Issues in public health funding

PUBLIC HEALTH FUNDING: SHIFTING THE PARADIGM

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ISSUE

Despite comparatively high levels of spending on healthcare, the health of the U. S. population continues to lag that of its counterparts (Alper, 2014). In this paper, we evaluate the current landscape of funding for public health initiatives, the lack of uniformity of financial accounting standards for public health spending, and our proposal to address the existing funding structures of the public health system. Our multi-faceted approach includes:

- Federal, state and local government funding through a tax on medical services, with an emphasis on developing predictable funding based on funding cost-effective, evidence-based interventions.
- Investment by the healthcare industry through accelerated payment reform that incentivizes initiatives in population health management.
- Increased contributions to NGOs working in the public health arena through provision of expanded tax credits for individual and corporate donations to these organizations.

ASSESSMENT The U. S. faces an urgent need for fundamental structural reform of its public health funding. Current public health funding streams are highly erratic and generally inadequate, in part due to a “ fixation” upon clinical spending (Teutsch et al., 2012). Therefore, while per capita spending on healthcare in the U. S. exceeds that of other wealthy countries, the U. S. continues to experience comparatively poor health outcomes (Teutsch, 2012).

LITERATURE REVIEW

Challenges inCurrent Funding Methods

The federal government provides a significant portion of both state and local health public health spending. Federal agencies subsequently influence provision of public health services at the state and local levels (Ogden, 2012). In essence, by being a primary funder and policy driver, the federal government often substantially influences the priorities and policies used to implement health services at all levels (Ogden, 2012). Consequently, state and local health agencies are often confined to the directives set forth by the federal government, which can result in various distortions in expenditure and service provision. One example is the federal government’s sudden shift of attention and funding allocation at moments of acute concern regarding infectious disease crises, such as with SARS and the more recent Ebola outbreaks (Weintraub, 2014).

Aside from federal influence, there is considerable variation in sources and the amount of public health spending at the state and local level (Ogden, Sellars, et al., 2012). Additionally, a reliance on inconsistent formula-based

funding allocations often results in ineffective and inequitable public health spending. Funding formulas are often hampered by low-quality data, inconsistent calculation methods, and the complex political realities that ultimately shape allocations decisions (Honore, 2007).

Challenges in Current Accounting Methods

In a recent IOM Roundtable, David Kindig notes the need for a reallocation of spending away from ineffective interventions, and the parallel need for new strategic alignment of the interests of multiple sectors to find what he informally calls the “ sweet spot” (Alper, 2014). Kindig notes that one of the main challenges is deciding how to spend the money (Alper, 2014).

A significant barrier to deciding where to spend public health funding has been the historical lack of standardized financial accounting methods utilized in the public health sector. Honore et al. point out the relatively lack of financial transparency in public health and call for reforms including a uniform chart of accounts, uniform classification of expenses and revenues, creation of a professional public health financial managers association, and standardized electronic data reporting (Honore et al., 2007). Any funding organization making an investment in public health will increasingly require this greater transparency (Honore et al., 2007). Ogden et al. also calls for development of standardized accounting methods to facilitate comparisons across organizations (Ogden, Sellars, et al, 2012).

Additionally, evidenced-based public health (EBPH), a practice currently encouraged of public health organizations, insists on cost-effective interventions (Brownson, 2009). One component of EBPH is economic

evaluation. Until we have robust and uniform financial accounting standards, it will be difficult to evaluate the success of various healthcare initiatives. Even in the arena of government funding, there is an increasing demand for close financial accounting of funds allocated to public health departments (Levi, 2007). Such demands include a demonstration of how monies are being spent to support the core functions of public health, these being assessment, policy development, and assurance (Turnock, 2012).

RECOMMENDATIONS

To overcome the current problems with fragmented and declining revenue streams for public health, we propose an alternative approach specifically intended as a sustainable funding model sufficient to support core public health functions at appropriate levels.

1. Sustained and coordinated government funding.

As noted above, current government funding is highly fragmented and dependent on a mix of local resources combined with federal funds that are often restricted to specific programming (Ogden, 2012). Like Kindig, we call for a move from “ grants and short term appropriations” to a more coordinated effort across government departments based on a comprehensive, long range focused public health effort (Alper 2014). Diminishing government revenue can be addressed through a small tax on clinical healthcare services (IOM, 2012). If a sustained, dedicated revenue stream in the form of a clinical medical services tax can be achieved, we believe that the nation’s overall public health infrastructure can substantially improve population-based outcomes across the U. S.

2. Increased population health spending by the healthcare industry.

Private, for-profit healthcare providers can play a major role in “ transforming” their communities through a combination of health interventions (Alper, 2014). Gunderson notes it will require a shift from “ reactive” spending to “ proactive” spending (Alper, 2014). The current shift in basis for payment for medical care from episodic care to population “ pay for performance” mechanisms has the potential to create the environment where healthcare systems see such community-based investments as financially attractive, perhaps even obligatory for their financial survival. However, the transition to “ pay for performance” mechanisms presents several challenges. Slow pace of change, lack of experience by healthcare organizations in public health management, and threats to vital revenue for “ critical access” organizations in resource poor communities all pose significant hurdles (Alper, 2014). A shift from medicalized spending to public health investment is critical, and progressive healthcare organizations can play a vital role in creating this awareness and facilitating and modeling transition steps.

3. Enhanced spending by NGOs in the public health arena.

The IOM roundtable notes the success of community development strategies in improving health (Alper, 2014). Many of these efforts can be best carried out by NGOs or other organizations that already maintain high levels of financial transparency. NGOs also offer a nimbleness that is often lacking in the government bureaucracy due to their governance structures and financial transparency. Additionally, as James Hester has noted, such

organizations can play the role of “ integrator” (Alper, 2014). As such, these organizations can help to manage and coordinate revenue streams, capital requirements, community resources, and local health needs. However, in order to have adequate funding, specifically for those non-profit entities that depend largely on private donations, NGOs must have a reliable donor pool. In order to encourage donations to NGOs, we recommend passage of legislation authorizing enhanced tax credits for individuals and entities contributing to these entities. Through such a mechanism, NGOs will have the resources to take a leadership role alongside public health departments in developing, managing, and evaluating community-based public health interventions.

CONCLUSION

Despite rising levels of healthcare spending, the U. S. continues to fall behind in most measures of health (Teustsch, 2012). The U. S. risks falling further behind in health status unless there is a shift in focus from spending on medical interventions to spending on the well-documented determinants of health, including community, social, economic, and built environments (Teustsch, 2012). Such investments will ensure the continued economic growth and competitiveness of the US in the global economy (Teustsch, 2012). The historically fragmented and financially opaque public health system requires immediate and comprehensive reform. Effective reform will propel a shift from reactive illness-based spending to proactive community-based public health preventative investment. As discussions focused on this critical problem continue, we recommend implementation of the specific measures set out above.

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