

Prevention and National Health Reform

By Steven Jonas, MD, MPH

Introduction

The *Patient Protection and Affordable Care Act* (P.L. 111-148), passed by the 111th Congress and signed into law by President Obama on March 23, 2010, and the *Health Care and Education Reconciliation Act of 2010* (P.L. 111-152), signed into law on March 30, 2010, are commonly referred to as “national health care reform.” From the perspective of someone who has spent 40-plus years in the field of health policy analysis and created the first textbook on the U.S. health care delivery system (1) in the 1970s, what was passed reads more like national health insurance reform than national health care reform. It does, however, represent a major step forward for a nation that still is the only developed country in the world without a comprehensive national health care system. It also represents a major step forward for a nation in which every attempt at creating some form of national health insurance system since Teddy Roosevelt first put it on the national political agenda in the presidential election of 1912 has met with defeat. But the subject of this column is neither the Acts, and what they might do to the U.S. health care system in general, nor the politics of national health insurance. Rather it is about how they might affect preventive health services, including those concerned with promoting healthful activities like regular exercise.

According to an article in *The New York Times* specifically focused on those initiatives (2): “Congress with little fanfare approved a set of wide-ranging public initiatives to prevent disease and encourage healthy behavior. The initiatives provide a big dose of prevention in an effort to counter the powerful forces that encourage people to engage in sedentary lifestyles, to smoke, and to eat fatty foods. The emphasis on disease prevention comes nine months after President Obama signed a law that gave sweeping author-

ity to the Food and Drug Administration to regulate tobacco products. . . . [For example,] [u]nder the law, chain restaurants [with 20 or more locations] will have to provide nutrition information on their menus. Employers must provide “reasonable break time” for nursing mothers. Health insurance companies will soon have to cover all recommended screenings, preventive care, and vaccines without charging co-payments or deductibles. Medicare beneficiaries will get free annual physicals. Medicaid will cover drugs and counseling to help pregnant women stop smoking. And a new federal trust fund will pay for more bicycle paths, playgrounds, sidewalks, and hiking trails. Under the law, insurers must provide coverage for all services recommended by an independent panel of experts (the United States Preventive Services Task Force) and cannot impose ‘any cost-sharing requirements.’”

For those of us who work in prevention, these provisions (and the significant amounts of money placed behind them) represent some major steps forward. In this column, I want to mention some concerns that will have to be dealt with if the money is to be well-spent. Let us begin with a review of some definitions.

Primary, Secondary, and Tertiary Prevention

“Prevention” comes in three flavors: primary, secondary, and tertiary. Primary prevention is stopping the development of disease or states of ill-health before they start. It includes measures ranging from childhood immunization to smoking prevention programs for current non-smokers to the promotion of regular exercise for the reduction of risk for a whole range of diseases and states of ill-health. Secondary prevention is the detection of existing disease before it becomes clinically apparent (more on that one later). Tertiary prevention is the comprehensive management of clinically apparent disease, such as diabetes, to diminish the risk of the development of the known complications of it. I will leave any detailed treatment of the latter until

another time. In the realm of primary prevention, the “personal health promotion” aspects of it, like the promotion of regular exercise or weight loss, already receive a great deal of attention, in both the professional and the lay realms.

That attention is usually focused on the provision of what to do in terms of an exercise or weight loss program and/or in terms of “why do it” in terms of its health benefits. But if that is all that were needed, our population should be composed of totally fit people of normal weight. They are bombarded every day, especially in the mass media, with information in both of those realms. So that isn’t it. Missing is the piece about “why do it for yourself, now.” Missing is information on and help with mobilizing one’s motivation in order to make health promoting behavior change. If new programs, funded under the Acts, fail to do this, for the most part the money will be wasted.

Screening

In the minds of significant sectors of the general public and, it appears, their elected representatives as well, “prevention equals screening.” Since both primary and tertiary prevention also exist, it is obvious that this statement simply isn’t true. So there is significant education to be done on that score. Furthermore, there are several considerations about screening *per se* if it is to be both effective and cost-effective (3). First, for each screening intervention is there an effective treatment available? Second, does early detection of a given disease coupled with effective treatment mean that the patient’s life and well-being have truly been extended? Third, are there one or more effective treatment/management regimens available? Fourth, can early detection lead to harmful outcomes (and this one is a current hot topic in the management of prostate cancer)? Fifth, whose recommendations are to be followed and why? The latter are not simply scientific/medical questions but also political ones, as the recent controversy over the recommendations on breast cancer screening of the U.S. Task Force on Preventive Services showed clearly.

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Training Health Care Providers

While there certainly is training in both secondary and tertiary prevention, health care professionals currently receive very little, if any, training in the health promotion components of primary prevention. To my knowledge, for example, most medical schools do not teach their students anything about regular exercise and how to help patients become regular exercisers. There is an increasing amount of attention to nutrition science, certainly laudable, but to my knowledge little on which interventions are effective for weight loss. I think that similar concerns apply across-the-board in health sciences education. As for continuing education, the challenge is even more daunting. There is targeted money in the Acts for training residents in the preventive medicine specialty (which happens to be mine). But unless I missed something—the bills are very long—the more general health sciences education concerns are not addressed.

Paying for Prevention Effectively

Finally, there is the matter of paying for prevention effectively. There are two primary influences on physician behavior: how they are trained and how they are paid. Of course, the active, enthusiastic, knowledgeable participation of physicians in the endeavor is essential if prevention is to become a regular feature of clinical medicine. We have already dealt with the education issue briefly. As far as payment is concerned, focusing just on the physicians, can fee-for-service do the trick? Much of primary prevention regarding patient behavior change is “talk-therapy” and health insurance companies already have major reservations about paying for such services. How can they know if what has been billed for has actually been delivered? Furthermore, the provision of health promotion services like exercise prescription (4) takes time, time that many physicians don’t have (if required to provide the whole educational experience themselves). Apart from the “who-should-do-this” ques-

tion, there is the one of how they would be paid. Presumably by salary, but who would administer the services and how would they be budgeted? Unfortunately, most hospitals and many physicians know little about how to effectively deliver primary preventive services; this would also need to be addressed.

It is laudable that the new health care reform legislation includes some real money in support of prevention. Just how that money will be spent is a matter of some importance.

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