles of the other health care funders – the states, the private insurers and business. In particular, the US is well ahead of Australia in terms of how business and health insurers see the importance of these preventive health efforts, even if the main driver is the protection of their financial bottom lines.

SLIDE

My concluding thoughts: President Obama is showing real leadership in health care reform and in preventive health. He's taking bold bites of his hamburger and making a meal of it.

In contrast, my assessment is that Prime Minister Rudd has nibbled at the pie crust and put it aside. Presumably he's waiting for the sauce bottle to show up to add some flavour and increase his appetite for action?