Rethinking Financing Public Health in an Era of Health Reform

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Overview

- The context of the budgetary and policy pressures facing public health
- How we should rethink the role of public health
- Reality and vision – will they collide or collude?
  - A hard conversation…beginning now…
Major trends affecting public health

- Health reform
  - What should public health continue to do?
  - What must it learn to do?
- Emphasis on policy and system change over program or service delivery
  - Demand for ROI
- Preparedness
- Technology
- Health in all policies – public health can’t and shouldn’t do it all

Countervailing trends

- Personal responsibility
- Distrust of government and the “nanny state”
- Diminishing levels of investment in public health and social services
  - Prevention Fund challenges – transformation or gap filling?
Affordable Care Act Inspires Transformative Thinking

- Health in All Policies should be the norm
  - National Prevention Council/Strategy
- Prevention outside the clinic has equal standing
  - Prevention Fund, Community Transformation Grants
- Population health is a responsibility of the clinical system as well
  - Preventive services first dollar coverage
  - Center for Medicare and Medicaid Innovation
  - Community Benefit

The tsunami that is about to hit…

- Budget sequestration
- A new budget deal
- Review of public health programs in the context of health reform
Prevention....not just for public health any more

- National Prevention Council and National Prevention Strategy assume a broad cast of characters affecting prevention where we live, work, learn, and play
- Affordable Care Act (ACA) moves beyond the clinic to structural, policy, and systems change and to incentivizing the clinical system to focus on population health

What principles should guide us?

- RWJF/RESOLVE project:
- Charge to the convening:
  - Developing guidance for PH officials & policymakers in prioritizing vital PH functions in a shifting political and fiscal landscape
Rationale: Opportunities/Challenges

- Unprecedented period of change and opportunity
  - Health system transformation
  - Build on public health achievements
  - Health challenges increasingly chronic diseases
  - Growing recognition of importance of “health in all policies” and social determinants of health
  - Evolution of health IT
- Fiscal environment
- Skepticism about role of government

Call to Action

To achieve a healthier nation, governmental public health must:

- Build skills sets to address new health challenges, while protecting/leveraging successes
- Establish & demonstrate unique skills, insights, & expertise
- Develop strategic partnerships within & outside of health sector
- Make compelling case for governmental PH departments, interventions, & community prevention
Health departments must possess foundational capabilities that are crosscutting & integral to their functioning

- Departments vary in their capacity to carry out functions, in part, due to funding constraints
- Building capabilities may be incremental, based on local need, & require new skills sets
- Should be goal of governmental health officials to possess these capabilities

- Developing policy to effectively promote health
- Using integrated data sets for assessment, surveillance, & evaluation to identify critical health challenges, best practices, & better health
- Communicating with the public & other audiences to disseminate – & receive – information in an effective manner for health, including health promotion, access to care, & prevention
Foundational Capabilities (3)

- Building new models that integrate clinical & population health
- Cultivating leadership – along with organizational, management, & business – skills needed to build & sustain an effective health department & workforce to promote and improve health
- Demonstrating accountability for what governmental PH does directly & that it oversees through accreditation, continuous quality improvement, & transparency

Foundational Capabilities (4)

- Protecting the public in the event of an emergency or disaster, responding to day-to-day challenges or threats, with a cross-trained workforce
Prioritizing Programs/Services (1)

- Important considerations for governmental PH in developing a framework for prioritizing
  - Ensuring what is being done is being done as well & efficiently as possible
  - Coordinating across all levels of the governmental PH system, other governmental agencies, & jurisdictions to maximize impact
  - Cultivating and/or training a workforce that can deliver foundational capabilities when implementing programs

Prioritizing Programs/Services (2)

- Governmental PH may need to directly deliver clinical & non clinical services when they:
  - Are effective in promoting health & preventing disease/injury to individuals, as well as the broader community, i.e. tobacco cessation or vaccines
  - Can be delivered efficiently by a PH department
  - Are not sufficiently provided by others
In sum…

“Health departments need to decide what to stop doing, start doing, what to do continue to do based on these & other community based needs and parameters.”

The Bottom Line

- We have to begin to show the consequences of budget cuts – we can’t keep making do with less
  - BUT we can’t avoid the tough discussions
- We can’t and shouldn’t continue to support the current way of doing business
  - What needs doing is different
    - We are structured using a communicable disease and/or clinically oriented model when we need to be thinking systemically
  - Who should be doing it is broader than it has been
  - Health reform means new opportunities
Reduce the stovepipes (1)

- Community prevention approaches should make us think in terms of interventions, not conditions
  - Physical activity addresses multiple conditions, yet is usually funded in the context of obesity or other chronic diseases
- Social determinants and health in all policies approaches mean a shared responsibility with other agencies
  - Health creating investments may not show up in the public health budget

Reduce the stovepipes (2)

- Health Information Technology provides an opportunity to rethink surveillance and epidemiology
  - Do we still need to build disease-specific surveillance systems?
  - Do others have incentives to do surveillance and quality assurance?
    - Accountable Care Organizations, medical homes
### If we really eliminated stovepipes…

- Focusing within public health on what we do best and with a new vision about cross-cutting approaches to:
  - core infrastructure -- surveillance, epidemiology, research, workforce
  - community prevention
  - clinical interventions
  - Preparedness

- Does the federal structure also create unnecessary stovepipes?
  - $ from Prevention Fund to integrate programs that perhaps should be separate?
  - Where is the line between treatment and prevention?

### Short-term/mid-term

- Efficiencies from better structure
- Giving up what health reform now does
- Payer of last resort as an ethical principle
- Preserve essential public health capacity
  - Public health agencies will not necessarily be providing all the essential services – if health reform is structured right
- Structure federal funding to assure where you live doesn’t determine how well you are protected
The long-term: Cost Containment

- Global budgeting of some kind inevitable
  - Will we be able to convince ourselves and others that public health/prevention should be part of that global approach
    - Vermont, Massachusetts are leading the way
  - An ROI – in terms of cost, quality, and outcomes (the triple aim) – will be our passport
  - We have answers that the health care system needs, if we speak their language
    - From coordinating and “integrator” functions to true melding

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**Improving Population Health Outcomes Depends on Transforming the Health System to Coordinate and Integrate Primary Care, Public Health and Community Prevention Efforts**

- Interventions at the intersection of primary care, public health and the social determinants of health require:
  - Common agendas and goals
  - Shared responsibility
  - A compelling story
  - Partnerships and collaboration
  - Leadership and Integrators
  - Data
  - Financing systems
  - Accountability mechanisms

- Incentives for providers to achieve pop. health outcomes and improve quality
- Incentives for plans/ACOs to address population health outcomes
- Funding mechanisms that enable braiding of financing streams

- Primary care & team based care
- Patient assessments include personal data and SDOH regarding patients’ homes and communities
- Quality improvement
- Leveraging, linkages and referrals to community resources
- Data collection & EHRs contribute to community health data base
- Coordination with community health outreach workers
- Chronic disease mgmt

- Social and support services
- Disease prevention and management programs
- Outreach and referral to clinicians
- Education, including health education
- Coalitions and advocacy to address SDOH
- Community engagement

**Public policy is a critical lever to support all of these activities**

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Reality and vision – crash course or melding?

- If public health is really about creating a healthier population...we must welcome change and we must welcome new players
- We must make our arguments within the context of current expectations:
  - Quality, cost and population health
- We must only do what we must do, not what we like to do or have always done
- But it’s going to be a very, very rough ride

Finding the consensus document

- Google Transforming Public Health or:
- http://www.rwjf.org/publichealth/product.jsp?id=74594