

Is Preventive Care Really the Answer?

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I. INTRODUCTION

The utilization of preventive care services is a key component of the health care reform legislation and is persistently at the forefront of discussions regarding the need to improve public health in our country. On March 23, 2010 President Obama signed into law the Patient Protection and Affordable Care Act (PPACA).¹ The enactment of PPACA takes a two-pronged approach to improving the utilization of preventive health care. First, the act establishes new requirements for insurance plans intended to compel increased coverage of preventive services, requiring all new plans to cover a variety of preventive services. Second, the act establishes two new task forces, the U.S. Preventive Services Task Force and the Community Preventive Services Task Force, designed to both execute and regulate such preventive services and to measure their effectiveness.² More specifically, these two task forces were charged with overseeing PPACA's preventive health care efforts, each with the duty of reviewing the effectiveness of certain clinical or population-based preventive services.³

Theoretically, providing preventive services to the public appears to be the most cost-efficient approach to health care.⁴ Taken at face value, the availability of preventive care, ranging from required annual screenings to free immunizations, appears to be not only the best answer for the health of Americans, but also the most cost-efficient. However, this article examines whether, speaking strictly in monetary terms, preventive medicine really is the best answer to cut costs and decrease overall health care spending. This

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1. Patient Protection and Affordable Care Act ("PPACA"), Pub. L. No. 111-148, 124 Stat. § 4003 (2010).

2. *Id.*

3. *Id.*

4. Louise B. Russell et al., *Prevention's Potential for Slowing the Growth of Medical Spending*, NAT'L COAL. ON HEALTH CARE 1 (2007).

article will first discuss how preventive care services are analyzed from a cost perspective. It will analyze several studies and methods used, and demonstrate the difficulty in accurately tracking preventive care savings. Next, the article will address whether actual preventive care savings will meet the cost projections laid out in the PPACA. Finally, it will conclude that preventive care services may not solve the cost problem in healthcare.

II. PREVENTIVE CARE: COST EFFICIENCY

At the most basic level, diagnosing conditions at a time when acute treatment is most effective should reduce long-term costs.⁵ For example, it seems more cost-efficient to provide annual pap smear screenings for young women than to pay hundreds of thousands of dollars once a woman is diagnosed with Stage IV cervical cancer. With examples like this in mind, it is easy to see why preventive medicine may appear to be the most reasonable and logical decision. However, accurately measuring the cost efficiency of care is usually not that simple.

A. Costs and Savings: More Than Just Dollars and Cents

Analyzing the overall effect of preventive services on the population as a way to demonstrate its prospective savings versus its upfront costs is, at best, difficult, and at worst, a shot in the dark.⁶ This can become problematic in determining whether this type of care is actually more cost-efficient than other alternatives, such as treating the disease or condition once it has developed. For example, most studies do not compare costs and savings exclusively in a financial sense.⁷ Results of preventive services are often provided as part of a broader evaluation of health outcomes.⁸ Therefore, it can be difficult to identify measures that accurately determine whether preventive intervention actually results in net savings. In fact, one study of childhood vaccinations presented its results as a ratio of dollars saved to dollars spent. The study estimated the utility of the parents' time when their children did not develop the illness that the vaccination intended

5. *Id.*

6. *Id.* at 2.

7. *Id.* at 2.

8. *Id.*

to prevent and valued that time at the wage rate.⁹ Additionally, it considered the children's future earnings as part of the calculation.¹⁰ The medical costs were then compared with the sum of (1) the medical savings and (2) the savings in parents' time and children's future earnings, which resulted in a conclusion that the vaccination saved money.¹¹ Another illustration of the difficulty in deciphering between the financial benefit and a broader evaluation of health outcomes is evident in the widely used, and varying defined, concept of "cost-effectiveness."¹² The Tufts-New England Medical Center Cost-Effectiveness Analysis Registry (CEA Registry) is a comprehensive database of cost-utility analyses and contains detailed extracted information on a wide variety of published cost-effectiveness studies over a period of time.¹³ Cost-effectiveness in these studies is measured by quality-adjusted life-years (QALYs).¹⁴ QALYs are the quantified result of incremental costs, divided by the incremental health benefits of a specific medical treatment or 'intervention'.¹⁵ In this context, an intervention is considered cost-effective if QALYs can be accumulated inexpensively, and further, an intervention is labeled 'cost-saving' if it reduces costs while improving health.¹⁶ The CEA Registry expands the definition of 'cost' in its analysis of an intervention's cost-effectiveness to include more than just money saved.¹⁷ Therefore, studies concluding that a certain preventive health measure is cost-effective can be misleading.

While not all preventive measures save money, they may still be considered a worthwhile investment because they result in substantial health benefits relative to their cost.¹⁸ In contrast, however, some preventive measures are expensive even in relation to their health benefits.¹⁹ In general, determining the positive or negative value of a preventive measure depends on various factors.²⁰ These factors include target population

9. *Id.*

10. *Id.*

11. *Id.*

12. Joshua T. Cohen et al., *Does Preventive Care Save Money? Health Economics and the Presidential Candidates*, 358 *NEW. ENG. J. MED.* 661, 661-62 (2008).

13. *Id.* at 662.

14. *Id.*

15. *Id.*

16. *Id.*

17. Cohen et al., *supra* note **Error! Bookmark not defined.**, at 662.

18. *Id.*

19. *Id.*

20. *Id.*

and efficiency screening. For example, the population targeted in a study is often a key determinative in the effect of certain preventive measures, with high-risk populations typically resulting in greatest cost-efficiency. Additionally, more frequent screening results in greater health benefits, but less overall efficiency.²¹ In response to skepticism of the predicted health care savings of preventive care, the communications director for the White House, Linda Douglass, stated that in order to work, prevention must be the main target for populations that need it and that the White House will continue to do what it can to ensure that resources are spent on preventive services that will give U.S. citizens “the biggest bang for their buck.”²² She also emphasized, however, the significance of preventive health care benefits that cannot be measured monetarily. She stressed that preventive care creates longer and healthier lives, “yielding savings that don’t typically show up on a score sheet.”²³ The White House’s argument boils down to a simple theory — that reducing medical visits to the hospital or physician office in the long-term through utilization of less expensive preventive care will save money.²⁴ Taken at face value, this theory sounds like the logical choice for attacking the health care crisis in this country, but it may not be that simple.

III. CAN PREVENTIVE MEDICINE LIVE UP TO OUR EXPECTATIONS?

It may be nearly impossible to deny the positive effects associated with greater implementation of preventive services on public health in the U.S. However, some experts are skeptical of its largely theoretical cost cutting projections.²⁵ Among these critics is Douglas W. Elmendorf, the Director of the Congressional Budget Office (CBO), the nonpartisan federal agency mandated to provide Congress with objective analyses of proposed government-funded programs.²⁶ Acting as the official arbitrator of the cost of

21. *Id.*

22. *Congressional Budget Expert Says Preventive Care Will Raise – Not Cut – Costs*, ABCNEWS.COM (August 9, 2009, 9:27 AM), <http://blogs.abcnews.com/politicalpunch/2009/08/congressional-budget-expert-says-preventive-care-will-raise-not-cut-costs.html><http://blogs.abcnews.com/politicalpunch/2009/08/congressional-budget-expert-says-preventive-care-will-raise-not-cut-costs.html>.

23. *Id.*

24. *Id.*

25. Letter to Subcommittee on Health Committee on Energy and Commerce in the United States House of Representatives by Douglas W. Elmendorf (Aug. 7, 2009), <http://www.cbo.gov/ftpdocs/104xx/doc10492/08-07-Prevention.pdf>

26. *Id.*

legislation, the CBO has found that increased utilization of preventive services would lead to increased long-term spending as well.²⁷ The analysis took into account “any estimated savings that would result from [both] greater use of such care as well as the estimated costs of that additional care.”²⁸ In this analysis, the CBO stressed the need to look at the overall budgetary effects of preventive care, primarily through total spending.²⁹

An important, and often overlooked, factor that should be considered in the analysis of the cost-effectiveness of preventive care, is that doctors do not necessarily know in advance which patients are going to develop high-cost illnesses.³⁰ For example, much of the data supporting preventive health care as a way to significantly reduce long-term health care costs points to cases where a simple medical test could uncover a condition treatable at a significantly lower cost than if it had progressed.³¹ The significant cost benefits predicted with the implementation of preventive health care services assumes that each service will be provided to those individuals who are most likely to suffer from the particular medical problem the service is intended to prevent.³² For example, one study gave this example: “if a coronary-artery bypass graft procedure costs \$50,000, then avoiding that procedure could save up to \$50,000.”³³

Additionally, it seems logical that prevention of a disease will directly result in avoidance of its associated costs. However, this is not the reality of prevention. Often, in order to prevent one case of an illness, patients who would not have suffered from that illness also receive preventive services.³⁴ As a result, even if the cost of a preventive service is low, the aggregate cost quickly accumulates when a large number of patients are treated.³⁵ In order to accurately judge the overall effect of preventive care on medical spending, both the savings and the cost of each treatment must be calculated.³⁶ The

27. *Id.*

28. *Id.*

29. *Id.*

30. Elmendorf Letter, *supra* note 24.

31. *Id.*

32. *Id.*

33. James F. Fries, et al., *Reducing Health Care Costs by Reducing the Need and Demand for Medical Services*, 329 NEW ENG. J. MED. 321, 322 (1993).

34. Elmendorf Letter, *supra* note 24.

35. *Id.*

36. *Id.*

calculation cannot solely report the savings from avoidance of more expensive long-term costs as a result of the preventive treatment, but must also report the significant costs of preventive care for those individuals who would remain healthy even without the treatment.³⁷ In addition, another improper inference of many studies is caused by the commonly-used method of comparing the costs and benefits of a preventive service versus the costs and benefits of doing nothing.³⁸ As a result, many studies project unrealistic potential savings.³⁹

In evaluating total cost savings of a preventive medical service, the costs required to provide that service are compared with the medical costs that would be necessary if that service were not provided at all.⁴⁰ Expansion of preventive services under PPACA, with a goal of improving access to preventive services for individuals, may actually result in paying for services that many individuals are already receiving.⁴¹ Although this does increase access to preventive services, from a purely economic perspective this would add to upfront government costs without reducing long-term spending.⁴²

When determining the budgetary effects of increased government support of preventive medicine, in order to achieve accurate results, studies must balance two factors: (1) the savings generated from a reduction in government spending for people who reduce their future use of medical care as a result of the preventive services, and (2) the costs to the government of providing the services.⁴³ Medicare currently covers some preventive services that have been proven to reduce costs.⁴⁴ The enactment of PPACA will now eliminate cost-sharing for Medicare-covered preventive services that are recommended by the U.S. Preventive Services Task Force, and will waive the Medicare deductible for colorectal screening tests.⁴⁵ Medicare spending is projected to increase from \$523 billion in 2010 to \$845 billion in 2019, taking into account the changes

37. *Id.*

38. *Id.*

39. *Id.*

40. Russell, *supra* note 4, at 1.

41. Elmendorf Letter, *supra* note 24.

42. *Id.*

43. *Id.*

44. *Id.*

45. MEDICARE: MEDICARE SPENDING AND FINANCING, KAISER FAM. FOUND. (August 2010), <http://www.kff.org/medicare/upload/7305-05.pdf>.

incorporated by PPACA.⁴⁶ By incorporating several changes in Medicare, the enactment of PPACA is projected to reduce annual growth in Medicare spending over the next decade and beyond. These changes include: reducing the growth in Medicare payments to health care providers and Medicare Advantage plans, establishing several new policies and programs designed to reduce costs and improve quality of patient care, and creation of a new Independent Payment Advisory Board to recommend Medicare spending reductions if projected spending exceeds target growth rates.⁴⁷ Altogether, the Medicare provisions of the health care reform law are estimated to result in a net Medicare spending reduction of \$428 billion between 2010 and 2019, including \$533 billion in savings and \$105 billion in new Medicare spending.⁴⁸ The CBO, however, argues that these predicted savings may be overreaching.⁴⁹

Another issue that some researchers believe to add to the overreaching focus on cost-effectiveness analyses of preventive care is that most often they do not directly address the issue of whether such preventive services are more efficient than the treatment of existing conditions.⁵⁰ Researchers who have addressed this issue state that this consideration of whether the preventive service is more cost-efficient than merely treating the existing condition is important to the cost and benefit analyses of specific interventions because some technologically-advanced treatments may, in certain circumstances, represent an efficient use of resources.⁵¹ Furthermore, the focus on prevention is consistent with our ideals of improving health and saving lives. In terms of healthcare costs, however, the reality is that longevity adds to federal spending.⁵² Even if the argument that preventive services provided to an individual throughout their lifetime will lower their risk of a particular illness, a longer lifespan presents the challenge of allowing for more time to incur other health care expenses associated with age.⁵³

46. *Id.*

47. *Id.*

48. *Id.*

49. Elmendorf Letter, *supra* note 24 (referring to the three arguments made by the CBO that are illustrated in the letter and addressed in this paper previously).

50. Cohen, *supra* note 11, at 662.

51. *Id.*

52. Elmendorf Letter, *supra* note 24.

53. *Id.*

IV. CONCLUSION

In summary, while increase implementation of preventive medicine would most likely result in longer, healthier lives for the citizens of this country, therefore yielding savings that wouldn't necessarily show up on analyses, broad generalizations made in regards to the cost efficiency of preventive services can be misleading.⁵⁴ With the implementation of PPACA, the focus on preventive medicine as the solution to the rising health care cost curve is at an all time high.⁵⁵ As the official arbitrator of the cost of legislation, CBO has voiced skepticism of sweeping statements made in regards to the cost-saving potential of preventive medicine.⁵⁶ However, former Speaker of the House Nancy Pelosi has expressed frustration with the CBOs review of the idea of preventive care stating that “[i]t has always been a source. . .[of] frustration, for many of us in Congress that the CBO will always give the worst-case scenario on one initiative and never . . . [give] any credit for anything that happens if you have early intervention, health care. If you have prevention, if you have wellness . . . you name any positive investment that we make, that we know reduces costs, brings money to the treasury in the case of education but never scored positively by the CBO.”⁵⁷ With the implementation of PPACA, preventive care has surfaced as an attractive solution to the many problems of our current state of health care, but, as stated above, these benefits may be overstated. Looking strictly at costs, preventive care may not be the final answer.

54. *Congressional Budget Expert Says Preventive Care Will Raise – Not Cut – Costs*, *supra* note 19.

55. Elmendorf Letter, *supra* note 24.

56. *Id.*

57. *Id.*