Analysis of public health budgetary construction

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Introduction

The public health system is comprised of complex layers of federal, state and local powers that come together to address the needs of many. The programs, organizations and clinics that serve these needs require support at all levels and are often subject to inadequate and unpredictable funding, varied infrastructure and shifting priorities. These factors require a combination of greater cohesiveness across all levels and a higher creativity in allocation of funding. We propose a Community Health Improvement Plan (CHIP) plan that will support evidence-based population health solutions by allocating resources to specific needs and better reaching those in every sect of the population.

Nature of Public Health Funding

Federal funding to state and local public health departments takes a number of different forms. As pointed out in Ogden et al, the average state public health agency receives 49% of its funding for federal grants, contracts, and cooperative agreements. This is much higher than the 25% of total expenditures supported by federal grants, making public health uniquely subject to federal sway (Ogden, 2012). The two major federal funding streams can be classified as those which are statutorily mandated, and those, which are derived from discretionary funds (Ogden, Sellers, Sammartino, Buehler& Bernet, 2007; Ogden, 2012). Mandatory funding supports health service delivery programs, such as Medicare and Medicaid

and represent 88% of the budget of the US Department of Health and Human Services (Ogden et al, 2007). This route serves to ensure that medical care is available across the country, and to some extent independent of the fiscal health of the state or local authority and their ability to fund care. Discretionary funding on the other hand, is awarded by the choosing of the federal agency (within the confines of congressional budget authorizations) and can either be formula-driven or competitive. Among the mechanisms for disbursing discretionary funds are cooperative agreements, grants, contracts, and partnership agreements. Some federal funds are awarded to states and localities for the express purpose of further distribution to smaller subunits of governments or charitable or private contractors (US Department of Health and Human Services [HHS], n. d.). These awards can further the program or policy objectives of the issuing agency by promoting adjustments in state and local programs to match funding opportunities (Ogden, 2012).

Inefficiencies and Risks in Current Funding Models

The current system of funding public health care in the United States is unsustainable because of major systemic fiscal problems. These issues include but are not limited to lack of accounting uniformity and transparency, along with a disproportionate appropriation of funds for medical interventions versus social determinants of health. AsTeutsch et al. points out, medical interventions shape only 10-20% of health outcomes but account for 97% of health spending (Teutsch et al., 2012).). A study of health spending in Florida for the years 2005-2006 as dedicated to each essential public health service found that 69% of the aggregate budget was allocated

to access and delivery of health care (Turnock 2012). Although this percentage may vary some across states, it is not uncommon for immediate services like number of health care facilities in a certain area, or treatment given to be primary concerns.

Inadequacy of Taxation as a Fiscal Solution

It may appear that there is an obvious case for a tax to appropriate more funds to social determinants. Taxation strategies can range from charges on consumer products to health care related fees and can have negative consequences ranging from economic unrest to increased insurance costs. The medical device excise tax for example, originally passed as a part of the Affordable Care Act was intended to generate funds to help offset the cost of providing health insurance subsidies (Lee, 2014). Over its first two quarters in effect, however, it has brought in less than anticipated and is also squarely in the crosshairs of the upcoming Congress to repeal (Schouten, 2014). These changes emphasize the gaps in current strategies and the need for increased change.

Unpredictability in Current Funding Structures

The variability that exists in funding services as well as actual care given from place to place throughout the country leads to a greater need for balanced administration and infrastructure. In a 2011 report the federal funding spent on both prevention and general health improvement in communities ranged from $14. 20 per capita in Ohio to $51. 98 in Alaska and state funding exhibited an even greater gap with $3. 45 allocated to each Nevadan and almost $155. 00 to each Hawaiian (The Fund for America’s

Health [TFAH], 2012). Rural and urban areas also differ in their needs and in a recent report highlighting this coming years health allocations, cuts are being made to the workforce pipeline in these and other disadvantaged areas (Parker, 2014). There needs to be greater transparency in how money is used within departments, especially when states are running on extremely tight budgets. Reduced funding can cause the transfer of prevention funds to other areas, such as administration, that is not as population-based and can, in turn, lead to poorer health outcomes in the long run.

Federal Role in State and Local Health Funding

The federal government supplies states with much needed stimulus that adds to the general health services provided and the overall workforce that delivers them. This greater influx of money also gives communities the flexibility to target special problems and needs and develop programs that are specific to individual population features. In addition it guarantees that there is a minimum level of care provided in any given area and a certain level of continuity among the services available. Federal backing also increases the propensity for collaboration among different sects both at the national and local level (Ogden, 2012). Overall, most states don’t have the financial means to implement public health initiatives independently and knowing that greater funds can bring both greater health outcomes and economic stability to their populations is always a positive force.

Consequences of Inadequate or Inefficient Funding

The risks of insufficient funding and misallocated resources are many and have the greatest influence on individuals that rely solely on public

assistance for their health care. Cuts in services greatly reduce the scope and quality of care that individuals receive and when funds are misallocated, confidence is highly reduced in the quality of care. Further, the productivity of programs can greatly suffer from lacking funds and the number of individuals that can be served is also greatly reduced. Reduction of services in general can lead to sicker and less productive people and communities, and this also increases the overall bottom line in health care spending.

The greatest concern within this system is a lack of guaranteed support and with varying amounts from year to year a higher burden is a significant risk in rural areas where both infrastructure and community resources are already scarce (Ogden et al., 2007). Generally, these areas do get higher funding per capita, but state health departments still find it difficult to balance both the priorities of small, often sicker populations with the communities and resources needed statewide. This is especially true when more money does not necessarily translate to better outcomes. In addition, it is problematic for local health departments to both plan for the future and provide the new programs necessary to combat the most prominent chronic conditions Institute of Medicine [IOM], 2013). The dedication to treatment and prevention must always be balanced with the assessment, policy development and assurance, which are also costly and a requirement of further funding (IOM, 2013). The various levels of government also make it difficult to have both cohesive goals and policies that will reach those they are intended to, and as Ogden mentions, this type of American federalism makes for constantly shifting priorities by the powers that be (Ogden, 2012). Therefore, both the effectiveness and efficiency of such efforts can suffer

and leave last year’s needs unresolved if something more pressing comes up. This can sometimes lead to “ piecemeal healthcare” and an understating of preventive services. But, while funding is a large issue, there are several other key changes that must be made to the public health system in order for it to function properly and best serve the individuals that utilize it.

Conceptualizing a New Funding Strategy

To address the systemic risks of the current construction of public health funding streams, we propose a redesign that emphasizes transparency and strategic planning. As discussed above, a variety of factors from changing political landscapes to disparate funding formulas create disparities in public health funding among state and local peers. Allocating funding based on empirically proven health needs rather than arbitrary policy preferences will allow agencies to direct funding to the most significant challenges to the community’s health.

Similar to the planning necessary prior to the development of a new initiative, a comprehensive needs assessment of the population should be performed (Brownson, Baker, Leet, Gillespie, & True, 2003). We propose realigning federal funding of states and state funding of local units to the priorities identified in a CHIP. A CHIP will identify the most critical priorities for a community, which would presumably also be the priorities for funding support (National Association of City and County Health Officials [NACCHO], 2014). Further, as CHIPs require stakeholder cooperation and input (Minnesota Department of Health [MDH], n. d.), they naturally promote transparency and public participation in budget allocation. Lastly, this model

permits flexibility to address each community’s unique needs, rather than fixed priorities dictated by others. For example, one community may emphasize spending on injury prevention while another may find it needs to invest most heavily in infectious disease control. This allows localities to seek the greatest return on investment in the public health space according to its needs. After the community’s specific CHIP-based plan has been implemented, quantifiable performance measures will disclose health improvement data to administrators, business and nonprofit partners, and community stakeholders. This data will emphasize “ best practice” models for future decision-making (Turnock 2012, pp 242-3). In order to share economic impact data, The Centers for Disease Control and Prevention lists models of economic analysis to quantify the budgetary impact of public health interventions. The “ economic evaluation” model allows for the comparison of more than one identified intervention derived from the CHIP analysis. This tool provides cost effectiveness and cost benefit information which will be critical for assessing budgetary feasibility and future public health program implementation. In the quest for transparency, accuracy and concision, it would be worth investigating the cost of health economist consultation in preparing this analysis (CDC. gov).

Conclusion

Despite the extensive discussion of the futility of improving public health funding, significant opportunities do exist to improve the efficiency of spending to achieve better health outcomes for the same dollar figure. We have proposed a system that aligns efforts to critically assess public health program management with funding allocation. We believe this model would

improve community buy-in, enhance transparency, and most importantly, advance population health indicators.

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