

# Public Health Financing: New Opportunities

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# What are we spending now

- CDC: \$20.25 per person in FY 2010
  - Range of \$13.96 in Ohio to \$51.89 in Alaska
    - No rationale for these discrepancies
      - Money distributed based on mixture of incidence, prevalence, population, and competition
  - State funding (TFAH review of state budgets)
    - FY10 median: \$30.61 per person
      - Range: \$3.40 in Nevada to \$171.30 in Hawaii
    - 33 states reduced spending
  - Local (Glen Mays, 2009)
    - \$29.57 per person
      - \$8 (bottom 20%); \$102 (top 20%)
    - Very weak data and no standardized approach to assessing spending at the federal, state or local level

# What do we need?

- TFAH *Blueprint for a Healthier America* expert panel
  - US should spend \$55-\$60 billion annually (\$187 per person)
  - Shortfall of \$20 billion
    - 60% a federal responsibility (\$12 billion)
- Based on comparison of OECD countries and estimates from Washington State exercise
  - Truth: These are educated shots in the dark

# First steps

- Before determining how to finance public health, we need to determine:
  - What is the core mission of public health?
    - We have lots of variation in what public health agencies do across the country, not just in how much money they have
  - What does delivering that core mission cost?
  - What is the division of responsibility between the federal government and state and local governments?
    - Are there some functions that are so critical that the federal government should fund at 100 percent to assure common capacity across the nation?

# Wanted: A New Business Model

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- Prevention and Public Health Fund
  - Continued emphasis on modernization and transformation even though base is facing cuts
  - Use to leverage change in how health departments do business
    - Example: HIT and surveillance
    - Example: Business/billing practices

# New Business Model (2)

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- Health Reform and Public Health's Role
  - Are there health department functions that can be absorbed by aspects of the delivery system?
  - Where direct services are still provided by health departments, discretionary dollars must be the payer of last resort
    - USPSTF, ACIP, etc. services should not use discretionary dollars

# New Business Model (3)

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- Medicare, Medicaid, Exchanges, Accountable Care Organizations, Medical Homes
  - Creativity regarding *what* is reimbursed
    - If third party payers benefit from a community prevention program, they should help pay for it
  - Creativity regarding *who* is reimbursed
    - Non-traditional, non-medical providers, including local health departments

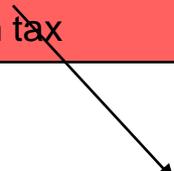
# Those who benefit should contribute

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- Multiple stakeholders benefit from public health but don't contribute
- Are there mechanisms (voluntary or not) that can create a mutually beneficial arrangement
  - Public health has the capacity to bring prevention to scale (geographically) in a way that other interested parties cannot

**\$\$\$ from**  
**Plans/Purchasers/  
Employers**

- Voluntary contributions
- Premium tax



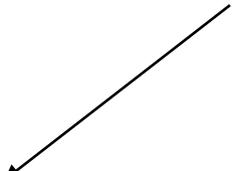
**\$\$\$ from**  
**State (or Other) Government**

- Dedicated appropriations
- Medicaid
- Food/alcohol/tobacco taxes
- As purchaser



**\$\$\$ from**  
**Federal Government**

- Grants
- Medicare



**State (or Community) Wellness Trust**

A public/private partnership that determines prevention priorities and allocates funding to entities below to implement evidence based interventions and/or promote policies.

- Governance Issues
- New Entity or Existing Mechanism (e.g. Community Trust)?



**Implementation**

\$\$\$ allocated for integrated vision of clinical and community prevention that includes role for plans/purchasers, community based organizations, and local health departments.