Public Health and Payers—Bridging the Gap to Boost Public Health Investment

Suhas Gondi, MD, MBA; Dave A. Chokshi, MD, MSc

Most public health services in the US are delivered by state and local health departments. Despite the public’s reliance on these agencies in the face of mounting health threats, funding for public health has declined in recent years. Between 2010 and 2019, spending for state and local public health departments decreased by 16% and 18%, respectively.¹ The number of full-time staff at local public health agencies decreased by 16% between 2008 and 2019, and state health agencies lost almost 10% of their workforce between 2012 and 2019.²

In 2019, an expert panel called for $4.5 billion in new annual investment in public health to close the funding gap between spending on public health ($19 per capita) and the cost ($32 per capita) of foundational public health capabilities.³ Despite short-term funding for COVID-19 response, this funding gap persists. Strategies to boost public health funding, including private philanthropy and political appeals for more taxpayer dollars, have done little to address the shortfall.

Because several public health interventions can lead to reductions in downstream health care spending, collaboration between public health departments and health care payers could help to close the gap.

Natural Partners

Public health departments have local expertise, skills implementing high-value interventions, and trust with many populations, but financial constraints often limit their success and reach. Meanwhile, payers—both public and private—have financial incentives to preserve and promote the health of their members, who live in areas served by public health departments. Despite greater scale and more resources, health care payers’ success is often constrained by insufficient member and community engagement, lack of local knowledge and experience, and limited awareness and trust.

Interventions that promote health and may reduce future spending create an alignment of interests between these 2 natural partners. Both public health departments and health care payers can better serve their populations by working together, leveraging payers’ resources to finance interventions implemented by local public health departments. Precedents exist for this type of collaboration. In New York City, the local health department partnered with health plans to administer a COVID-19 vaccine outreach and counseling program, encouraging clinicians to engage their patients proactively on the need for vaccination.

Public Health Bonds

New financing mechanisms are needed to capitalize on this potential alignment between health departments and payers. We offer that “public health bonds” might facilitate such partnerships.

In this kind of effort, a payer and a local health department would identify communities of interest and specific interventions with evidence-based potential to improve health and reduce health care expenditures. An example of such an intervention is the Nurse-Family Partnership, a home visitation program for low-income, first-time mothers during pregnancy that has shown positive return on investment from reductions in preterm births and health care costs for mothers and children.⁴ Other potential interventions include adolescent pregnancy prevention programs,
tobacco cessation programs for hospitalized smokers, and case management to prevent recurrent homelessness in people with serious mental illness.

To finance the project, the payer and local health department can develop a public health bond, a financial transfer from payers to public health departments earmarked for prespecified interventions and populations that is priced based on the costs of the interventions and the potential returns to the payer (eg, from lower health care expenditures). The local health department could either directly provide services or create a network of local community-based organizations to do so.

The bonds could also include outcomes-based incentives wherein the local health department or its community partners receive additional payments based on predetermined metrics, such as utilization reductions. Such incentives would better align the payer, the health department, and partners while also allowing the health department to share in some of the downstream savings generated by its upstream interventions. In some arrangements, well-organized local health departments could bear some financial risk and reap the rewards of doing so, allowing public health agencies to capture and reinvest some of the value they create.

Challenges

Creative financing approaches to improve population health are not new. Social impact bonds, pay-for-success initiatives, and community health trusts all attempt to attract private capital to underfunded public health priorities, but these approaches have achieved limited effect and scale. Public health bonds would also face challenges in design and implementation.

One key hurdle in engaging payers for prior initiatives has been limited evidence for some health interventions, combined with the fact that some interventions may improve health without generating net cost savings. Fortunately, participants can draw from collections of evidence-based interventions, such as the Community Guide, which is assembled by the Community Preventive Services Task Force and includes economic evaluations. Furthermore, rigorous and preplanned evaluation with a neutral academic partner must be a central component of public health bonds, which provide important opportunities to generate new evidence. The results of these studies would identify downstream health care savings attributable to the intervention, helping price the bonds and calculate outcomes-based bonuses while also expanding the evidence base for future public health bonds.

Another challenge is the "wrong pocket" problem, in which the entity that makes the investment fails to capture benefits that instead accrue to another entity. For instance, when a local health department funds a smoking cessation campaign, some of the financial returns on that investment (lower medical costs) are captured by health insurers. Public health bonds mitigate this problem by asking payers to help cover the start-up costs of new initiatives and allowing local health departments to share in the savings. However, the wrong pocket issue may not be fully addressed by these measures, given that savings from public health also accrue to other entities, including jails, foster care, or social services.

In addition, it takes time—sometimes several years—for some public health investments to generate savings, which dampens a payer’s incentive to invest in prevention because enrollees may switch health plans before the payer making the investment realizes any financial benefits from it. One approach to mitigate this challenge is multipayer alignment at the regional level, building on prior models to finance primary care practice transformation. Another approach is to focus on government payers that can adopt longer time horizons. Although beneficiaries do churn among managed care plans in both Medicare and Medicaid, the federal and state governments ultimately bear the financial burden and stand to benefit from improvements in population health. Local health departments could leverage this interest by partnering with their state Medicaid agency, which could request regulatory flexibility to pursue public health bonds through a §1115 waiver.

Ultimately, bridging the public health funding gap will demand substantial investment from the federal, state, and local governments. Public health bonds or similar programs are unlikely to attract...
sufficient capital to fund public health fully. However, innovative financing mechanisms that bring
payers and public health agencies together may begin to narrow the gap while laying the foundation
for closer collaboration. The potential of such partnerships to advance population health is significant
but remains untapped.

REFERENCES
1. Weber L, Ungar L, Smith MR. Hollowed-out public health system faces more cuts amid virus. Published July 1,
more-cuts-amid-covid-pandemic/
2. Lieberman DA, McKillop M. The impact of chronic underfunding on America's public health system: trends,
underinvesting-in-public-health-lives-livelihoods-risk
evidence-summary
jama.2019.22153
6. Lantz PM, Rosenbaum S, Ku L, Iovan S. Pay for success and population health: early results from eleven projects
7. Chokshi DA, Singh P, Stine NW. Using community health trusts to address social determinants of health.
fullarticle/2760685
8. McCullough JM. Declines in spending despite positive returns on investment: understanding public health's