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Public Health Provisions in the Patient Protection and Affordable Care Act (PPACA)

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Live sensibly - among a thousand people, only one dies a natural death, the rest succumb to irrational modes of living.

Maimonides, 12th Century Jewish physician

Same as it ever was.

Talking Heads, 1980

Overview

- **What is disease prevention?**
- **Overview of prevention and wellness provisions in the health reform law**
  - PPACA, P.L. 111-148 as amended
- **Description of selected community-based prevention provisions**
- **Three questions regarding implementation**
  - Infrastructure
  - Accountability
  - Cost

The Prevention Continuum

	Absence of disease or of risk factors →	Asymptomatic disease, or presence of risk factors →	Symptomatic disease
	PRIMARY PREVENTION Community-based prevention	**SECONDARY PREVENTION** Clinical preventive services	**TERTIARY PREVENTION** Disease treatment
Influenza	Immunization	Antiviral drugs	Respiratory therapy
Breast Cancer	*Causation not well understood*	Screening mammography	Chemo- and radiation therapy
Smoking-related illnesses	Tobacco taxes, smoke-free laws	Reimbursement for smoking cessation	Treatment for cancer, care of premature infant, etc.

Prevention and Wellness: Overview

Aims to improve the health of the population.

May address growing health burdens and costs associated with chronic diseases or "modifiable risk factors" such as tobacco use or sedentary lifestyle.

Federal task forces evaluate the effectiveness of clinical and community-based prevention interventions.

Whether prevention can control costs or save money depends on the intervention and the analytic approach.

- Most clinical preventive services yield a net *cost* for *payers*. (CBO scored Medicare and Medicaid expansions in the health reform law accordingly.)
- Lack of consensus on how to value community preventive services.

PPACA: Approaches to Prevention and Wellness

Clinical preventive services

Expands required coverage under Medicare, Medicaid, and private insurance.

Employer-based wellness programs

Provides for employer incentives and implementation grants, among other things.

Workforce

Authorizes several new training and placement programs for public health workers.

Community-based prevention activities

New authorities (including grant-making), appropriations, and mandates. The focus of today's forum.

Community-Based Prevention Activities: Strategic Planning and Funding

Strategic planning

- *National Prevention, Health Promotion and Public Health Council*.
  - Established by Executive Order on June 10, 2010.
  - Provides federal leadership.
  - Develops national strategy and measurable goals.

Appropriations

- *Prevention and Public Health Fund*, a permanent appropriation ($15 billion over ten years),
  - "...for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs."
- Also funds CHIPRA childhood obesity demonstration and other prevention programs.

Prevention and Public Health Fund: Allocation of FY2010 Funds ($500 million)

Allocations announced last week (See handouts.)

$250 million to bolster the primary care workforce

$250 million for prevention and wellness activities

- Community-based programs to address tobacco use, obesity, and HIV-related health disparities. ($106 million)
- Primary care and behavioral health integration. ($20 million)
- Public health infrastructure improvements for control of infectious and chronic diseases. ($70 million)
- Information gathering to aid strategic planning. ($21 million)
- Funding for evidence review task forces. ($10 million)
- Public health workforce expansions. ($23 million)

Community-Based Prevention Activities: Grant-making

New grant-making authorities

- Community prevention pilots for 55-64 year-olds.
- Individualized wellness plan pilots at community health centers.
- Evaluation of community disease prevention and management programs for Medicare beneficiaries.
- Many others.

A new grant-making approach

- Focus on common *modifiable risk factors* (e.g., smoking, inactivity) rather than on specific diseases (e.g., heart disease or cancer).
- Example: Community Transformation Grants to address "policy, environmental, programmatic, and infrastructure changes needed to promote healthy living and reduce health disparities."

Community-Based Prevention Activities: New Regulatory and Revenue Authorities

Examples:

Restaurant menu / vending machine labeling

- Chains of 20 or more locations must display calorie content for all standard items.
- Some evidence of effectiveness in changing behavior, limited evidence of effectiveness for weight loss.

Break time for nursing mothers

- Employers must provide break time (may be unpaid) and private location to express breast milk.

Accessible medical diagnostic equipment

- Requires standards for accessibility of such equipment by persons with disabilities.

Tax (10%) on indoor tanning services

QUESTION:
What Constitutes Basic Infrastructure for Chronic Disease Prevention?

Infectious disease prevention and control

Trend over past two decades away from “categorical” funding (i.e., one disease at a time), toward defining and funding flexible core capacities: surveillance and laboratory infrastructure, core workforce capabilities, etc.

More responsive, e.g., adapts to SARS, pandemic flu.

Chronic disease prevention and control

What are the core capacities for a flexible, responsive national infrastructure for chronic disease prevention, in terms of:

- Information collection and management?
- Workforce competencies?
- Funding?
- Other?

QUESTION:
How Is Accountability Assured for Risk-Factor Based (vs. Outcomes Based) Prevention Funding?

Evidence of the relationship of a risk factor to a health outcome is more clear for some things (e.g., smoking) than for others (e.g., playgrounds).

The evidence review process is limited to available studies, and is inherently conservative.

What should be measured to determine if funding is "working"? Rates of smoking? Body mass index?

Is it easier to measure risk factors than to measure outcomes?

How should programs be conducted when evidence linking the risk factor to the outcome is unclear?

QUESTION:
What is the Federal Government's Role in Evaluating Costs and Savings from Prevention?

U.S. Preventive Services Task Force is authorized to consider cost-effectiveness, is developing an approach.

Task Force on Community Preventive Services considers cost-effectiveness evidence when available.

CBO typically limits its analysis to effects on federal programs.

A comprehensive review of this question is not among the mandated activities of the National Prevention, Health Promotion and Public Health Council.

Where should federal leadership on this matter reside?

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