1. Hello and welcome to “Public Financing of Public Health.” The content for this lecture is taken, among other cited sources, from *Public Health Administration* by Lloyd F. Novick, et al., chapter 1, “Defining Public Health,” and chapter 7, “Financing the Public’s Health.”

2. The objectives of this lecture are:
   - Distinguish public health from personal health services
   - Recognize the fragmented nature of public health financing and administration
   - Generalize the sources of funding for local public health agencies
   - Describe local health department financial budgeting and strategic planning process
   - Identify challenges in public health financing

3. The last year for which this chart data were taken, 2012, the U.S. national health spending was almost $2.8 trillion, or about 17.2% of the U.S. Gross Domestic Product, which was $16.2 trillion. As you can see the personal health expenditures make up 84% of this total, but public health spending is only 3%. To put this in perspective using a different study, in 1996, Americans spent $4,000 on personal healthcare per capita, but only $44 on public health per capita.

4. Public health seeks prevention; personal health means intervention. A growth in the American medical enterprise in the 20th century solidified the funding preference for personal health, especially for building hospitals and training medical professionals. Much of what we think of as the healthcare system became privatized in the early 20th century. Our public financial support for direct medical care created our reliance on hospital-based diagnostic technologies and treatment interventions. Whereas, the publically financed system of preventing disease – immunizations, education, screening – was largely ignored.

   According to the Novick text, “a population-based strategy [is one that] is directed toward changing the prevalence of risk factors for the entire community, such as tobacco control programs, rather than toward identifying and targeting interventions for high-risk individuals.”

   Today, our society has a greater awareness of the disparities between prevention and intervention efforts. The first publication of Healthy People by the U.S. Surgeon General in 1979 marked a turning point. The result of this effort can be seen in workplace wellness programs, managed care disease management programs, and improved funding for preventive services in our health policy efforts. Still, our country continues to strive for the right balance of prevention and intervention.

5. It should be said that there is not a bright line between the roles of public health and the medical establishment. Rather, public health provides personal health services, such as HIV/AIDS treatment clinics, WIC programs, pregnancy outreach and education, etc. In fact, in a 2009 study by Robert Brooks, M.D. and his colleagues found that 68.7% of funding for public health in Florida is for individual health services. On the other hand, remember that the medical establishment provides many preventive services, such as wellness checks, education, and immunizations in the primary care setting.

6. There are many funding methods for public health throughout the United States. First, reimbursement funding is where LHDs are reimbursed for a specific set of services based on the
expenditures that the agencies incur while providing the services. Next, per capita funding is a set amount of funding for each person served in the area. Another way to fund public health is through local taxes, inspection fees, etc.

Furthermore, the administration of these funds differs greatly throughout the U.S. public health system. Administration of these funds can take place at multiple levels, including Local Health Departments, County Health Departments, State Health Departments, and Metropolitan Health Departments. The message here is that there are so many different ways that public health is funded and administered.

7. There are multiple streams for public health financing. Funds are distributed to the public health agencies from federal, state, and local governments, as well as charitable organizations.

8. As an example of the variation in the sources of LHD funding, Wisconsin got 79% of its total public health funding from local sources, but Massachusetts only got 7.4% of the total public health funding from local sources.

In addition to multiple streams of funding, the relative contributions from those sources can fluctuate from year to year.

Also, a study by Mays et al. shows that there is wide variation in the spending depending on the location of the public health agency. In 2005 the lowest 20% funded agencies averaged less than $8 per capita in spending compared to $102 per capita among the highest 20% funded agencies.

9. This is a chart of the funding source of the “average” Local Health Department. Of course, “average” is really misleading given the heterogeneity of the levels and proportions of funding throughout the U.S. public health system. Nonetheless, it is helpful to see that funding for local public health departments and programs come from many sources. According to the Chartbook for Local Public Health Agencies published in 2001 by the National Association of City and County Health Officials, on average, funding for LHD came mostly from local sources (44%) and state sources (30%). These include dollars from the federal governments that are given to states and localities. There is a portion, three percent (3%), which came directly from federal sources. On average, 19% came from payment for services provided to patients, which included fees, Medicaid, Medicare, and insurance reimbursements.

10. There are many federal government funding models for public health. Here are a few of the general types that you should understand. Keep in mind that there can be hybrid models, also. Block grants are dollars provided to the state or local governments with general provisions on how the money should be spent. An example includes the Maternal and Child Health block grants, also known as Title V funding. The MCH grants help to build to develop public health infrastructure intended to address maternal and child health challenges, such as infant mortality, pregnancy health, childhood immunization, adolescent pregnancy, and nutritional needs. These grants are administered by the U.S. Department of Health and Human Services agency called the Health Resources and Services Administration (HRSA).

In contrast, categorical grants require more specificity as to the purposes and eligibility for the public health programs. A good example is the Special Supplemental Food Program for Women, Infants, and Children (or WIC). These grants include administrative and reporting requirements that ensure financial and programmatic accountability to the federal funding agencies. It should be recognized that categorical grants can lead to perverse funding decisions because federal
preferences (and dollars) may be available for one type of program, but the needs of the local population may be for another.

Finally, matching funds are when the grants require that the state government spending their funds first, and then they qualify for additional dollars from the federal government. For example, Medicaid and SCHIP are both matching programs. In these state-run health insurance programs, when a state spends one dollar on health care services, the federal government “matches,” or contributes, about a dollar back to the state. The actual formula depends on the per capita income level of the state, but the federal government contributes between 50% and 77% of the Medicaid budget in states. A similar federal contribution is true for SCHIP.

11. In a previous lecture, the difference between discretionary vs. mandatory spending by the federal government was presented. In the context of public health funding, this distinction is also important. The largest federal funding area to states for public health is Medicaid and SCHIP, both considered mandatory spending. From the federal perspective, when the state spends money on health services for Medicaid for eligible individuals, then the federal government must allocate their funds to those states (through appropriations). Most other federal funds for state public health programs are considered discretionary.

12. The heterogeneity of funding sources and models makes measurement of dollars spent almost impossible. While there is no national standard, many state-level efforts undertaken to collect expenditure data.

Also, there is a lack of understanding in population health outcomes. We need to do a better job of understanding morbidity and mortality (Erwin 2011, Mays & Smith 2011).

What the combination of bad cost data and bad outcomes measurement is that effectiveness difficult to determine. As a consequence, public health is vulnerable to cuts to funding by federal and state legislators. As an example of this, the State of New York was able to conduct a three year cost analysis of 58 local public health agencies. This information was able to restore funding for programs, especially those tied to revenues, according to Leviss & Novick (2004).

13. There are trends in Public Health funding not mentioned elsewhere in this lecture that you should be aware of. First, there is a wide range of organizations that deliver public health services (both population-based and personal health services). Also, the reliance on Medicaid as a funding stream contributes to public health identity problem. Finally, some states are merging public health agencies with other agencies, such as social services or mental health. This leads to a decreased ability of state governments to positively impact population health.

14. Public budgets translate a government’s policies into decisions on how meet public health needs. In this process, decisions are made for public or collective good, not to benefit individuals. These decisions may be intentionally inefficient by providing services the private sector will not (e.g., nursing home care to poor elderly persons). These budgets are made as a part of public health agencies’ responsibility to their constituents and governmental requirements. Motivation behind budget decisions is not profit; but does include determining cost.

15. At local levels, budgets were originally intended to protect against theft. So budget control acts as a deterrent to misappropriation of funds - expenditures must agree with appropriation. Also, budgets are used to assess progress toward goals and for future planning.

16. Budget requirements are not consistent across all political jurisdictions. At the federal government level, a budget has limited legal status. For local governments, a budget may become an official working document. They can use a series of documents – operating budget, capital
budget, special funds budget – to administer funds for public health. In public health budgeting, there is a greater emphasis on expenditures than revenues.

17. Let’s connect many of the concepts presented in this lecture in order to give you a concrete example of how policy impacts public health operations. A report by Kurland and Walker in 2004 addressed the 30% cut in state funding to the Massachusetts Department of Health from 2001 through 2004. Significant budget cuts from the state legislature, totaling almost $160 million for this period, highlight the large proportion of dollars that public health receives from state governments. Cuts from federal funding streams only removed about $28 million.

Cuts happened from local funding streams, also. The report states that funds for school health dollars are provided at the local level, and that services for programs, such as asthma control and teen pregnancy prevention, have been negatively impacted.

In terms of strategic action, the report suggested that the state legislators create a “Prevention Caucus” that could advocate for public health funding. This serves to educate the legislature as to the distinction between prevention efforts of public health and the intervention practices of the medical establishment.

In fact, the prevention/intervention dichotomy was clearly communicated by the authors. The authors wrote, “Immunizations for hepatitis A are a tiny fraction of the cost of treatment, and the infection puts others at risk. In July 2003 the state eliminated funding for the hepatitis A vaccine, for which Massachusetts has been paying since it was approved. Within six months hepatitis A infections in Boston doubled, the worst rate in a decade.”

As for budgeting, the report recommended that the public health leaders relate any budget cuts to the programs concerned, the people served, the agencies involved, and outcomes associated with the expenditures.

18. As the report regarding the Massachusetts Department of Health makes clear, public health leaders should be expected to operate the business of Public Health. That is, they are responsible for communicating to stakeholders the value of public health services. In other words, the cost competitiveness of public health services relative medical intervention is high.

19. There are still significant public health financing challenges for the future. According to the Institute of Medicine’s report called The Future of the Public's Health in the 21st Century published in 2003, there is a need for national expenditure reporting system. Also, a lack of stable funding sources for infrastructure weakens the role of public health in the transition from a treatment intensive to a prevention oriented health system. Also, the role of government in providing public health services will need to be addressed. Finally, given the need to support the effectiveness of public health funding, the workforce will need to improve financial skills, including budgeting, cost measurement, and outcomes measurement.

20. This concludes the lecture on “Public Financing of Public Health.” The following questions are some that you will be expected to know:

1. Explain why it is difficult to measure Public Health effectiveness.
2. Relative to personal health, what is the portion of spent on public health?
3. What is the primary source of funding for the “average” local health department?
4. Describe the different funding streams for a LHD.