Despite spending more on health care than every other industrialized country, the U.S. ranks 37th in health outcomes. These differences cannot be explained away with differences in age and income, or even with quality of care. And, the rate of growth in health care spending in the U.S. continues to increase. The share of the Gross Domestic Product (GDP) attributable to health care grew from 9% in 1980 to more than 17% in 2011. Health care costs are projected to account for more than one-fifth of our economy by 2021. Despite spending more and more, the U.S. does not have better health outcomes than other countries. Worse, our increasing spending is largely attributable to preventable conditions. More than 85 cents of every dollar spent on health in the U.S. are spent on the treatment and management of chronic diseases, such as those caused by preventable conditions related to obesity and tobacco use.

The implementation of the Patient Protection and Affordable Care Act (ACA) promises to ensure better access to health care for many Americans through expanded public and private insurance coverage, including basic preventive health care. However, health insurance does not guarantee better health. More than 60% of a person’s health is determined by lifestyle, behavior, and environmental and social factors, and not by what happens in the health care provider’s office. Policy and systems changes that reduce exposure and risk factors, known as primary prevention, are more effective at keeping disease and injury from happening in the first place and lead to reductions in health care and social costs of treating and managing disease and injury after they occur. For example, even when delivered to large numbers of people, counseling and education about the dangers of tobacco use or cessation services do not have the same impact on population health as a policy that reduces exposure to tobacco and tobacco marketing and advertising.

While the ACA is a step in the right direction for the delivery of individual health care services, its most far-reaching impact may be that it opens the door to transform our health system to improve population health in a real way. Public health officials must seize
this critical opportunity by taking steps to ensure that prevention, especially primary prevention, is embedded in our health system for the benefit of patients, providers, and communities.

**Oregon’s Experience**

Oregon is known for pioneering health reform efforts going back nearly 20 years. The State has recently undertaken the next step to transform its health care system. In early 2012, Oregon’s Legislature adopted House Bill 3650 that forms Coordinated Care Organizations (CCOs). Akin to ACA’s accountable care organizations, CCOs for Oregon Medicaid clients are local organizations that operate under a global budget with a fixed rate of growth, are governed by a board of representatives from the public and private sectors, and are accountable for health outcomes. The U.S. Department of Health and Human Services has supported this new model with a waiver under section 1115(a)(1) of the Social Security Act. Through this waiver, if certain criteria are met, Oregon will benefit from a projected federal investment in Medicaid and the CCOs of approximately $1.9 billion dollars over a 5-year period.9

Oregon’s CCOs are currently less than a year old. Many details remain to be determined, including the extent to which bridges will be built between the CCOs and local public health authorities. However, an emphasis on public health prevention will be critical to bending the health care cost curve and ultimately the success of the CCOs.

While Oregon’s experiment is unique and the policy levers for change in each state vary, based on our recent experience, we believe there are four areas where public health officials across the U.S. can immediately take the opportunities created by the ACA to ensure that prevention is a key component of health reform. These are: (1) leading the way on community health assessments (CHAs); (2) linking clinical and community prevention; (3) supporting the development of alternative payment methodologies to pay for prevention; and (4) serving as a community resource for the coordination of care and building the non-traditional health workforce.

**Leading the Way on Community Health Assessments**

The CHA and the Community Health Improvement Plan (CHIP) are two parts of an emerging continuous improvement approach to examine the health of the population, to assess the assets in a community that can be used to improve the health of that population, and to encourage engagement across organizations to improve health.10

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pitals, and state and national requirements for public health agencies. Public health authorities can add value to the health assessment process, specifically related to the development of population health indicators, the interpretation of data, and community engagement.

Linking Clinical and Community Prevention
When most people think about prevention, they think of preventive health services and primary care. Primary care and clinical preventive health services, both a major focus of the ACA, are delivered in public and private settings. In some areas, public health delivers primary care services to both the insured and the uninsured while in other places local governments have partnered with a Federally-Qualified Health Center to deliver primary care. Under ACA Section 2713, health insurers must cover, without a deductible, services that are recommended as effective by the U.S. Preventive Services Task Force, immunizations recommended by CDC’s Advisory Committee on Immunization Practices, and evidence-informed screenings for infants and children recommended by the Health Resources and Services Administration.

However, prevention extends beyond the delivery of preventive health services and other secondary and tertiary approaches to shortening the duration and minimizing the effects of disease or injury. Primary prevention reduces the incidence of disease and injury—stopping the disease or injury before it happens.14 The public health system is uniquely positioned to develop and implement primary prevention strategies in the community which are essential to the success of coordinated clinical health services.

For example, in Oregon tobacco kills more than 7,000 people a year. It is the leading cause of death and costs the State more than $2.4 billion annually. Oregon’s Medicaid program, known as the Oregon Health Plan, paid more than $374 million for tobacco-related treatments annually.15 This is true despite the fact that tobacco cessation services are covered, making it clear that community prevention is essential to avoiding tobacco-related health care costs. For clinical health services like tobacco cessation counseling to achieve their intended purposes, primary prevention strategies in the community must be in place, including strategies to reduce exposure to tobacco and secondhand smoke for all people, increase the price of tobacco to make it less accessible (particularly for youth most at risk of starting to smoke), and monitor the shifting use of tobacco products in the community. In Oregon, the statewide Tobacco Prevention and Education Program works with and through local organizations to implement these approaches to community prevention. Between 1996, the year before TPEP was established, and 2006 there was a 22 percent drop in the prevalence of tobacco use among Oregon adults.16 Washington State’s comprehensive tobacco prevention program has been found to have a return on investment of more than $5 to $1. Oregon’s tobacco prevention program is similar in comprehensiveness, although until recently funded at lower per capita levels compared with Washington’s.17 Both clinical and community interventions are needed to make progress on the other leading causes of death in Oregon as well.

Supporting the Development Alternative Payment Methodologies for Prevention
The ACA requires insurers to pay for certain individual preventive health services without a copay by insured. The U.S. National Prevention Strategy recommends supporting the implementation of community-based preventive services and linkages with clinical care and developing supporting payment approaches.18

While most health costs are paid by insurers when a provider submits a claim for an individual service rather than population-level interventions, health insurers have flexibility to design alternative payment approaches for prevention strategies that work, and some have already done this successfully. For example, United Healthcare has partnered with the Young Men’s Christian Association (YMCA) to deliver an intervention known as the Diabetes Prevention Program, a group program that helps people with pre-diabetes and others at high risk of developing type 2 diabetes prevent or delay the onset of the disease through lifestyle changes. The insurer uses an alternative payment methodology for the group classes.19 Payments for these types of community-level interventions could yield significant return on investment. Oregon overall could save $24.7 billion a year in social and health care costs and the Oregon Health Plan alone could save $35.8 million annually if we could achieve a 5 percent reduction in diabetes and hypertension.20

However, there is more work to be done to develop payment mechanisms for community-based prevention. This highly technical area of work will require health insurance experts to work closely with public health experts to align incentives and pay for health outcomes. The stakes for inaction are high. A $10 per person increase in investments in prevention could save the U.S. over $16 billion within 5 years.21

Serving as a Community Resource for the Coordination of Care
In many places, public health is already serving as a community resource for the coordination of care for the most vulnerable populations. For example, in
many counties in Oregon, local public health departments provide nurse home visiting, care coordination, and targeted case management services to women and children in their communities. This experience and these capabilities will be vitally important to a reformed health system.

Public health also serves as a conduit between health and social services. For example, Benton County, Oregon, runs a needle exchange program where a community health worker provides clean needles to IV drug users, some of whom live in local shelters, to reduce the potential spread of disease. That community health worker also encourages HIV, tuberculosis, and hepatitis testing for clients, and helps to coordinate their access to other health services, including mental health services. Public health workers are often familiar with families in their communities that require extensive care and case management, and have close working relationships with social services providers. In this way, public health is a key partner in the development of the non-traditional health workforce that is essential to health reform. And, many public health agencies have workers with cultural competence and linguistic abilities that are also essential to the effective provision of care by publicly funded providers.

Much work remains ahead to seize the opportunities created by the ACA to transform the health system into one that emphasizes and values prevention in its own right and as a means to address rising health care costs. Public health can play a key role in this transformation to ensure that people and communities have the tools to be healthy for decades to come. To do this, public health and public and private payors must collaborate to measure the health of the population, knit together reinforcing systems of community and clinical prevention, pay for approaches that create healthy communities, and build upon existing community resources for care coordination and develop the community health workforce.

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References
4. See Kaiser Family Foundation, supra note 2.
10. See Turnock, supra note 8.
20. Personal communication with Danne Hastings, Oregon Health Promotion and Chronic Disease Prevention Section, November 16, 2012.