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HEALTHY COMMUNITIES PROGRAMS UNDER FISCAL PRESSURE: SMART PRACTICES GENERATING NEW RESOURCES AND IMPROVING EFFICIENCY

By

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for
Public Health Law & Policy

Executive Summary

While resource constraints are not a new reality for the field of community health, states and localities, and their partner agencies and organizations, are confronting increasing fiscal challenges in the wake of the Great Recession. Yet the substance of community health policies and programs have never been more sophisticated or innovative, and the fabric of public health professions and practice is stronger than they've ever been. But the working lives of administrators, planners, policy leaders, and service providers in the field have been stressed and strained by increasing budgetary pressure. Programs have been cut, pilots for new approaches have been upended midstream, and the federal and state juggernauts of austerity have taken a real toll on the field.

This report describes and surveys the current fiscal and policy context for healthy communities programs, in an effort to highlight those activities providing strong cause for hope and optimism despite the daunting challenges. After documenting the fiscal environment and setting the policy stage (in the wake of the enactment of health care reform and other shifts), the discussion turns to key features of public health finance, namely, that local innovation and resource growth can increase incrementally but likely will not, and should not, shoulder the majority of financial responsibility for programs designed to benefit the entire population. The report than addresses the ways in which the field has been and continues to be ill-equipped to convert itself from the protector and advancer of the public's health into a heavily bureaucratic, full-accounting budgetary system. To its credit, the field has recognized these areas for strengthening training, operations, and administration, and its capacity to navigate fiscal conditions (good and bad) has never been greater. After addressing the study's research strategy and the limits upon its scope, the report turns to describing a select series of emerging, smart practices which may yield incremental resource growth. Where appropriate, case examples are brought to bear, to illustrate how these practices are implemented and the conditions under which they are likely to work best.

Smart practices covered in this report include:

- Revenues gained via property tax approaches, including health districts
- Social-impact bonds, where programs and investors are paid for by the taxpayers only when specific outcomes are attained
- Community development corporations and finance institutions, familiar in the nonprofit real estate industry and its redevelopment activities in disadvantaged neighborhoods, and now applied toward such health-specific activities as supermarket construction in "food deserts" lacking health access
- The burgeoning "Health and All Policies" movement and its effort to involve a broad swath of government agencies (and their budgets) in renewed, coordinated, collaborative community-health programming
- Federal health care reform and its investment approach toward reducing health care costs via invigorated disease prevention and health promotion
- The community benefit requirements imposed upon nonprofit hospitals under the tax code, and methods for increasing the net contribution of this regulated industry toward population health programming, education, and services
- Collaborations between educational institutions and public health agencies and organizations, in which the academy's resources are brought to bear in advancing public health initiatives
- Increased fees upon unhealthy products like sugar sweetened beverages, ensuring that manufacturers and consumers absorb the cost of unhealthy choices
- Community-health or "public goods" surcharges on public and private health insurance
- State and local government entrepreneurship, selling commodities and services toward renewable revenue generation and managing property assets strategically
- Regionalization and shared service plans, realizing savings and efficiency gains while preserving program performance standards

Three key conclusions spring from this survey of emerging, innovative resource approaches. First, when substantial infusions of new moneys grow unlikely, efficiencies in production naturally develop, most often in the economies of scale available via partnership and coordination (or even consolidation and shared service), and economies of scope in the adaptation toward health of strategies familiar in other fields. Second, in a selective manner, such as in the case of local investment in facilities which boost both public health and aggregate property values, taxpayers may be interested in improving the quality of life of the places where they reside and where they work. Once the health aspects of amenity enhancement are highlighted, the willingness of households to pay, for benefits their children and

future generations will enjoy, may perhaps be summoned anew. Finally, the direction of state and federal leadership concerning the basic economics of prevention and promotion – namely, the slowing of the growth of costs in the health care services sector – has never been more resolute. This fact bodes well for cultivating new fiscal resources throughout the health policy system. Local invention should be communicated to state and national thought leaders, who should continue to reward innovators and fund the most promising public health and public policy approaches. Perhaps more importantly, whenever policy reaches some level of maturity in its development, bringing recognized practices to scale ought to become a more pressing need than continuing to pilot new ones.

Promising directions for additional research include: increased fees upon unhealthy products, ensuring that manufacturers and consumers absorb the cost of unhealthy choices; community-health surcharges on public and private health insurance; state and local government entrepreneurship, selling commodities and services toward renewable revenue generation; regionalization and shared service plans; and utilizing public real estate to generate proceeds via joint use agreements, leaseback and other arrangements.

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I. Introduction

This report will examine the ways America's states and localities are financing public health programs and infrastructure in times of unprecedented fiscal distress.

Innovation is proceeding in this realm, but the problem is hardly brand new. For those working hardest to protect Americans from community health risk, the chronic underfunding of programs is unfortunately quite familiar territory. Even prior to the economic downturn, strategists in the wellness promotion/disease prevention fields struggled with ways to turn policymakers' attention to the urgency of unmet need, and the magnitude of potential medical savings being squandered.

The problem is conceived as national in scope and, as will be discussed below, there are very good reasons public health should continue to be financed primarily at the federal level. As the Bush years wound down, the Trust for America's Health's *Blueprint for a Healthier America*, in a careful estimate conducted jointly with the New York Academy of Medicine, estimated the funding shortfall at $20 billion. This is a tidy sum, to be sure, but in relative terms the deficiency represents less than one percent of the nation's overall health expenditures. An increase to ameliorate this deficiency would bring the US more into line with the proportion of national health dollars spent on prevention services in advanced economies around the world. Successful program expansion and innovation more than pay for themselves in terms of the avoided health expenditures on preventable, chronic disease and disability (TFAH, 2008).

Subsequent to the 2008 election, momentum to address the longstanding policy failures in this area increased at the national level. The movement advocating a healthy communities approach toward combating runaway health expenditures won key victories. As detailed in greater detail below, the passage of the Patient Protection and Affordable Care Act (ACA) represented, at least on an authorization basis, quite successful upgrading of the investments in prevention and promotion, for years to come. Unfortunately, the impact of this historic legislative success has been greatly muted by

the twin forces of political retrenchment and, even more alarmingly, the increasing fiscal crisis being faced by the states and their local governments. And while the national effort's success may translate to greater capacity at the local level for the time being, the financial crisis threatening critically important population-health practice in our communities is grave. With new stories appearing in the national media regarding potential city and county bankruptcies, the need for fiscal creativity in local programs has never been greater.

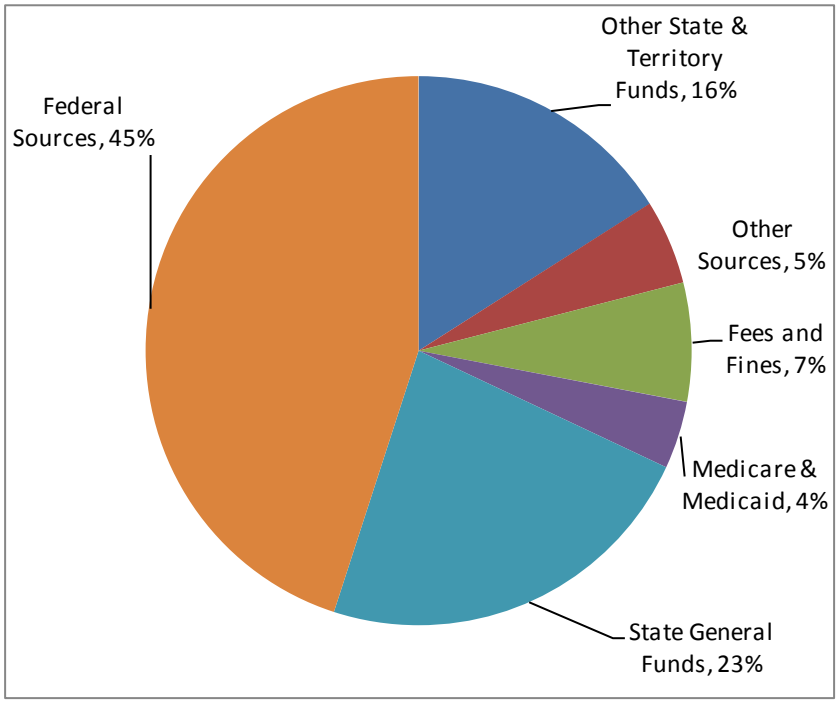

Figure 1. State Health Agency Revenue Sources, FY09 (Sellers, 2011).

As shown in Figure 1, the traditional proportion among funding sources indicates that sustainable, self-generated local revenue for healthy communities work plays a substantial role but remains small in relative terms. Federal grants and state transfers (from general funds and other sources) comprise more than seven-eighths of the moneys available (or 88%). According to this data from the Association of State and Territorial Health Officers (ASTHO), in FY08 fees, fines, and other sources (like foundation grants) accounted for only 12% of state agency resources. These proportions are often difficult to alter,

particularly in an era of shrinking net funding and organizational stress. While the historic proportion is a baseline, and perhaps a constraint, those envisioning a brighter fiscal future for public health are forced to identify compensating resources wherever they can locate them. This will particularly be the case should state population health budgets further decline, let alone the nightmarish scenarios involving deep and lasting federal budget cuts and appropriations falling short of ACA targets.

The scope of America's state and local fiscal crisis is vast and increasing. Many sectors of public service already faced worrisome structural deficits, prior to the precipitous decline in home values and property tax receipts, and the resulting economic contraction and job losses of the Great Recession. As we turn toward the 2012 elections, the sluggish recovery, deepening social need, the rebalanced global economy, and a dim revenue forecast are combining to present elected officials and their financial officers budgetary challenges of unprecedented magnitude. Nowhere is the pinch felt more immediately than in the areas of social service and community infrastructure.

Recent data reflect the budget and job losses in local health departments. A June 2011 briefing on job losses and program cuts, by the National Association of County and City Health Officials (NACCHO), indicated that over half of all local health departments (LHDs) reported negative impacts. Since 2008, 29,000 jobs in the sector were lost to attrition or new cuts, and another 31,000 were affected by reduction in hours or mandatory furlough arrangements. Larger agencies suffered greater losses, and programmatic restrictions in one form or another affected jurisdictions speaking for nearly three-quarters of the nation's population (NACCHO, 2011). Many NACCHO member agencies reported that merit and seniority raises are now delayed, further imperiling not only the quantity of services they provide, but the overall quality as well. Over forty percent of LHDs cut at least one program in its entirety, and almost one in six such agencies had to eliminate three service-categories or more. One in

five local departments reported decreasing or eliminating services for vulnerable populations of women, new mothers, and children.[1]

These conditions are mirrored by how stressful they make life for LHD managers and employees. For times of fiscal duress not only threaten the true bottom line, and imperil categorical programs, but also stress cash flow systems. Business as usual yields to a new "normal," which can for many practitioners make program survival a month-to-month proposition. Numerous LHDs around the country operate at such thin margins that threats to year-over-year carry-forward funds (through statewide claw-back and the sudden or even retroactive imposition of "use it or lose it" decrees) can make operations unstable and fluster central managers' relationships with branch operations and line staff.

The increasing burdens faced by LHDs come amid the continuing budgetary struggles faced by the states. The most recent *Fiscal Survey of States* by the National Governors Association (NGA) documents substantial shortfalls and fiscal strain due to lagged effects of the recession and the winding down of federal stimulus spending. Revenues since the nadir of economic growth in 2008-2009 have consistently fallen short of forecast, causing a regular discipline of across-the-board and/or targeted cuts, and even midyear budgetary tightening, in many states. On the health front, over forty states have reduced Medicaid payments in some fashion, with over twenty states lowering spending on prescription drugs and/or other covered services. In its response to the NGA survey, New York reported over $50 million in cuts to vital public health activities (NGA/NASBO, 2011).

Meanwhile, the forging of ideal targets for healthy communities programs marches bravely forward through the fiscal wreckage. In June 2011, the National Prevention, Health Promotion, and Public Health Council (NPHPPHC) released the *National Prevention Strategy: America's Plan for Better Health and*

[1] NACCHO's "Stories From The Field" series documents programmatic losses over the last few years, in places such as Everett, WA, Reno, NV, Altus, OK, Hurley, WI, Jackson and Lorain (both in OH), and Newton, IL. See http://naccho.org/topics/infrastructure/lhdbudget/index.cfm.

Wellness, which provides a blueprint for revitalizing the health of the US population and its communities. The roadmap for enhancing coordination of disease prevention and health promotion activities throughout the public, private and nonprofit sectors is enlightened, ambitious, and comprehensive. Most impressive is the NPHPPHC's leadership on priority-setting, generation of outcomes, and accountability for making the nation's prevention/promotion systems more productive and efficient in the future. The strategy calls for involving all agencies of the federal government in a collaborative, cross-pollinating effort, to coordinate and enhance all activities relating directly or indirectly to community health enhancement. This places the strategy squarely at the forefront of the "Health in All Policies" movement gaining traction in the US and around the world.

Understandably less prominent in NPHPPHC's vision – and to be fair, essentially missing from its policy-advising charge under ACA as well – is any substantial emphasis on new revenues and resources. Rather, cutting-edge programming seeks new efficiencies and savings primarily via coordination and collaboration. And, given the way programs are designed and rolled out, boosts in the effectiveness of health promotion and disease prevention lower the average cost of helping additional persons touched by these efforts. These are heartening points on which to focus, and they represent genuine, bipartisan leadership from Washington. There remains need, however, for national attention to be paid to the perennial, and increasing, resource deficiencies facing the field as a whole.

The current report intends to survey the field of practice innovation – invention born of necessity – as strategists, advocates, planners and leaders come to terms with the longer-range fiscal challenges facing the healthy communities field. It is intended as a learning tool, accessible to a broad set of practitioners. This work represents a selective but comprehensive survey of US state and local activity and, where appropriate, provides detail on adoption and implementation, political strategy, lessons learned, and directions for further research effort.

In addition, this work anticipates the results of an important, ongoing effort at the national level. The Institute of Medicine's leadership group on fiscal and other matters – its Committee on Public Health Strategies to Improve Health [IOM-CPHS] (within the Board on Population Health and Public Health Practice) - convened a three-phase study in 2009. The first two rounds focused on current issues facing the field in the areas of measurement governance, and finance. The third phase focuses on issues relating closely to this study; IOM-CPHS plans to review funding structures, explore connections between fund utilization and health outcomes, address the problem of disruptions and fluctuations in resource flows, and identify innovative policies and mechanisms for making funding sources more sustainable. This IOM-CPHS report on community health finance is expected sometime during 2012 and will further inform this inquiry.

The next section of the report will address some key conceptual points regarding public finance and federalism. There are good reasons national and state governments have shouldered responsibility for financing healthy communities programs; these realities must be borne in mind as we survey local resource innovations and fiscal reforms. Section III of the report will address structural challenges facing the enhancement of public health finance, and how these challenges have been finessed and overcome with increasing efficiency and sophistication in recent years. Section IV will address the study's methods and limitations. Section V will enumerate and describe a select list of interesting fiscal innovations, policy reforms and shifts, and other developments informing how prevention and promotion programs continue to flourish, despite daunting budgetary realities in the states and communities in which they operate. Section VI will conclude with some summary remarks and promising directions for further research.

II. A Word About Public Finance and Federalism

The world in which moneys flow toward healthy communities programs is part of the complex American public finance system. In the broadest sense, public finance considers how revenues are

collected and expenditures made to maximize the common good. In practical terms, these processes combine quite technical judgments (like the adjustment of federally determined interest rates and the money supply) with political ones (like reckoning with budgetary and taxation choices). Much public finance practice involves insulating the government's work stabilizing the consumer economy from the changing conditions in the political system.

Historically it has been *sound practice*, from a public finance standpoint, to fund community health programs primarily at the federal and state level. The reasons for this are several:

Local variation. Cities and counties vary greatly in terms of wealth and income, education, health status, risk aversion, presence of environmental threats, behavior relative to nutrition and exercise, and numerous other factors. To the extent that disease prevention, health promotion, and the other key outputs of community health are designed for boosting the survival and longevity of all adults and children, regardless of circumstances, the baseline of provision should not vary according to differences in local political will and sophistication. If there is variability in implementation, it should be based upon an intervention model, addressing the gravest threats to the public health with the most urgency. Such judgments across jurisdictions are best made at higher levels of government.

Collective good. The readiest example of how state and federal governments are better positioned than local government is epidemics. Divisions among levels of government are artificial; the spread of disease is not sped up or slowed down by the presence city and county boundaries on the map. When vaccine programs are offered locally, the reduction of risk is enjoyed by neighboring residents as well others located far from where the vaccines are dispensed. Each vaccine has positive, external effects beyond those enjoyed by the individual recipient. The availability of vaccine programs, to be fully effective, needs to be coordinated at the state and federal level. If it is not advanced in this fashion, public finance theory and research shows that the collective benefit of such "positive externalities" or "positive spillovers" will be systematically underprovided.

Diffuse benefits. While a number of healthy communities programs directly impact clients via treatment, much of the benefits are diffuse and thus difficult for individuals, let alone cities and counties, to register and measure carefully. Not becoming ill, not experiencing a deterioration of health status – these are the benefits of successful population-health policies that all healthy individuals and families experience every day. But the linkage between these benefits and the incidence of taxes paying for them is less immediate for most residents, and voters. In the public mind, the connection between property tax and the fixing of a pothole is a tight one, the connection between taxes and public health programs less so. The more diffuse the benefit, the harder it will be politically for local government to finance sustainably, and the more appropriate and successful state and federal coordination and policy implementation become.

> *Economies of scale.* From the standpoint how wisely we utilize resources, we also must consider whether local provision creates unnecessary multiplication of effort. To the extent that program content need not vary widely from place to place, it makes the most sense for more centralized authorities at the state and federal level to set general parameters, goals and performance criteria. When the work in particular areas of community health reaches time-tested practices which are sound and workable, the work disseminating such practices for local adaptation should also be centralized. Indeed, the dream of all public health innovators is to bring their ideas "to scale," meaning that savings from consistent application in different times and places can be realized.

For these and other reasons, the fact that about $0.70 of every public health dollar is generated via the state and federal governments aligns with how things *should* operate under public finance principles. The national scope of major foundations creates an additional source of centralized focus, helping to harmonize local practice and take advantage of these public finance realities.

Naturally these features provide little solace when those levels of government most responsible for the ongoing provision of community health scale back those efforts drastically. There is every hope that the resources available for prevention and promotion will rebound as the economy does. However that may proceed, the preferred apportionment of responsibility for revenue raising and budget allocation would keep the majority of the burden where it has been located, historically and logically, at the state and federal government levels. Any shift toward local ingenuity (and political wherewithal) to fill the widening gap between resource and need should be viewed as incrementally increasing the local share of financial responsibility, not relieving the responsibility of higher government. These creative efforts are welcome, energizing and reassuring. But expanding the city/county revenue role beyond reasonable bounds would run against the logic and heritage of federalism in public health policy, within and among the states.

III. Challenges Facing Public Health Finance Systems

The current fiscal crisis facing healthy communities programs continues and exacerbates, in broader context, the longstanding deficiency of resources in the sector. The Institute of Medicine's two well-known national reports on the public health system (*The Future of Public Health,* 1988; *The Future of the*

Public's Health in the 21st Century, 2002) portrayed a system in disarray, chronically underfunded and understaffed, in which the mission of population health is often given lower priority than health care services delivery. Strapped agencies find themselves unable to make ends meet, let alone develop the performance and accountability systems necessary to ensure that existing and future resources are spent to produce the greatest health-stimulating impacts (Tilson, 2004).

Indeed, the now-developing field of "public health finance" has been hindered historically by a number of structural factors. First, public health practice, while bureaucratized to an extent, mostly lacks the top-to-bottom input-output tracking and controls mechanisms, such as advance Management Information Systems (MIS), implemented elsewhere. This kind of "systems orientation" greatly facilitates the development of more elaborate finance systems. Another factor involves the often split roles of principal and agent in implementation, a lack of systems-orientation, diffusion of responsibility among program funders and implementers, and limits on sophistication of financial practice within administrative bodies. The deficit in financial knowhow in state and local agencies is rather well documented (Costich, Honoré, and Scutchfield, 2009; Honoré and Costich, 2009).

When the unit of analysis is the agency, expenditures on health care services are tangled with those on healthy community programs like prevention and promotion, so that the cost efficiency of either category becomes difficult to assess. Moreover, many programs outside what is traditionally thought of as "public health" have a positive impact on community wellness. Were the sole test the existence of substantial indirect benefit outside specific program impacts, agencies regulating the environment, diverting drug users from the criminal justice system, and licensing barber shops should likely find their way into the broadest accounting of government activity affecting health (Moulton, Halverson et al., 2004). This situation is more than a matter of underdeveloped bookkeeping.

In a world of shrinking budgets, resistance to taxes, and declining public appreciation for the benefits of government programming generally, the struggle to secure resources is twinned with an

often more daunting requirement: proving that such expenditures accomplish their stated goals in verifiable ways. In this sense, it is difficult to explore financial innovation in isolation, outside related processes such as those striving to create standardized systems for goal-setting, budgeting, performance, impact assessment, and accounting (e.g., Brooks, Beitsch et al., 2009 [mismatches between performance standards and budget allocations] Merrill, Meier et al., 2009 [health-agency enabling statutes]; Gebbie, 2004 [complexities of accounting in the prevention-promotion fields]).

The arrival of the National Public Health Performance Standards[2] system is a mixed blessing in this regard. Practitioners welcome the targeted assessment of their work, yet bemoan the time and resources such efforts drain away from the work itself. At the same time, the imposition of performance standards means to grapple with the wide variation in the quality and quantity of programs throughout the states and localities. Standardization is viewed as the bitter medicine necessary to formalize practice, insure its stability, and secure needed resources moving forward (Browning, Cube, and Leibrand, 2004). This is particularly so when it comes to the fiscal aspects of performance. State-level recordkeeping practices and requirements vary wildly, and reliable financial data of even the simplest nature is essentially unavailable (Sellers, 2011). Those wishing to study the fiscal behavior of the field – in this time of urgent analytical need - are having to invent their own methods for generating new data and field-wide surveys. The push for measurement systems for outcomes is particularly pronounced at the federal level, where interagency collaboration is most prized currently, and population-health expenditures perhaps appear most threatened (e.g., IOM, 2010).

We also must observe that preoccupation with financing as a subfield within public health has been perceived, by some, to be a distraction from the key challenges of public health, or at least an unwanted

[2] The National Public Health Performance Standards Program (NPHPSP) is a partnership initiative promoting the establishment and use of performance standards in public health. Part of the effort involves the development of uniform assessment tools to promote continuous quality improvement. For more information on the NPHPSP see http://www.cdc.gov/nphpsp/.

dilution of attention. A common paradigm in training and practice involves the perennial shortage of needed resources. Experience teaches that the pursuit of additional staffing, infrastructure and material is often futile. Boosting resources often involves the friction of politics, among audiences not persuaded toward public health priorities by the overwhelming evidence, either on their fundamental importance or the logic of economic reasoning making the funding case incontrovertible. "There will never be enough money!!!" proclaimed one editorialist (all exclamation points hers) in the *Journal of Public Health Management and Finance* in 2005.[3] "To improve health, don't follow the money" opined another, in the title of an editorial appearing in the *Journal of Preventative Medicine* just this year.[4]

How indeed can money be the focus, when there is so much important work to do? Conditions in the population are dynamic. Threats to health and well-being are often cyclical in nature. The community health field's performance is necessarily one of adjustment, adaptation and invention. These structural of features of practice inevitably become challenging financially; too often experimentation, and related changes in the profession, make program stability difficult to maintain. What this means is that effort which might best be applied toward bringing successful pilot efforts to scale is spent instead mustering resources for new innovation. The Robert Wood Johnson Foundation (RWJF) Commission to Build a Healthier America, in its "Beyond Health Care" report two years ago, put it this way: "Repeatedly, we heard testimony that continuity of funding is a chronic problem. Too often, while start-up funds are provided to establish programs, funders move on to other issues once programs are under way " (RWJF Commission, 2009).

In the end, it is hard to make the evolution of practice anything other than paramount. Over the history of the field, the emergence of strong and stable consensus on so many key approaches – really means the overall attention is right where it should properly be: dollars alone do not promise progress

[3] Bailey, 2005.
[4] Fielding, 2011.

on key determinants and measures of population health. The subtext, however, is that the fight for resources is bound to be an uphill battle, especially in sustaining and expanding programs beyond their proof-of-concept phase. For all these reasons, those pursuing the most strategic, integrative forms of leadership have long recognized that the population health field needs to boost capacity and sophistication when it comes to *financial* innovation, to match and motivate innovation in the delivery of prevention and promotion.

IV. Comments on Search Methods and Findings

The research goal of this study is to identify innovative models for enhancing and stabilizing revenues for public health programs and infrastructure. National web-based, email and telephone outreach was conducted throughout the spring of 2011, in addition to plumbing traditional research and professional literatures in the community health field. Time and resource limits, as well as the open-ended search for ideas (rather than the empirical testing of them), necessitated a process of informed selection based upon essentially journalistic techniques. The strategies detailed below were chosen according to numerous criteria, including: (a) extent of policy development; (b) duration and frequency of implementation; (c) clarity, and ease of dissemination; (d) state and national prominence of referral sources; and (e) flexibility.

Naturally in a study such as this, not all strategies chosen for inclusion here deliver strongly upon all these dimensions. A novel and creative idea may deserve at least some mention even if it has not yet had wide utilization in the field. While some of the strategies have not advanced measurably beyond proposal-stage, the discussion which follows nevertheless provides description, background, and

commentary upon a number of intriguing developments. This narrative thus attempts to lay a foundation for deeper case-based research as well as analysis of survey data on local health practice.[5]

A. Scope of the Inquiry

Prior to turning to the revenue strategies themselves, it makes sense to acknowledge some important considerations lying beyond the scope of this report but providing significant context and background for its findings. First, agencies, providers, and funders throughout the healthy communities field are addressing fiscal crisis via management adjustments rather than revenue raising. The emphasis is upon finding efficiency improvements and producing the same or better outcomes utilizing fewer resources. Money newly saved represents additional cash, which can be spent to stanch programmatic cuts, or at least to mitigate their impact upon the neediest client and patient populations. Transforming the "delivery system" for community health – in the interest of securing such cost savings – is best understood in the context of the broader history of program implementation, and lies beyond the scope of this discussion. Next, of course, it is necessary to point out that annual budget constraints, and cutbacks versus expansions in state and local capacity, depend upon federal spending emphases and programmatic directions.[6] With only a few exceptions, the emphasis in this discussion is upon state and local strategies, but whether new revenues can compensate for overarching cutbacks in federal programs remains to be seen.

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[5] One such survey of local health department revenues and expenditures, funding source categories, recent budget-cut experience and reserve levels is the recently completed, 2010 sample of local health departments conducted biannually by the National Association of County and City Health Officials (NACCHO) in Washington. The data unfortunately will not be released until the late summer, 2011, after this report has gone to press. A request to NACCHO for special early release of the data – so that it could be analyzed for the current report – was declined.

[6] The CDC tracks state-level federal grants (http://wwwn.cdc.gov/fundingprofiles/). For a recent example of external monitoring of the federal preventative health budget – from the series regularly produced by the Trust for America's Health in Washington – see http://www.tfah.org/assets/files/FY12%20Prevention%20Fund%20Chart.pdf.

Third, rarely is it the case that revenue supporting healthy communities programs is raised as discretionary cash for operations, to be deposited into state or local agency general funds. In fiscal conditions such as these, every dollar must be accounted for, and new monetary infusions often require new programming and justification. When strategies involving tax extensions are broached, for instance, the political debate leads inexorably toward questions such as "Exactly what do we get in return?" As discussed above, it is difficult to make diffuse, generalized population benefit palpable and concrete in the heat of such debates.

Political battles must be fought within local settings and it is difficult in a study such as this to be very prescriptive about how to improve the chances of prevailing. The intention here is to broaden the menu of available options. And while most financial strategies described here are necessarily anchored in specific program experience, most feature a measure of flexibility as well, making them adaptable beyond the specifics of their current form. For example, while most applications of community development finance involve physical construction rather than program development, recent innovations suggest this strategy may hold great promise for community health funding. The key is to read these strategies for broad conceptual emphases when analyzing how to best deploy them in specific cases. With vision and creativity, these strategies may find diverse application across the spectrum of public health practice.

A word about leadership is called for as well. The list developed below, for contemplation and discussion among experts in the field, speaks to the remarkable advancement activities already directed by the thousands of finance and development professionals at work in US community health efforts today. Grappling with resource constraints is nothing new for this agile and resourceful field. Public budgets have never sufficed to fund the ambitious, laudable prevention and promotion goals inspiring these fundraising efforts. The future sustenance of critically important programs lies first with the career commitments of those whose stewardship has been providing the lifeblood of public health practice all

along.[7] A number of these organizations and experts have helped point this research in fruitful directions. Needless to say, those regions which have at their disposal established, professionalized community health foundations charged with securing and allocating new revenues for the cause enjoy great advantages over those places where such capacity is lacking.[8]

B. Networks and Policy "Export"

In searching for and compiling financial practices of promise, two additional points must be born in mind. First, success in sharing innovation often depends upon specific factors in the policy environment, including often dynamic political conditions and organizational settings. This is particularly the case during times of fiscal stress. Just because a new idea works in one place does not mean it will be easily adopted and implemented elsewhere. Therefore the dissemination of novel and exciting ideas can itself be a rather demanding enterprise (Bardach, 2008). Such complications must be borne in mind concerning any lists of emerging options on the public health finance front.

Second, communities of practice such as those in public health – with its myriad of professional networks, and leadership and advocacy organizations - often succeed at informing members regarding promising developments and strategies. However, those lines of communication are much better developed when it comes to specific community health practices than they are in the realms of finance and management. In this respect it is now well recognized, but only recently so, that finance, function and performance standards must be aligned and unified if future advancement of the

[7] For a short yet instructive recent paper on one developing philanthropic intersection – environmental health – see Fortunato and Sessions (2011).

[8] Indeed, the establishment of community health foundations – building fundraising and strategic partnership capacities for their geographic regions – is a notion so well recognized in the field that it might be termed an exciting innovation of the past. For example, one such grass-roots foundation was created by the health district in Greene County, OH (outside Dayton) in 1991, and commended as an outstanding practice by NACCHO more than a decade later. See http://www.naccho.org/topics/modelpractices/database/view_category.cfm?categoryID=21. Few would argue that community foundations alone might suffice to ameliorate the historically desperate budget conditions local public health faces today. All the same, those regions sporting substantial human capital in the health philanthropy field may find themselves better positioned to navigate the situation than others do.

prevention/promotion field is to be maximized (Brooks, Beitsch et al., 2009). This, too, is a challenging undertaking.

Along these lines, though, every policy-change effort needing new resource streams must navigate such complexities. There is reason for guarded optimism regarding the community health field's preparedness to elevate critically important expansion and improvement among other, competing budgetary priorities. For example, the field has formed a strong consensus upon the components of essential public health assessment tools (Reedy, Luna et al., 2005). This demonstrates the capacity of community health practice to learn and adapt in dynamic policy settings, and such capacities are critical in managing the continuing fiscal crisis.

We now turn to discussion of the featured resource enhancement strategies.

V. Emerging Resource-Enhancement Strategies

A. Property Tax Revenues To Fund Healthy Communities

Most states cities and counties enjoy broad police powers to place incremental levies upon land and improvements to fund portfolios of public service. Schools, public safety, parks and recreation, and numerous other categories of local government output rely on property tax revenue. Intact, vibrant communities demand a baseline of such services, and numerous jurisdictions include traditional public health activities within that baseline.

The enjoyment of public services - and the responsibility for financing them - rests with all residents. Holders of single-family, multifamily, and commercial/industrial locations and structures calculate the annual costs of ownership of real property; the tax bill is a standard financial element in the real estate world. Once they learn of property tax realities, long-term renters come to expect that their monthly costs include payments toward the property tax obligations of their landlords.

The implementation of such property tax strategies depends in large part upon civic tradition. Once healthy communities programs are transparently funded through property tax – perhaps by explicit

mention of a public health line-item in the annual tax bill owners receive - new residents (purchasers and renters) come to expect that component of ownership and occupancy costs. For example, a family residing at the same location for a generation may blanch when a public health property tax extension is introduced; within a year or two, however, they will adjust their financial arrangements accordingly. By contrast, buyers evaluating sales opportunities after such a tax is introduced will simply factor that element into their mortgage calculation in choosing what new home suits them best and the extent of mortgage borrowing necessary. Moreover, well operated public health systems add substantial residential value; healthier, safer communities are more desirable places to live, and this fact registers among the amenities influencing bid-prices set in the real estate economy. Implementing new levies, or extending the reach and extent of existing ones, is politically burdensome. But once this burden is born, market expectations adjust. For these reasons, the ad property tax approach has special appeal.

That does not mean that popular resistance to new taxation of any kind is easy to overcome. Nor do success stories from the community health field offer any ready "tricks of the trade" politically. One potentially successful approach, however, may be to convince voters that new taxes are "matching funds" necessary to realize the full community health potential of an existing asset or one available for reuse from a prior owner or authority. The "rails to trails" movement has a number of such examples to offer, and often the adaptation of abandoned railway easements into walk-run-hike-bike paths is funded through a mix of public and private funds. The community health benefits of these activities are obvious. One jurisdiction successful in persuading local voters to finance a new outdoor facility via a property tax extension is Marquette County, Michigan.[9] The City of Marquette has a long-established network of bike trails ringing its boundaries with numerous prominent arteries included for cross-city transit. In this instance, local political leadership and organization of volunteers generated a successful campaign to

[9] This policy narrative was provided to the author by Dr. Harvey Wallace or Northern Michigan University and the Public Health Foundation (email communication).

establish the county-level Iron Ore Heritage Recreation Authority.[10] After one failed election effort, the Authority and its supporters persuaded voters to adopt a dedicated property tax extension (known as a "millage" in Michigan) to fund the Iron Ore Heritage Trail system.[11] The trails are maintained on an all-season basis, including cross-country skiing during the winter. Citizens in seven municipalities agreed in August 2010 to pay additional property tax for the trail expansion project. The rate increase lasts for six years and will eventually create a 48-mile system.[12]

Cities and counties interested in replicating the Marquette example would be wise to build into their campaigns an important fact: communities investing in such outdoor trail systems typically increase neighboring property values in the process (Nicholls and Crompton, 2005). Improving amenities and liveability not only advances community health; it makes the place more desirable to future buyers. To the extent property owners can be convinced that new taxes will lead to compensating increases in their home equity, they may be more readily persuaded to support the expenditure.

1. Health Districts: Creating Local Organizations Aligned With Property-Tax Authority

Some states authorize the establishment of separate health-promoting tax authorities, or "districts." These entities have their own elected or appointed boards and operate as independent publicly chartered business entities. The most familiar health-sector entity is the hospital district providing in-patient, emergency and clinical services to the indigent. Such districts, in some states called simply "hospital authorities," constitute key elements of the safety nets in the states which have established

[10] http://www.mqtcty.org/authority_iron_ore.html.
[11] http://ironoreheritage.com/final/index.php.
[12] News story downloaded via http://www.uppermichiganssource.com/news/story.aspx?list=194550&id=492337.

them.[13] Typically it is up to state governments to authorize utilization of property taxes in this fashion and establishment of local utilization/management districts. But the establishment and maintenance of such entities are local matters, dictated by the will and determination of cities and counties. Such districts or authorities act as agencies for the collection and expenditure of property tax revenue and the administration of hospitals and other facilities.

A recent study of southern and Mississippi delta region states that enabled the establishment of public health districts and associated property taxation provides some interesting detail (Honoré et al., 2008). Based upon 2005 data, between forty and sixty percent of local jurisdictions able to pursue the property-tax-based finance and management strategy for public health had done so during the years since receiving statutory authorization. The resulting revenue stream yielded a per capita taxation range of between $6 and $15 (where levies ranged from about one-half percent up to five percent). By way of comparison, such public health levies compare to a per capita property tax range for education funding in those states of $102 to $865. The authors opined that, in general, the frequency and durability of such establishments over time depends upon local political conditions, the structure and operation of state tax systems in which such new levies might be introduced, the reorganization of public health systems, and other factors.

Regardless the complexities facing adoption in a given jurisdiction, there appears good reason for keeping the property tax strategy in play moving forward. Solid property-based financing for health programs produces a sturdier health infrastructure. The studies which have compared such jurisdictions with those lacking levies for public health have found that deployment of such finance mechanisms are

[13] States in which health-sector districts or authorities operate, via property tax assessments, include Alabama, California, Colorado, Florida, Georgia, Idaho, Illinois, Indiana, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, North Dakota, Ohio, Oregon, South Carolina, Texas, Virginia, Washington, and Wyoming. Like other public agencies, health districts and authorities have come under increasing public scrutiny and austerity pressures during the current fiscal crisis (e.g., Hudak [2011]).

associated with positive outcomes for disease prevention and health promotion (Studnicki, Gipson et al., 2007 [Florida]; Honoré, Hodge, Denison et al., 2009 [southern states]).

Though promising from a fiscal responsibility standpoint, the risks inherent in property-tax financing have been made quite difficult to ignore by the economic downturn and, in particular, the collapse of housing prices. Much of the current budgetary pain and red ink in US states and communities stem directly from depressed property tax proceeds, due to loss of ownership equity and subsequent downward reassessments. For homeowners this represents a genuine decrease in wealth, and these losses translate directly to the bottom-lines of the jurisdictions suffering the most pronounced disruptions in their housing and real estate markets. The foreclosure crisis – and the bloated inventories of distressed properties bogging down all sales – carries with it greatly depressed expectations for property tax revenue, into the foreseeable future. Even if the housing market were to stabilize soon, there is a considerable backlog of properties awaiting downward assessment and appraisal. Even though property tax rates remain relatively unchanged, the perception among taxpayers during hard times is that tax burdens have grown more onerous in dollar terms. The enactment of new health-benefit property taxes – or the deployment of new "healthy communities districts," for example – may need to await the return of more positive economic and political conditions.

For autonomous public hospital authorities, there are often cost savings and revenue stabilization realized from political independence alone, even without the property-taxing power of traditional districts. For example, in the late 1990s North Carolina provided county health agencies the power to organize themselves autonomously – outside county governance – as public health authorities. One successful authority is the Carrabus (Co.) Health Alliance (outside Charlotte), which has boosted its public and foundation grants, as well as partnership arrangements, simply by working itself free of the

stringent bureaucratic environment in which it used to operate.[14] Instead the county now transfers a regular stipend (generated under the county's tax authority and pass-through funds from the state) to the Alliance, for provision of state mandated programs like communicable disease prevention and vital records. The "Healthy Cabarrus" coalition organizes thirty member agencies, community organizations, private medical and dental offices, and community leaders, who meet regularly to strategize regarding outreach and efficiency improvements. About two percent of the Alliance's FY12 grant from the county ($4.2 million) represents flexible resources it can utilize for discretionary programs. These county resources are matched by nearly $9 million of other public and private revenues from grants and contracts. In recent debate over the possible realignment of the Alliance – returning it to county agency status – its CEO set the added administrative costs (mostly from grant-application and compliance oversight it now avoids) at nearly $1 million annually. County commissioners voted to retain the Alliance's independence as a health authority (Wilson, 2011).

B. Stimulating Private and Mixed-Source Investment in Healthy Communities

Via municipal bond transactions, real estate partnerships, and other investment vehicles, community improvement can successfully attract private investors and then pay them modest, usually tax-exempt returns on their money. Accessing private investment capital in this fashion - particularly for those too long dependent for program survival upon categorical inter-government grants and philanthropic sources - holds great surface appeal. The "business" case for improvements in population health is clear, via reduction in rates of preventable disease and disability. Prospects for medical cost savings and enhanced economic productivity are substantial, if only from reducing health disparities

[14] The Carrabus Health Alliance's transfer from local county agency to independent health authority was recognized as a model practice by NACCHO in 2006. See http://www.naccho.org/topics/modelpractices/database/practice.cfm?practiceID=304.

driven by differences in wealth, education and other factors. One recent estimate of the economic value of raising the health and longevity of those lacking a college education to the levels enjoyed by those having that education set the commensurate economic gain at more than $1 trillion annually (Schoeni, Dow et al., 2011). The true, aggregate gains from successful investments in healthy communities programs are too enormous to ignore.

The need is obvious, and the economic case is strong. The challenge from a financial standpoint, at a time of dire fiscal conditions facing the public sector, is creating attractive investment opportunities which pay returns back to investors when health savings are realized. More specifically, what are the most promising vehicles for pressing *private* capital into action, to finance expansion and innovation in healthy communities programs?

1. Social Impact Bonds

One innovative proposal for structuring private participation in social spending involves the sale of "social impact bonds" (SIBs) to investors.

The intention is to tap the wisdom of investment markets to fund programs currently operated under government contracts with nonprofit and other providers. An intermediary entity is formed to issue the bonds; the term of art characterizing the intermediary is the "social impact bond-issuing organization," or SIBIO (Liebman, 2011). The SIBIO creates the bonds and sells them into the financial markets. The SIBIO then utilizes the proceeds to engage service providers. Investors' returns on the bonds are made contingent upon those providers accomplishing very specific outcomes. For this reason SIBs are sometimes referred to as a type of "performance-based award" operating under a "pay for success" framework (Overland, 2011). The bonds are "guaranteed" by the government, *but only conditionally*. If the performance requirements of the SIBIO's contracts with providers are explicitly met, the government pays back the bondholders, who receive their original investment plus some capital gain funded by the savings government realizes due to the underlying program's success. The catch: if

the performance thresholds are not met, the government does not pay a dime, and taxpayers owe nothing. In that event, the bondholders are not paid off, ever. Instead, their investments convert to a capital loss or, depending upon how the bonds are written, perhaps tax-deductible charitable donations.

The most prominent example of SIB experiments in action arises in the United Kingdom's prison system. The UK Justice Ministry entered an agreement with a social investment bank known as Social Finance (the SIBIO in this instance) to provide services reducing recidivism rates among inmates at the prison in Peterborough (Travis, 2010). There are gradations of potential success and commensurate upside in investor returns. For example, a sustained 10% reduction in the recidivism rate over eight years requires a government-funded return to investors of 7.5% per year. If the minimum reduction in the rate is not met, bondholders get nothing, and the taxpayers have no liability for financing the experiment at all (Liebman, 2011).

The appeal of the SIB model – and its claimed advantage over traditional public finance – is that over time SIBIOs will bring the same wisdom of investment selectivity, and differentiation among winning and losing propositions, to bear in spending their bond-backed assets on social need. In theory, higher risk vehicles will have to pay investors higher premiums; for the most readily achievable social aims, the government will have to pay less for the capital that investors provide. Put more simply, SIBs bring the "competitive discipline of the market to government programs" (Leonhardt, 2011). From a public policy standpoint, the aggregate gains depend upon the SIBIOs being more intelligent than the government, in terms of increasing the proportion of social expenditures which succeed.

The SIB concept has garnered considerable attention and some early seed money. The Obama Administration's FY12 budget included up to $100 million to explore "pay for success" vehicles in such areas as job training, juvenile justice, elder care and child disabilities (Li, 2011). The Rockefeller Foundation has contributed additional resources toward investigating and piloting the SIB concept, via a $400,000 grant to be utilized and administered by the Nonprofit Finance Fund (Banjo, 2011). RF

participated as a bond investor in the Peterborough prison experiment in the UK, which closed successfully.

To date the SIB effort is only in its formative stages in the United States. While the Obama Administration has mentioned implementation in some areas bearing on the public health generally (e.g., elder care, child disabilities), neither the White House nor potential funders have identified community health programs specifically as promising avenues. The matter bears further inquiry, and circumspection. If they are to be successful, SIBIOs and their grantees will need to produce concrete results within set time frames. Failures will make SIBs far less attractive to both government sponsors and investors, so the stakes for early pilots of the concept are high. This means that early adopters should be those healthy communities programs with the most likely and most concrete measures of success. It remains to be seen how adaptable SIBs will be to the realities of community health practice, but the "pay for success" concept is provocative and should be explored.

2. Community Development Corporations (CDCs) and Financial Institutions (CDFIs)

A promising avenue for boosting capacity in community health work is establishing partnerships with project and program leaders in the world of community development.

For purposes of this discussion, "community development" refers to policies and activities centered upon the physical and economic improvement of disadvantaged local neighborhoods and their residents' quality of life. The federal "Community Development Block Grants" (CDBG) program was established in 1974 and is administered by the US Department of Housing and Urban Development (HUD). Originally envisioned as a program benefiting large, urban areas, the program has been adapted to include the economic development of rural areas as well. To qualify for CDBG funding, cities and counties submit consolidated plans to HUD, outlining local need and specific projects based in part upon input from community members. Congress sets a total annual CDBG appropriation, and HUD allocates

funds according to formulas based upon such factors as poverty rates, age of housing stock, and growth patterns.

The block-grant structure for the federal CDBG program is quite flexible, allowing funds to be used toward a wide variety of economic development purposes. These include: real estate project costs (like land acquisition and demolition) for new construction or rehabilitation of existing residential and commercial buildings; historic preservation; infrastructure projects water, sewer, street maintenance, and the like; community-based facilities like schools, libraries and neighborhood centers; and other expenditures designed to boost the local economy via small-business subsidy and job training. Rarely is it the case that CDBG funds alone suffice to finance entire projects; other grant and loan sources are necessary. To perform the necessary revenue raising, manage projects to completion, and administer new programs and activities, local governments frequently contract with nonprofit entities. A tier of more than 3,500 professionalized, nonprofit "community development corporations" (CDCs) – 501(c)(3) real estate companies operating in the public interest - partner with local government to implement the CDBG and make the economic improvement of disadvantaged neighborhoods a reality. Examples of longstanding CDCs include San Francisco's Tenderloin Neighborhood Development Corporation, the Chicago Community Development Corporation, and New York's Hope Community, Inc.

Though born historically of rather separate disciplines, programs and professionals in community development and community health are quite natural allies. The CDBG program focuses upon placed-based efforts, improving neighborhoods, upgrading residential opportunities, and reusing land and buildings in the public interest. While the field necessarily has a strong real estate bent, much people-based social improvement has been engineered by the CDCs and their partners in government and the private sector. When they are successful, these players marry federal housing and urban improvement moneys with private investment to lift up opportunity zones in urban and rural areas, primarily through upgrading and expanding built space (Frisch and Servon, 2006).

Though its professional heritage lies on the public interest side of residential and commercial building and land improvement, the community development field continues to evolve towards a more holistic, people-centered view of its core goals, focusing especially on prevention models in early childhood education and child care (Andrews and Kremer, 2009). These initiatives, in a sense, return housing and community development policies to their mid-century roots, namely, relieving the threats to health and safety posed by the deterioration of the housing stock (Lang and Sohmer, 2000). Viewed in historical context, the professional division between community health and housing/community development belies the shared heritage of these fields, devoting public resources toward the well-being of people in America's cities and towns. Ultimately, the social returns to the expansion of usable space depend upon the uses to which that space is put. Square footage alone does not an anti-poverty and neighborhood revitalization program make.

Recently leaders in both the community development and public health fields have been exploring new partnerships, crafting coalitions which will refuel work across their respective, intersecting policy landscapes (RWJF, 2011). Key players include the Robert Wood Johnson Foundation, GPS Capital Partners (with pilot development/health partnership sites in King County, WA, Alameda & Los Angeles Counties, CA, and Clark County, NV), and the Center for Community Development Investments at the Federal Reserve Bank of San Francisco. One area where community development and health intersect is the construction of local health centers.[15] Other programmatic overlaps include inner-city food access efforts and environmental justice activity addressing poverty concentrations near brownfields and other threats to child and adult health. Practitioners have long recognized the ways that livable cities and lower-sprawl, less auto-dependent "smart growth" patterns produce their own benefits (Dannenberg

[15] Two such CDBG-funded community health centers, one in Bremerton, WA and the other in Garland, TX, were listed by HUD as notable success stories on the occasion of the thirtieth anniversary of the CDBG program in 2004 (US HUD, 2004).

and Jackson, 2003). Community development and public health have growing interest in assessing and trumpeting the positive impacts of their efforts. These impacts intersect and complement each other. [16] Specific cases and approaches are discussed in greater detail later in this section.

There are natural intersections in terms of community development finance, as well. An analysis of existing operations in the healthy communities sector may find a number of limiting factors similar to those traditionally facing inner-city investments in the urban revitalization field. For example, small and fragmented programs operating in distressed neighborhoods may lack the assets and credit histories necessary to attract risk-based investment capital. Reorganizing the ownership and management of such programs may boost their credit-worthiness and established a minimally sufficient asset base. Likewise, so long as the field is dominated by innovations in the testing phase, which are defunded upon the arrival of new and interesting experiments, the investment community may lack the necessary proof-of-concept. This prerequisite is not unlike the kind threshold surpassed when a start-up generates stable enough profits to make a initial public offering of common stock successful.. In public and private enterprise, venture capital is notoriously migratory, seeking the next hot idea. Those with institutional memory may see similar patterns in the financing of innovation in public health and other service sectors. The mode of competition is quite different, but the lack of durability is actually quite comparable.

At one level, the availability of new resources for healthy communities may rest upon just these kinds of strategic partnerships. Under this model, those agencies and nonprofit organizations expert in community health program design and implementation would enter social-service provision contracts with the sponsors and operators of new community facilities. Health-focused services are funded via

[16] Of course, in the predominantly real-estate-driven culture which informs community development practice, public health outcomes are liable to be characterized as “non-financial” (Thornley and Dailey, 2010), and this perception needs to be corrected.

traditional public agencies seeking on-site provision; in addition, CDCs also utilize new facilities to motivate fundraising campaigns promoting new site-based programs. In other instances, "mixed-use" projects include space for market-rate residential units and for-profit storefronts; a portion of these revenue streams can be utilized for health-related programs in a kind of cross-subsidy arrangement. Examples of these arrangements are abundant, such as those that can be found in the "service enriched shelter" industry supporting vulnerable populations living in affordable housing developments. Projects developed by the Corporation for Supportive Housing (CSH) and similar organizations infuse traditional affordable housing policy with public health thinking and practice. They develop residential projects which become nodes for treatment of vulnerable populations.

Wonderful results are possible when public health departments incorporate supportive-shelter access as an explicit division of practice. In northern California, the "Direct Access to Housing" program (DAH) was established in 1998 within the Community Programs Division of the San Francisco Department of Public Health[17] (Richter, 2009). Driven by a cross-agency working group addressing the city's chronic homeless population, DAH master leases single-room occupancy and other units from private building owners and installs on-side mental health, drug treatment and job-skills services, often on-site. City departments collaborating in the effort, and providing staff and resources, include the human services and mental health agencies. Funding originally derived from federal and state program sources was boosted under Mayor Gavin Newsom's Care Not Cash effort.

[17] http://www.csh.org/index.cfm?fuseaction=Page.viewPage&pageId=501.

A related example in San Francisco involving new construction is the Canon Barcus Community House, an award-winning, service-enriched 48-unit residential development for the homeless and special-needs families.[18] Operated by Episcopal Community Services, the residence hosts social, health, education and related services, including a health clinic, child care, after-school programs for youth and teens, and children's mental health maintenance. Like many such programs in the housing and community development field, operating funds are provided from a variety of sources, including federal McKinney Act Shelter Plus Care grants and other public and philanthropic funding. Construction loans were provided by the San Francisco Redevelopment Agency. CDBG funding may be flexibly applied toward a variety of local prerogatives, and many localities are utilizing these moneys towards the establishment of clinics providing not only medical care but health education and promotion as well.[19]

Over the years, CDCs have become relatively sophisticated players, undertaking real estate projects in the public interest. Just as CDCs have become a more and more professionalized field, other organizations have arrived on the scene to concentrate on delivering the financial services necessary to the success of complex, multiple-source projects. We will explore how these *community development financial institutions* (CDFIs) can play a key financial role in the sustaining of healthy communities programs. First, however, it is important to recognize the specialized financial environment in which CDFIs have developed.

In the areas of housing and community development the federal government, and some states, have stimulated neighborhood-level private investment in various ways. The professional expertise of

[18] http://www.csh.org/index.cfm?fuseaction=Page.viewPage&pageId=757 (downloaded 04Apr11).

[19] A recent example is the use of CDBG funding for the acquisition of space for an after-hours clinic in the city of Buenaventura Lakes, Osceola County, Florida. http://www.osceola.org/public_information_office/111-18265-0/county_takes_next_step_in_bringing_clinic_to_bvl.cfm (downloaded 22Jun11).

CDFIs (and CDCs as well) have developed as a result of these mechanisms. Supplementing existing categorical grant programs at the federal and state levels, each of the key financial innovations was strategically implemented via existing law: the regulation of financial institutions, the income tax code, the land taxation system, and policy-driven grant programs.

- The Community Reinvestment Act (CRA), for example, provides financial institutions specific incentives to invest in distressed local communities via grants, loans and service expansion (Gabriel and Rosenthal, 2009).

- The Low Income Housing Tax Credit (LIHTC), introduced in the Tax Reform Act of 1986, and the New Markets Tax Credit (NMTC) (adopted in 2000) modeled after it, provide investors in low-income projects and neighborhoods income tax credits of specified duration, in exchange for their qualifying investments in funds and projects complying with applicable sections of the tax code and IRS regulations (Roberts, 2009/2010).

- State redevelopment finance equips local agencies with the power to leverage their financial participation in new projects against the expected growth in ad valorem receipts, based upon enhanced property values. Such "tax increment financing" is a common element in urban redevelopment in the residential and commercial sectors (Man and Rosentraub, 1998).

For each specific project, the assembly and harmonizing of multiple, diverse resource streams – each with its own approval, audit and compliance schedule - calls for creativity and patience. The CDFIs, CDCs and other intermediary institutions participate in a quite professionalized sub-industry, specializing in just this kind financial engineering.

a) Food Access and Supermarket Development

One area where this kind of project-level financing can directly benefit healthy communities goals is the development of new centers to enhance access to nutritious food. In too many geographic areas, supermarket chains fail to locate stores in disadvantaged neighborhoods, thereby depriving vulnerable populations access to healthy nutrition sources. . A recent federal study counted more than eleven million lower-income people living in poor areas more than a mile from a suitable food market (USDA, 2009). New policy attention – jointly informed by the philosophical approaches of both public health

and community development – has been brought to bear upon supermarket development projects which aim to close the "grocery gap."

In Washington DC's Ward 6, for example, the city approved a new grocery and department store to be operated by Walmart, as ground-floor retail in a building housing market-rate residential units on the upper floors. At first, community opposition was fierce, but the company maintained its optimism regarding the business opportunity and the city signaled continuing interest in revitalizing the neighborhood. Throughout the negotiations, everyone recognized the need for bringing new, much needed supermarket capacity to an underserved area of the city. Brokered by a local financial intermediary hired by the company, the resulting deal was part of a series of transactions the company entered with the city, based upon tax breaks and other exchanges under a "community benefits agreement"[20] (CBA) (DePillis, 2011). Provisions familiar in such CBA frameworks include setting aside jobs in the new store for neighborhood residents and price breaks for purchases by community organizations.

Inspired by the people-and-places approach championed by CDFIs and CDCs, a number of other encouraging efforts are afoot in the food access area. Bell and Standish (2009) describe successful installation of grocery markets in urban, suburban, and rural neighborhoods, including the Diamond neighborhood of San Diego and Chinle, Arizona within the Navajo Nation. Key resources for needed capital have included tobacco litigation settlement funds, NMTCs, tax increment finance in redevelopment zones, and the vigorous healthy-foods emphases of the Women, Infants and Children

[20] In general, the negotiation of a CBA - in which the community asks new residential and commercial development (as well as government projects) to participate in the provision of local need and act as a good neighbor, perhaps beyond the levels technically required by law – holds some promise as an avenue for healthy communities work. Benefits can include grocery store leasing commitments as well as other positive contributions towards neighborhoods, their environments, and the wellness of their residents. CBAs have secured a variety of potentially health-enhancing benefits directly from developers and project sponsors, including construction of youth center facilities, restrictions on truck idling, brownfield cleanup and contaminant removal (Moore and Nettles, 2010).

(WIC) and Supplemental Nutrition Assistance (SNAP) programs (bolstering demand for fruits, vegetables and key nutrition sources).

A national model for local financial incentives is the Pennsylvania Fresh Food Financing Initiative (FFFI) (Giang, Karpyn et al., 2008). The State of Pennsylvania authorized a seed fund of $30 million and entrusted its management to a well-established CDFI known as The Reinvestment Fund (TRF). Based upon the established fundamentals of locating profitable outlets in underserved neighborhoods, TRF utilized the state funds, NMTC moneys, and other sources to attract another $165 million for use as a flexible loan program. As of September 2009, TRF reports, FFFI had committed $59.7 million in grants and loans to 78 applicants.[21] More than seventy-five new stores have been established, creating thousands of local jobs for existing residents and enhancing food access for hundreds of thousands of people and a boost in neighboring property values. The FFFI model is now being replicated. Local, publicly provided seed funds are underway in New York City, New Orleans, and the states of Illinois and Louisiana; there is talk of a national program as well (Bell and Standish, 2009).

To attract grocery stores to low-income neighborhoods, information-sharing is also key. Supermarket chains are not reluctant to enter markets so long as risk can be managed and sufficient returns are in the offing. Some of the most successful work government can do in this realm is to correct the misperceptions of grocery store chains regarding potential profitability within vulnerable communities.[22] Leadership and deal-making comes from the community, especially where financial sophistication can be brought to bear by CDCs or CDFIs. Political sensitivity is also a prerequisite, to insure that local, lower-income populations are not displaced when new development promising

[21] http://www.trfund.com/stories/supermarkets.html (downloaded 08Jun11).

[22] A how-to guide for CDC supermarket development also lists success stories in Boston, New York, Newark, New Haven, Philadelphia, Washington, D.C., Miami, Houston, Charlotte, Kansas City, Chicago, Detroit, Milwaukee, Los Angeles, and Oakland (Abell, 2001). A number of these successes depended in no small part by having the supermarket chain share financial risk, at least in the first instance, with a CDC. Many of these supermarket developments also include low-interesting financing, if not soft-lending, from the host municipality.

community health improvements potentially increases neighboring property values and rents (Levy, Comey and Padilla, 2006/2007).

Needless to say, the movement toward healthy eating and the promotion of new grocery store development in disadvantaged neighborhoods is gaining significant momentum. The White House recently rolled out First Lady Michele Obama's effort, as part of her "Let's Move" initiative combating childhood obesity, to entice major grocery chains to add stores in "food desert" areas currently lacking convenient access to safe, fresh, nutritious and affordable food supplies. Participating companies and organizations include SUPERVALU (250 new stores promised), Wal Mart (275 to 300 new stores) and Walgreens (new food centers in over 1,000 existing stores).[23] This means that numerous financing models will be deployed with these and other companies leading the way. The enterprise represents a genuine stream of new resources for community health programming relating to nutrition, weight management, obesity prevention, and other food-related emphases.

b) Community Health Centers/Medical Homes

Development of community health centers (CHCs) is another crossover activity advancing collaborative interests in the health and revitalization fields. Like other elements within CDFI/CDC financial practice, there may be opportunities to utilize existing federal grant streams to attract new investment from private and related sources.

As of 2009, approximately 1,200 federal qualified health center organizations were operating over 8,000 delivery sites and serving some 20 million patients from vulnerable populations annually (NACHC, 2010a). Beyond their well established safety-net functions in the direct delivery of lower-income care services, CHCs are epicenters for prevention and promotion activity, providing annual medical cost savings of $24 billion. This logic drove key elements of investments under the Affordable Care Act (ACA)

[23] The White House's fact sheet on the "Access to Healthy, Affordable Food" element of the Let's Move initiative can be downloaded via http://www.letsmove.gov/sites/letsmove.gov/files/Food_access_factsheet.pdf.

in healthy communities, authorizing an $11 billion CHC Trust Fund. $9.5 billion is devoted toward expanded operations in existing facilities. The remaining $1.5 billion provides resources for capital improvements, maintenance, and construction of new facilities (NACHC, 2010b).

Conceivably, these and other moneys could be utilized to stimulate even greater financial infusions into CHCs, in part because CHCs are both drivers, and beneficiaries, of community revitalization. An interesting model is the Brockton (MA) Neighborhood Health Center (BNHC).[24] BNHC provides a variety of medical and prevention services in a distressed urban area suffering from substantial job losses in recent years, as well as a great influx of vulnerable immigrant populations requiring multilingual services and greater attention to HIV and other treatment emphases. After more than a decade operating out of mobile vans and leased space, BNHC completed a major downtown expansion in 2010. The new 58,000 square foot facility – adding sixteen exam rooms and tripling patient capacity would not have been possible without creative utilization of diverse financial sources, several of which were outside traditional health budgets. Contributions came from the Economic Development Administration, NMTCs, and federal stimulus moneys. The financial blending of various sources was managed by a noted CDFI, NCB Capital Impact. Creative revenue approaches overseen by this firm on the operations side have included:

- Partnering with market-rate pharmacies to facilitate participation in federal pharmaceutical purchasing programs (e.g., Community Health Center, Inc. in Middletown, CT).

- Charting successful capital-campaign fundraising for major expansion, supported by redevelopment finance, NMTCs, and low-interest CDFI lending, and partnership with

[24] The BNHC success story and other CHC initiatives undertaken in the CDFI sector are described by Sporte and Donovan (2009).

an affordable housing developer occupying upper floors of the clinic building (e.g., "Westbrook Plaza," South of Market Health Center, San Francisco).[25]

- Nonprofit Finance Fund, another CDFI involved in health care delivery within lower-income communities, contributed low-cost seed financing to help attract $145 million toward facility expansion, quality improvement, and administrative capacity for Medical Homes DC (Washington), a network of eleven CHCs in the nation's capital (Richter, 2009).

3. Diversifying Healthy-Communities Investment Sources: Some Considerations

CDFI and CDC involvement in financing healthy communities programs hold great promise, as do innovations such as social impact bonds. However, a number of considerations counsel proceeding with deliberation and care in this realm should proceed with caution when it comes to experimentation with private funding sources.

First, as affordable housing finance has shown over many years of experience, multiplying the sources in any given project can create a problem of "multiple masters," each with its own elaborate qualification, monitoring and compliance regimes. When tax increment or NMTC funding is brought into play, for example, the criteria measuring a project's success understandably move beyond traditional public health criteria. Making performance standards more uniform across the landscape of public interest spending in vulnerable community is an arena of positive progress in recent years, but much evolution remains to insure that every dollar is spent as efficiently as possible towards substantive, health-based outcomes.

Second, there is also the issue of transactions cost; broadening the set of available resource streams adds complexity and increases the management burden. The more complicated transactions become,

[25] See http://www.smhcsf.org/westbrook.html.

the more inefficient the use of the resource.[26] This is where financial intermediaries earn their appropriate share of project budgets: harmonizing and administering funds from disparate sources.

Third, private sources of the sort promised by the SIB model come with their own unique hazards. Attracting private capital to fund traditionally public functions can appear controversial in public perception. There is a thin line between private investment and outright privatization (see Ratigan, 2011). And, in order for "shares" to be sold, or operations eventually transfered to for-profit firms, profit expectations must be realistic. The efforts of governments and their nonprofit agency contractors have never been held to any standard of profitability in the past. Directing private investment toward the public good risks a kind of adverse selection: directing service toward paying customers, emphasizing financial gains over health promotion and equity. To deepen the involvement of private capital in the field, a culture shift in view and perspective will need to take place. Participating agencies and organizations will need to be those "both committed to improving conditions for vulnerable populations and capable of repaying investments" (Richter, 2009). Of course, such historical shifts are often born of necessity.

Fourth, the movement in community development finance toward a community health orientation for projects and programs is provocative - and welcome – but there is reason for circumspection here. It may be difficult to bring these concepts to scale without substantial new policy initiatives at the federal and state levels. Historically CDFI/CDC practice has benefited from important federal policies on neighborhood revitalization. The Community Reinvestment Act, for example, provides clear financial incentives for banks to do business in disadvantaged areas. There is genuine money to be made when depressed property values rise with new construction and other improvements. This reality drives much of the policy orientation of LIHTC, NMTC, enterprise zones, and redevelopment/tax increment. Outside

[26] For an instructive analysis of efficiency issues in LIHTC-based multiple-source affordable housing finance, see DiPasquale and Cummings (1999).

the case of supermarkets, it is hard to see how community health can motivate the work of private nonprofit firms in this fashion. (The closest parallel may be in the context of tax-exempt hospitals and their public service obligations; this case is treated in greater detail below). . Regardless of how easily CDC/CDFI approaches can be adapted, the critical point is that such projects must be mindful of their health-related impacts, and associated opportunities for health improvement. This holistic posture echoes the movement in federal and state governments to identify the health impacts of all policies (Health in All Policies or "HiAP" [discussed in detail in the next section below]).

Finally, a number of voices in the nonprofit sector caution that social impact bonds and similar vehicles are part of a longer history unfortunately capping sector ambitions, privatizing social needs provision, and downsizing the aggregate budget for social spending (e.g., Rosenman, 2011). There may be quite a difference, as a practical matter, between the performance data traditionally produced to show health agency success, on the one hand, and the stricter requirements of quasi-"profitability," on the other. Debates over outcomes measurement in the social services sector are, of course, nothing new (Francis, 2011). There is continuing discussion among reform proponents and traditionalists regarding both 1) reliable assessment of program impacts and 2) problems establishing that programs *caused* the improvements they claim. If returns to private investors must be based upon high-stakes determinations of program success, the impacts-assessment field may need to be further along in its development before any expansion of private-investment models can be brought to scale.

C. Regulated Pricing and Impact Fees for Dangerous Products: The Case of Sugar-Sweetened Beverages

One great challenge for community health is helping individuals and families make smart decisions concerning their own behavior and the products they choose to consume. In the case of dangerous products (or products which become dangerous if not used in moderation), public policy offers constructive options in terms of both health improvement and revenue generation. Consumer

protection and healthy communities go hand in hand, and regulated sales can offer the possibility of increased revenues for health promotion campaigns. “Sumptuary” taxes have been used frequently when it comes to potentially dangerous products, and such tax vehicles show great promise for boosting resources. Caution should be exercised in the design of such fees, however. There is some risk that such policies overly burden lower-income households, as well as giving rise to black- or grey-market distribution of the product to avoid the tax. The latter can bring with it substantial monitoring and enforcement costs to make the tax effective.

Childhood overweight status is strongly associated with later onset of type II diabetes, heart disease, cancer and stroke. In the fight to reduce childhood and adult obesity, national and community health leadership are engaged in a comprehensive advocacy effort to focus attention on the role of sugar-sweetened beverages (SSBs) in causing obesity and subsequent disease. As is the case with alcohol and tobacco regulation, such consumable goods which heighten the risk of serious disease provide a natural focus for community health policy. SSB consumption is on the increase, what with the recent growth in sales of sweetened teas, energy drinks, and flavored waters. The question facing state and local policymakers is whether to couple stern messages about negative health effects with price signals making the case even more forcefully to consumers.

Advocacy for tighter controls has a dual effect of educating the marketplace regarding the dangers of such products and encouraging manufacturers and distributors to take responsibility for the effects of their business on population health. These advocacy efforts on SSBs are being led by significant voices, such as the National Policy & Legal Analysis Network to Prevent Childhood Obesity (NPLAN) [a project of Public Health Law & Policy (PHLP)] and the Campaign for Healthy Kids. About two-thirds of all states tax soft drinks in some fashion, and this necessities some exclusion from the typical food and beverage exemption from sales taxation. Educating legislators about the health benefits of new taxes is

demanding work, and these efforts proceed apace with potential for new adoptions in many jurisdictions.

With respect to this report specifically, efforts to levy new or increased taxes and user fees on the purchase of sugar-sweetened beverages promises these health benefits as well as a stream of new revenue supporting healthy communities programming. Like government regulation of antisocial consumption and behavior, such fees also serve to correct the ways in which consumers are misinformed regarding the safety of goods and services, often due to incomplete or misleading information provided directly by the sellers. In the case of SSBs, the thirst and satiety responses seem rather dampened in many consumers – particularly those most prone to weight gain. This factor arguably supports adding sales taxes (or excise levies on wholesale transactions) that are large enough to make a genuine behavioral difference for those buying SSBs. Were these products sufficiently more expensive we should expect some reduction in overall demand levels.

Recent research by Yale economist Jason Fletcher and his colleagues provides only weak evidence supporting this claim, however. Incrementally higher soft drink taxes were associated in their study with positive reductions in body mass index (BMI) (Fletcher, Frisvold and Tefft, 2010). However, these authors' models find only small effects (albeit statistically significant ones) for soft drink tax rates that on average are quite moderate. This leaves open the possibility that more drastic tax increases could potentially spur greater decreases in the amounts consumed and greater population weight reductions as a result. In their discussion, Fletcher and his colleagues highlight Maine's twenty-percent increase in the underlying tax on soft-drinks as one policy to watch in this regard. Additional research will be necessary to assess the impacts of more stringent regulation of SSBs.

From a political standpoint, tax increases of any kind pose a particularly difficult advocacy burden right now, in general. The challenge is only intensified by the well known vitality and unity of the SSB industry and its lobbying agents, known to utilize anti-tax sentiment to rally voters and consumers to

their cause. Cautionary tales abound in recent news reports, where new SSB taxes were either withdrawn, narrowly defeated or repealed shortly after successful adoption. For example, in early 2010 the state of Washington adopted SB 6143, taxing all carbonated beverages at two cents for every twelve ounces at the wholesale level. That tax was repealed by popular initiative (ballot proposition 1107) in November of the same year. In New York a proposed penny per ounce excise tax on SSBs was projected to prevent hundreds of thousands of adult obesity cases and tens of thousands of diabetes cases per decade while saving billions in health care costs avoided. A $90 million advertisement campaign asked voters to "tell Albany to trim their budget fat and leave our groceries alone." In Washington DC the industry funded radio spots featuring stereotyped African American voices saying that "soda's 'bout to git waaay more expensive." These tax proposals were quickly withdrawn (Kamerow, 2010).

For the SSB-control movement, there are numerous alternatives to outright consumption taxes and other fees, including vending machine regulation, school-lunch menu upgrades, public service education campaigns, financial rewards to consumers for lowered use, and other steps. Nevertheless, regardless of the SSB tax's ultimate effectiveness, distributional effects and unanticipated consequences like grey markets, this policy approach can provide a substantial boost in the kind of healthy communities funding needed for pursuing these alternative steps. A multifaceted approach would seem optimal.

D. The Health in All Policies Movement

"Health in All Policies" (HiAP) is an important, burgeoning movement on the healthy communities front. The ambition is comprehensive and possibly transformative, namely, to coordinate and amplify all decisionmaking with direct and indirect impacts upon human and community health, across all conceivably pertinent aspects of government activity. Yet HiAP's bold intentions arise from relatively simple premises. In the broadest sense, nothing a civilized government does, or has ever been charged with responsibility for, falls far afield from the fundamental desire to promote the safety and welfare of citizens. It is from these premises, and its guarantees of liberty, that an evolved government derives its

legitimacy. Indeed, political philosophers aiming to define "the public interest" eventually arrive at conceptions of acceptable individual and aggregate thresholds of – first and foremost - human well-being. Just as holistic perspectives on individual health rightly emphasize obvious connections (physical, mental, emotional, family, work and play), HiAP asks that government begin a similar form of health policy integration. While the early efforts at implementing this vision do not immediately focus upon new revenue (or cost sharing) for health improvement specifically, future audits for successful programs will quite possibly show savings from efficiency and resource growth from interagency collaboration. With this emphasis, community health leaders in the US are joining an international movement exploring the HiAP approach.[27]

Out of its progressive starting blocks, HiAP first aims to derive a full and accurate accounting of all things government does and assess health impacts. The initial impulse is therefore to survey the full, current landscape of government practice. HiAP asks that government explore, across all activities by its elected principals and its professional agencies, ways to increase health promoting activities and decrease –or moderate the impact of those risking harm to the public's health. This formidable undertaking, even for counties or small states, poses substantial administrative challenges. As public health leaders mark the advancement of HiAP, the realities of institutional fixity, professional "turf," and other factors should be weighed mindfully.

1. California's HiPA Task Force: Planning Collaboration, Finding A Consensus Vision

By directive from former Governor Arnold Schwarzenegger and his Strategic Growth Council (SGC), California's HiAP Task Force began work in February 2010. Nineteen agencies of state government were

[27] International bodies leading the international HiAP movement include the World Health Organization (Europe) and the EU Open Health Forum (Jakab, 2010), and South Australia (Adelaide Statement, 2010).

designated for participation,[28] and point persons were selected from each agency for representation on the task force. The goals for the initial months of the task force's work were forthrightly interdisciplinary. Its charge springs from the essential recognition that, whatever the administrative returns may be to specialized and fragmented governance, population health must be an overarching goal-framework for all policy and implementation activity across the government. The SGC's charge to this task force required it to quickly "identify priority programs, policies, and strategies to improve the health of Californians while advancing the SGC's goals of improving air and water quality, protecting natural resources and agricultural lands, increasing the availability of affordable housing, improving infrastructure systems, promoting public health, planning sustainable communities, and meeting the state's climate change goals" (SGC, 2010). Across administrative, policy, jurisdictional and other subject-matter and procedural boundaries, the effort for the HiAP task force thus far has been to find the threads of healthy communities work across the breadth of state government and to weave those threads together in newly motivated and energized ways.

What the California HiPA task force has achieved over a very short period of time is nothing short of miraculous, and what it has achieved bodes well for the generation of new financial resources available for community health policies and programs. Working with agency liaisons from across the state government, the task force crafted and gained buy-in for "issue briefs" identifying health impacts and health-improvement opportunities throughout the policymaking community in Sacramento and around the state. Areas covered in this process included: agriculture; justice (attorney general); environmental

[28] A list of the agencies involved in California's groundbreaking effort provides some sense of the comprehensive, almost audacious expanse of the undertaking: Air Resources Board; Business, Transportation, and Housing Agency; Department of Community Services & Development; Department of Education; Department of Finance; Department of Food and Agriculture; Department of Forestry & Fire Protection; Department of Housing & Community Development; Department of Justice; Department of Parks and Recreation; Department of Social Services; Department of Transportation; Environmental Protection Agency; Governor's Office of Planning and Research; Health and Human Services Agency; Labor & Workforce Development Agency; Office of Gang & Youth Violence Policy; Office of Traffic Safety; and the Department of Public Health.

regulation; community services and development; public safety; schools; social services; housing; natural resources; transportation; and employment development and labor. In this process, and via public hearings conducted around the state, the task force compiled over one thousand health-policy recommendations. These ideas ran the gamut, including topical emphases such as workplace wellness for state employees, parks and urban greening, crime and violence prevention, alcohol and tobacco, nutrition, water, land use, interagency and state-local collaboration, civic and community engagement, and even political participation. The task force, all agency liaisons (with executive approval), and various collaborators then found consensus on priority areas for immediate policy attention and reform across the government:

- Active transportation through implementation of "complete streets," to be forged in part by sustainable land planning and zoning
- Smart housing siting via new approval processes identifying air quality and transit impacts
- Urban greening and access to green spaces
- Crime prevention efforts mediated via environmental design
- Violence prevention via data-informed training and community engagement
- Food access via affordable, local produce and "farm-to-fork" programs
- Healthy eating and sustainable local food systemsH
- Health and health equity perspectives in state guidance, surveys, and technical assistance publications
- Health-based criteria for scoring all state grant-assistance applications
- Add health analysis into existing state projects and activities
- Feasibility studies for adding health criteria to standard evaluation of proposed legislation and budget change proposals

(CA-HiAP Task Force, 2011).

These are bold, innovative, refreshing initiatives. California's HiAP task force is a model for other jurisdictions undertaking a collaborative review of policies and programs in the name of advancing public health with renewed momentum and effectiveness. From a fiscal standpoint, HiAP's promise should be obvious: its potential for bringing more agencies, along with their budgetary resources, into a larger and more comprehensive public health effort throughout the government. In this respect,

however, HiAP's fiscal impacts remain uncertain. The Strategic Growth Council and its HiAP task force have not yet determined needed budgetary commitments, nor have they confronted in a serious way the political effort success in that undertaking will require. The current budgetary environment in California is rather forbidding when it comes to broad-minded reform, and the HiAP effort is a careful and deliberate one. The groundwork for collaboration which has been put in place, and the immense effort to find consensus on a set of short- and long-range priorities, is impressive indeed. How successful implementation of these priorities may change the audited financial picture for community health in California remains to be seen.

E. Maximizing Sustainability: The Federal Patient Protection and Affordable Health Care Act (ACA)

The ACA's funding targets, awaiting annual appropriations, are impressive, and promise great progress. The initial authorization for PPHF in 2010 is $500 million. This is set to increase in $250 million increments through 2014, with the annual authorization reaching $2 billion in 2015 and beyond. The logic behind this aspect of ACA's comprehensive reform can be found in the statute itself, framing a national intention for investment in prevention and public health, to stem growth in health care cost. Programmatic avenues for this approach include four elements: clinical and community preventive services task forces, education and outreach campaigns, preventive services in Medicaid and Medicare, and community transformation grants (CTGs).

Just prior to the 2010 elections, some limited financial progress was indeed made. The US Department of Health and Human Services (DHHS) awarded $42.5 million from the PPHF to state, tribal, local, and territorial health departments, covering 94 projects under the Center for Disease Control (CDC) "Strengthening Public Health Infrastructure for Improved Health Outcomes" program (US DHHS, 2010). The funding was conceived under a five-year cooperative agreement between DHHS/CDC and the local, tribal and territorial agencies. Resources were targeted primarily toward buttressing existing

infrastructure. The dollars involved were indeed a boon but a minimal gain for struggling state programs, in relative terms. The five-year grant to California's Department of Public Health, by way of example, was set at about $2.1 million; this amount represents about one-half of one-percent of that department's annual budget overall for 2009-2010. Nevertheless, for 2011 DHHS provided an additional release of $34.2 million, deepening its commitment to the Public Health Improvement Initiative under ACA.

ACA-authorized resources gathered additional momentum on May 13, 2011, when DHHS announced the initial round of CTG funding in the amount of $100 million. Tied to the "Healthy People 2020" goals, CTGs will be devoted towards building capacity and collaborative enhancements in five strategic priorities ACA sets for making demonstrable progress in prevention and promotion: 1) weight, 2) nutrition, 3) physical activity, 4) tobacco, and 5) emotional well being and mental health (US DHHS, 2011a). For FY11, this CTG funding is included in substantial investments drawn from the PPHF under the ACA authorizations, increasing the annual level to $750 million overall (US DHHS, 2011b). Spending areas include community prevention ($298 million) [CTGs, tobacco, obesity/fitness], clinical prevention ($182 million) [critical wellness/preventive health, behavioral health screening], infrastructure and workforce ($137 million), research, tracking and monitoring ($133 million).

F. Nonprofit Hospitals and Their Increasing Community Benefit Obligations

In order to maintain their tax exempt status, nonprofit hospitals must demonstrate to the satisfaction of the federal government that they are serving community interests and generating community benefits. A similar analysis proceeds in many state jurisdictions, where qualifying nonprofit hospitals are eligible for exemption from a variety of state tax burdens. The prevailing justification is similar to that which governs the tax exemption of the nonprofit sector generally: the sector's provision of community benefit eases government's financial burden of producing that benefit itself. This policy, and nonprofit hospitals' financial and other motivations to participate, represents a substantial resource

for healthy community practice, one which may expand markedly in the future given recent regulatory changes.

The community benefit standard originally applied by the Internal Revenue Service (IRS) when it was put in place a half-century ago simply required that nonprofit hospitals provide charity care, and only charity care. This standard was modernized in 1969, when the IRS began allowing nonprofit hospitals a measure of discretion and flexibility in demonstrating the provision of community benefits. Beyond health care services for the indigent, qualifying services and activities came to include delivery of health education, screening of vulnerable populations, training for health professionals, medical research, and other expenditures benefiting the broader public good (US GAO, 2008). A compliance study recently performed by the IRS on a 2006 sample of nonprofit hospitals provided some interesting benchmarking for these activities. The profile of qualifying community benefit expenditures indicated they represented a mean annual share of 12.7% of total revenue (median: 9.8%). 42% of these amounts were uncompensated care, with medical education and training (26%), medical research (25%), and community programs (7%) representing the balance of the average amounts claimed (IRS, 2009). These data suggest that substantial sums are in play when it comes to the participation of nonprofit hospitals, in league with their healthy community partners, in the generation of prevention and promotion in the regions where they operate. With added incentives via advocacy and even legislation, it may be possible to increase the proportion and/or magnitude of this revenue stream for community health. In the broader balance of prevention and treatment, it is critically important that the baseline of compliance practice involves substantially more than provision of uncompensated care.

Of course, such activities are a regular feature of practice in many hospitals, nonprofit and otherwise. In recent years Congress, and government auditors and researchers, have questioned whether the community benefit standard is meaningfully observed – i.e., whether in practice nonprofit hospitals genuinely benefit the public interest any more than their for-profit counterparts in the

industry. Some careful comparative analysis, dimensionalizing uncompensated expenditures as a proportion of actual tax liability, suggested nonprofit hospitals actually lagged behind profit-based organizations in this regards (Schneider, 2007).

As a result, the annual Form 990H was upgraded substantially in late 2007, to enumerate qualifying activities and evidentiary requirements with much greater specificity. Activity categories include charity care, unreimbursed Medicaid and other means-tested government program costs, community health improvement services and operations, health professions education, subsidized health services, research, and cash/in-kind contributions to community groups. The annual form must show the numbers of persons served, total expenses in qualifying activities, any offsetting revenues, and resulting net community benefit expense (Bazzoli, Clement and Hsieh, 2010).

Perhaps more significantly, ACA imposes even more stringent requirements, in terms of community benefit production and assessment, on nonprofit hospitals claiming the exemption. Consistent with a schedule of mandatory reviews IRS will conduct, each claiming facility is now required under section 9007 of ACA to conduct a "community health needs assessment" once every three years, along with an implementation plan for meeting these needs. A key element which can likely be leveraged by leading regional experts in healthy communities: the needs assessment and implementation plan must be based upon input from a broad segment of the region served, including those with local public health expertise and experience. ACA thus envisions enhanced interplay between exemption-claimant hospitals and the community health professions. The legislation does not simply pay lip service in this regard. In fact, failure to complete the required assessment and implementation plan will result in substantial monetary penalties for the regulated facilities as well as excise tax liability (Wipfli, 2010). Importantly, the ACA envisions a functionally separate cycle of documentation for assisted care, suggesting that Congress intended to reinforce the public health aspects of community benefit as conceptually distinct from health care services for the indigent under these elements of that tax code. While the IRS has already

extended the timeframe for nonprofit hospitals to comply with the new rules (Bell, 2011), such facilities are actively pursuing plans for confronting the new reality of tax-exemption compliance.

Kaiser Permanente, and its nonprofit hospital group Kaiser Foundation Hospitals Inc., is a well known community benefits leader among the major nonprofit hospital operators nationally. Its strategic partnerships with collaborating organizations provide a depth and breadth of education, services, and leadership. Kaiser's community benefit activities – potentially adaptable by other nonprofit hospital operators developing a baseline of compliance, and beyond – include the following:[29]

- Every three years each of the firm's 38 member hospitals conducts a community needs assessment (CNA). This practice places Kaiser in the vanguard of operations now compelled for all nonprofit hospitals under ACA. Depending upon volume and other considerations, operating units conduct the CNA individually or in collaboration with other hospitals, government agencies and regional service organizations.

- Within the category of "community building activities," Kaiser's grants and in-kind contributions focus upon a number of whole-health vantages for health improvement. These include wraparound health and other supportive services provided on-site to the homeless and multiply diagnosed populations, as well as community-wide assessments of barriers to physical activity in local infrastructure. The diverse activities of grantees also encompassed such projects as reduction of childhood obesity, interventions against bullying and other forms of youth violence and emotional abuse, health advocacy in multilingual inner-city concentrations, and leadership and personal development workshops for minority individuals.

- Kaiser's "Health Eating, Active Living" (HEAL) initiative has made more than $80 million in grants since 2004, when this effort to ameliorate the national obesity epidemic got underway. Actually a diverse umbrella of programs, key HEAL emphases include local produce purchases (for inpatient hospital meals) and educational theater productions (ETPs) and community-based presentations, teaching children and adults about smart nutrition and exercise choices. "The Amazing Food Detective," an ETP play presented in school assemblies and

[29] Kaiser's community benefit activities for its hospitals operation are drawn from the 990 Schedule H the firm submitted to the IRS for tax year 2009. This is the most recent available via guidestar.org. Against total revenue of $14.5 billion for that year, the hospitals groups reported community benefit expenditures of about $1.1 billion (~7.5%). About three-quarters of this amount was charity care at cost and uncompensated care via means-test programs. The balance – more than $340 million – comprised other recognized categories of community benefit (health improvement services and benefit operations, health professions education, research, and grants or in-kind contributions to community benefit partners.

community centers, has even been turned into a video game, for even broader dissemination and public engagement. HEAL's early years of success led to the formation of The Convergence Partnership (TCP); important partners in TCP are Kaiser, RWJF, the W.K. Kellogg Foundation, and the CDC. TCP aims to foster expansion, evaluation, and evolution of the HEAL approach toward community partnerships in healthy food and lifelong exercise programs.

- Kaiser also supports the establishment and cultivation of community health markers such as public art, green space, gardens, music and theater, and cultural diversity and tolerance programming.

- Kaiser seeks and secures community partnerships not just to implement these efforts but also to augment available resources via request and provision of matching fund arrangements. An example during the 2009 tax year is the grants Kaiser helped secure from the Gordon and Betty Moore Foundation for work in the areas of a) sepsis mortality detection and prevention and b) healthy eating and food-system sustainability. Regarding the latter, Kaiser also focuses nutrition procurement on local farms and farmers markets for its patient and staff meal operations.

- Given its expertise, Kaiser is known for an active model of grantor oversight, including efforts to reach out to community partners with support and guidance. For example, partnerships with "safety net" providers of medical services to the uninsured and underserved are accompanied by training, technical assistance, volunteer medical staff and donated equipment and supplies.[30]

The provision of community benefits – in the form of prevention and promotion programs improving population health – helps nonprofit hospitals maintain their tax exemptions. Monitoring and oversight by tax authorities are intensifying. Healthy communities programs should continue to pursue partnerships with such hospitals, especially in settings where federal and state law provides the strongest basis establishing prevention and promotion as qualifying community benefit activities for tax purposes.[31] Rather than competing with traditional areas of qualifying practice, like uncompensated

[30] Kaiser's safety net partnerships, for its Southern California market region, are described in greater detail here:
http://info.kp.org/communitybenefit/html/our_communities/southern-california/our_communities_2_b.html.

[31] Numerous states arguably provide fruitful legal and regulatory environments for utilizing the community benefits tax exemption constructively. States recognizing prevention and promotion activities as qualifying community benefits for tax purposes, in an especially clear and explicit fashion, include California (Calif. Health & Safety Code §127355 [listing benefits for vulnerable populations other than health services, benefits for the broader community, health education, and even "nonquantifiable benefits"]) and Maryland ((Md. Code Ann.,

care for low-income patients, efforts should focus on how to utilize these emphases to broaden and deepen the impacts of community health efforts. The three-year community health needs assessments and implementation plans now required from participating hospital filers provide a potentially strategic foundation for renewing and reinvigorating partnerships between the nonprofit hospital sector and its colleagues on the frontier of prevention and promotion.

G. Partnerships and New Finance Models for Education-Based Clinics and Health Promotion

University environments – particularly those hosting medical schools and/or schools of public health – are natural settings for community partnerships. Credit-based coursework, if properly designed, can generate a renewable workforce consisting of advanced students in professional programs. When these students are consistently supervised by faculty and agency mentors in the community, such partnerships can supplement the workforce government agencies and their contractors bring to bear in operating programs and implementing innovative service models.

Such university-based partnerships are already quite familiar in a number of communities. Expanding operations to meet real need – especially near campus centers where such partnerships appear underdeveloped – may be an emphasis which should take on added urgency. In areas where such partnerships already thrive, there may be added momentum available in formalizing and expanding existing relationships, perhaps by reorganizing administration to encompass shared and mutually funded employment slots. For example, the Knox County (TN) Health Department and the University of Tennessee at Knoxville (UTK) are formalizing the establishment of an "academic health department" which will provide added vitality to existing placement operations, while innovating new community nodes and activities. These partners are jointly recruiting for a shared position to oversee the

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Health-Gen. § 19-303(a)(3) [listing disease prevention, direct financial and in-kind support of public health, screening, and prevention). Many other states interpret community benefit broadly in this context.

partnership and various forms of exchange it entails. University faculty are helping supervise a community planning process, based upon NACCHO's "Mobilizing for Planning and Partnership" (MAPP) protocol.[32] Other community organizations involved in prevention and promotion, such as the YMCA, are participating in planning and fundraising to expand feasible paths for partnering. The YMCA procured new grant resources via the CDC's Pioneering Healthy Communities (PHC) program, and that effort is being coordinated with the newly invigorated AHD vehicle. University representatives are optimistic that existing RWJF funding can be secured and enhanced on the basis of the AHD effort.[33] Other academic centers aiming to foster AHD programming include: the University of Arizona (tribal demonstration project with the Navajo, Tohono O'odham, and San Carlos Apache nations); Boston University (regional epidemiologic center for LHD training in the Boston metropolitan area); and Texas A&M ("virtual" partnership models for rural AHDs).[34]

The Knox County/UTK experience and those elsewhere are part of a broader movement exploring ways to energize such "town and gown" partnerships and keep them productive. Led by the Public Health Foundation (PHF) and a number of supporting organizations, the national effort is embodied within a collaborative working group known as the "Council on Linkages Between Academia and Public Health Practice." Formed in 1992, this Council currently fosters establishment of "Academic Health

[32] MAPP is a community-based strategic planning framework, designed by NACCHO for collaborating and reorganizing towards improvements in community health. MAPP builds upon a rich heritage of strategic planning in public health, including programs like Planned Approach to Community Health (PATCH) and the Assessment Protocol for Excellence in Public Health (APEXPH) (Lenihan, 2005). NACCHO maintains a repository of online resources on MAPP (http://www.naccho.org/topics/infrastructure/mapp/). Needless to say, expanding the scope and quality of partnership planning, using tools like MAPP, may become an increasingly important policy emphasis for community health in financially stressed regions.

[33] The Knox County/UTK vignette was described in email correspondence from Dr. Paul Campbell Erwin, professor and director of the Center for Public Health at UTK, and a member of the board of directors of the Public Health Foundation.

[34] These programs received 2007 development grants from the AHD program of the Association of Schools of Public Health (http://www.asph.org/document.cfm?page=967).

Department Learning Communities" (AHDLCs) to further deploy AHDs in as many regions as possible.[35] As a testament to their growing importance in the field, these efforts have received considerable attention among public health researchers.[36] By and large, the evaluation of AHD-style partnerships has been enthusiastic, albeit wary of the necessary precursors to successful interaction across agency and other boundaries. In Florida, for example, a recent survey of LHDs identified fifty existing AHD-style partnerships, with substantial evidence showing these arrangements increased capacity for regional public health systems (Livingood, Goldhagen et al., 2007). There is reason for at least guarded optimism when it comes to developing institutional staying power in AHDs, in order to find productive efficiency and boost funding prospects moving forward.

H. Community Health Surcharges on Public & Private Health Plans

Sometimes lost in the national debate over health care finance is a key economic fact: when community health initiatives are successful, public and private insurance systems stand to benefit. The reason is simple: as the volume of covered claims for chronic disease and other hospital and clinical services decreases, overall costs of coverage are reduced. Insurance plans are therefore logical partners in the process of improving the nation's promotion and prevention systems. The largest plans stand the most to gain and have the greatest capacity to identify areas of likely savings.

"Blueprint for a Healthier America," the landmark October 2008 report by the Trust for America's Health, proposed a bold national initiative to utilize health insurance surcharges, to give public and private plans the right incentives to help finance community health initiatives. Based upon longstanding ideas in public health finance, this proposal may warrant new consideration at the federal level and in the states.

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[35] PHF's source materials facilitating the founding and operation of AHDs are available via the PHF website, at http://www.phf.org/programs/AHDLC/Pages/Academic_Health_Department_Learning_Community.aspx.

[36] See, e.g., Livingood, Goldhagen et al. (2007), Conti, Chang et al. (2006), Kegler, Lifflander et al. (2006), and Swain, Bennett et al. (2006).

The report acknowledged that health savings impacts the bottom lines of private insurers, a fact often lost amid the prominent attention paid toward Medicare and Medicaid. To trigger decision-making aligned with that incentive, the Blueprint report proposed that a conditional surcharge be placed upon employer-sponsored insurance (including the Department of Defense health system and the Federal Employee Health Benefits Plan). The surcharge could be waived, were insurers to provide prevention investment packages encompassing such features as:

- Reimbursement for age-appropriate prevention services, including screening and immunizations;
- Amounts contributed toward local community-based prevention agencies;
- Employee wellness programs offered without charge to firms and their employees; and
- First-dollar coverage for maintenance drugs such as medication for high blood pressure and the like.

(TFAH, 2008). Implemented carefully enough, the waivable surcharge would thus motivate plan participation in the financing of community health, up to and potentially beyond the surcharge's dollar amount.

In a sense, a widely implemented surcharge would codify the good habits of those insurers and HMO's already contributing toward health promotion as a method of cost containment. As discussed, this behavior is prevalent in the nonprofit-hospital realm, due to tax incentives; the surcharge would integrate the same signals into the bottom lines of public and private plans. These actors are used to considering their markets in actuarial terms. The surcharge is rather analogous to the risk-adjusted premium adjustments they already impose upon their policyholders, based upon factors like smoking, age, and other indicators. Insurers not contributing toward community health create avoidable expense for others. Rather than a fixed, unconditional surcharge, the waivable fee structure allows each participating plan to make the community health investments most appropriate for the places and populations their markets comprise.

A related approach is already being utilized in a few state jurisdictions. For example, since 1997 New York's "Public Goods Pool" (NYPGP) has financed health care initiatives, indigent services, professional medical education, and other programs, via a surcharge tax upon care expenditures. Plans pay into the pool both a per-person-covered charge for New York residents and a separate fee covering non-resident claim volumes when care is delivered within the state (UMR, 2008). The resident portion is adjusted by the cost characteristics and industry features of separate market subregions. The resulting fund pools are spent by the New York Department of Health toward reimbursement of bad debt and charity care, specific programs such as maternity care and HIV treatment and prevention, and rural health clinics.

Massachusetts's health care reform provides another example of surcharges on existing care delivery. Created by the well known 2006 "Chapter 58" law, the state's "Health Safety Net" (HSN) pool is administered by its Division of Health Care Finance and Policy, to reimburse hospitals and community health centers for uncompensated care delivered to lower-income state residents who are uninsured or underinsured. The funds supporting the operation of this uncompensated care pool are derived from assessments on private hospitals' acute-care charges, a surcharge on HMOs' and others' payments to hospitals and ambulatory surgery centers, annual grants from the state's general funds, and offset funding for uncompensated care from the Medical Assistance Trust Fund (Massachusetts DHCFP, 2011). Of course, such state-supported contributions toward uncompensated care are in force in numerous states, to augment shortfalls in Medicaid and other sources. The Massachusetts model adds diversified funding sources and utilizes a measured surcharge and assessment mechanism which both provides cost-containment incentives for acute and ambulatory care and helps sustain improved quality of service for those in the uncompensated pool.

Key considerations for jurisdictions weighing adoption of new public-goods surcharges are two: (1) setting the surcharge levels (and associated nonpayment penalties) carefully to avoid excessive

increases in plan costs and pass-through burdens paid by individual and group policyholders; and (2) building the appropriate administrative capacities for collections, compliance monitoring and audits that any surcharge approach will entail.

The care-system emphasis of existing surcharge systems like those found in New York and Massachusetts differs from the prevention and promotion activities accentuated in the 2008 TFAH Blueprint's proposal. The New York law goes further than Massachusetts's, in recognizing that public goods extend beyond support for uncompensated care to areas like professional education and prevention. But neither of these state programs utilize the waiver mechanism to encourage private, place-specific community health investments. Despite the fact that current practice may not go far enough in diversifying health investments in any ideal fashion, overall the surcharge approach provides an appealing model for revenue generation. The linkages between public health expenditures and cost containment need to be fostered in this fashion, building upon existing partnerships among leaders in health promotion and health care service delivery.

I. Government Entrepreneurship: Cultivating New Revenue Sources and Managing Assets Strategically

In a continuing era of broad austerity and related government reform, state and local jurisdictions are looking far and wide for revenue-positive value propositions which further the public interest. It has become quite important for government to consider pursuing economic development opportunities based on existing facilities and resources. Public management reformers have long championed the benefit of treating voters, citizens, and service populations as "customers," in the interest of more efficient operations and increased satisfaction levels among users (e.g., Osborne and Gaebler, 1993). The more responsive public agencies can be to the needs of those utilizing their services, the more willing those customers will be when it comes to financing continued operations through the tax base. But the new entrepreneurial imperatives go a step further: states localities are having to find new

marketplaces in which to operate and sell services government originally was designed to deliver on a universal basis at little or no charge.

In the public health realm, the entrepreneurial impetus may find a toehold in the kinds of outreach agencies already do. LHA's have traditionally sponsored service delivery in business offices, small and large company locations, and community centers; service menus involve flu and cold clinics, CPR trainings, weight-loss/exercise promotion programs, skin cancer screenings and the like. These services can be worth substantial sums when furnished by for-profit providers. Traditional grant sources fueling such programs conceivably can be supplemented via genuine sales. Localities may need to begin reevaluating all the practice areas in which they can reasonably compete for what business opportunities there may be in their regions. The kind of promotion activities community health professionals have always done can be more deeply informed by *marketing,* to disseminate programs on a cost-recovery or even profit-generating basis by delivering them to willing buyers. In many instances these activities will require a philosophical reorientation.

One interesting model[37] involves making more of the sophisticated planning and analytical capacity already present in local health agencies. So long as it is undertaken in ways consistent with their mandates and governing state law, these units might explore providing health-related consulting products and services to private customers, or entering into multiagency or public-private consortia in order to do so. In other instances these services might be sold to other agencies on a chargeback basis.

For example, tax-exempt hospitals now require more frequent, in-depth community health needs assessments, as part of the federal initiatives discussed earlier in this report; local public health agencies

[37] This model is based upon product development and marketing outreach conducted by the Health Council of East Central Florida, one of a number of such state-chartered agencies created to deliver data analysis and other support services to public and private public health and health-service entities (see http://www.hcecf.org/). The author is thankful to Ken Peach, HCECF's executive director, for providing information on its innovative lines of service and market development.

may be nicely situated to compete for this business. Other products may involve certificates of need analyses (CON) in the licensing and regulation of acute care hospitals, MAPP-style strategic health planning for large organizations, data generation for skilled nursing utilization, and related studies. LHAs may also be equipped to design and distribute on-line triage systems to which employers can direct employees for health management and medical-visit reduction. Mobile kiosks can be designed to deliver blood pressure monitoring, body mass index testing, and other portable services for on-site screenings paid for by (1) local employers seeking cost savings and reduction in health-related work absence and (2) health care organizations likely to forge higher-volume client relationships as a result.

Such activities of community health agencies and their partners in the entrepreneurial realm are just some of the creative financial strategies available to government more generally. Even if these strategies are not undertaken directly by community health units, those units stand to benefit (along with others) whenever government assets are well managed, deficits are reduced, and revenue prospects are improved. We should list among these more familiar avenues the strategic management of municipal real estate assets.

What once was viewed as merely a custodial responsibility over taxpayer-owned property has evolved considerably. Public building portfolios are now managed in much the same way as private portfolios, with an eye towards acting strategically to insure growth in asset values and returns (Hentschel and Utter, 2006). For example, the well known sale/leasback device is often used to shift elements of a portfolio from the ownership to the rental category, when analysis of an asset and prevailing market conditions make it advantageous to do so (Kaganova, 2010). The essential features of a public sales-leaseback arrangement involves government-owned buildings being transferred via sale to private owners; the government occupant then leases the property back from the new owner on a long-term basis at a favorable rental rate.

The sales-leaseback device is often used to facilitate new capital investment and tax benefit for the parties; in the case of a government occupant, the tax benefits flow only to the new, private owner. The seller-lessee can realize immediate cash-flow to pay down debt in exchange for a reduced evaluation of its capital portfolio. The buyer-lessor receives investment value from the expected rental stream, expense deductions for tax purposes, and longer-term depreciation flowing from the property. Importantly for purposes of this report, however, there is little precedent for utilizing the proceeds to finance operations and programming of the type local public health budgets support. While public real estate assets should be managed strategically, and even entrepreneurially, in ways that benefit government's bottom line, it is the rare circumstance that those leading community health programs would be the ones to pursue such transactions on their own.

By contrast, there may be ways that health-provider networks in broader regions can participate in for-profit research efforts. These sometimes involve place-based projects with real estate features. Models for government participation in public-private partnerships – where public investments can lead to positive tax-base and other returns - include industrial parks, innovation incubators, technology-transfer arrangements, small-business promotion and social enterprise (see Link and Link, 2009). When local staff has the necessary expertise and motivation to participate in these kinds of partnerships, the agencies employing them should reward such initiatives and utilize them to develop and exploit marketing opportunities for their service portfolios. As has been the case with other reform initiatives summarized in this report, current circumstances are impelling agencies to become ever more imaginative, to find ways their public missions can be made financially sustainable.

Lastly along these lines, the considerable investments city and county governments now dedicate toward their on-line presence for high-traffic sites justify considering web-advertising sales. The expansion of "Dot-Gov" and "e-government" programs has established Internet outposts where private advertising placements theoretically can be sold, simply due to the "hit volumes" those sites receive. If

well designed and bounded within an on-screen page-display, web advertising can generate revenue without seriously undermining the public purpose of such sites.

In January 2011, the State of Washington's transportation secretary, Paula Hammond, okayed the renting of state web space for the purpose of generating ad revenue. A later writeup in the Wall Street Journal, recognizing an important threshold had been overcome with Secretary Hammond's order, compared the business model to adopt-a-highway programs involving corporate sponsors, asking the question "Why not cash in?" (Lewyn, 2011.) Governments at various levels are recognizing that the web-traffic they host at high-use sites (e.g., e-filing for taxes, motor vehicle renewals) are a genuine public asset which will be exploited by Google and its competitors unless site owners act to exact their feasible share of the proceeds.

Viewed in this fashion, direct sales of web space for advertising can conceivably capture for the public fisc a resource of genuine value which otherwise would not exist. Though there is a federal restriction on selling advertising via websites sporting the .gov suffix, many states are now establishing .com mirrors to facilitate such business. Others are either exploring advocacy encouraging the federal government to lift the .gov ban or simply creating web-advertising opportunities on those sites despite the ban. Ad sales remain sparse, focused most often upon transit websites for airports, tourism promotions, and public university athletic websites.[38]

As fiscal duress mounts, however, a number of for-profit activities like web advertising - once seen as threats to public values and public service – are becoming too attractive for financially strapped governments to ignore.

[38] Prominent instances of government web advertising include the Cook County (IL) Assessor's Office, and the Experience Washington (state), Travel Oregon and Visit California state tourism offices (Addams, 2011). As with all such undertakings, there is some risk that sales programs may make little positive revenue or even lose money, particularly where strong competition is present.

J. Regionalization, Consolidation, and Shared Service Opportunities

This report has attempted to focus primarily upon financial approaches toward generating new resources for healthy communities programs. But the report would be incomplete were we not to mention specifically all the brave administrative efforts underway to generate resources via savings rather than new revenues.

Community health programs are known for their inventiveness and resourcefulness. Their mettle in this regard is being sorely tested in the current budgetary environment. But compared to government units where consolidation is more difficult – such as fire and public safety, where effective policing and response requires that some threshold numbers of personnel must be placed proximate to all population clusters – some healthy communities programs may offer as yet underutilized economies of scale. Geographic coordination, and centralization of certain functions, is the prudent course in many cases. That being said, the mere suggestion threatens some bitter fiscal medicine being administered to a field long known for getting the short end of the budgetary stick. Regionalization, consolidation and shared-service opportunities, while attractive to deficit hawks in state capitals and in Washington, often translate into genuine downsizing, disrupted careers, eliminated or reduced programs, and fractured partnerships within agencies and across their collaborative networks. Obviously it takes far less time to undo program accomplishments than it takes to achieve them. Consolidation should be limited to those situations where the benefits are clear and successful implementation is feasible.

Nevertheless, the topic is receiving great attention in a variety of contexts. Leadership groups in the field, from ASTHO and NACCHO to the US Conference of Mayors and the National Association of Counties, have featured shared service and regionalization toipcs in recent meetings and roundtables. The glossary of terminology surrounding these strategies – including “cross-jurisdictional relationships,” “mutual aid pacts,” and service purchase arrangements – seems only to multiply. The field continues to brace itself for changes that increasingly appear unavoidable. As always seems to be the case in public

health, initial disturbances are quickly followed by renewed enthusiasm for making programs effective in an ever more challenging policy environment.

The opportunities for cooperation and sharing across jurisdictions are hardly generic. Memoranda of understanding and more formal contracting address agency realities in great detail, and these vary greatly by local circumstance. The provisions for these arrangements must attend to regulatory realities within each state, and much of the work must therefore be undertaken by legal experts handling the critical details. Genuine, thorny issues may involve such topics as forms of governance and authority, shared funding streams and legal power to conduct public health administration across jurisdictional boundaries. Data sharing and confidentiality must be weighed; emergency authority for quarantines and facility closures need to be clearly delineated (Public Health Law Network, 2011).

These efforts are not without a measure of policy risk. In the midst of facing the idiosyncratic legal realities in each proposed redrawing of the administrative map, costly adjustments may prove necessary, and sometimes these costs will eliminate much of the projected savings motivating the effort in the first place. Responsible management requires that these financial features be well understood before drastic consolidation measures are undertaken.

In work funded by RWJF, Patrick Libbey and Bruce Miyahara (2011) have conducted what they call a "preliminary scan" of the field, and the findings are somewhat encouraging. First, the adoption of more uniform performance standards for LHAs was well underway before the current fiscal crises hit. In many states, community health leaders were already beginning to address what these standards mean for rural LHAs unable to raise performance without some measure of cross-jurisdictional sharing. Through the Public Health Accreditation Board (PHAB) and its peer organizations, shared service arrangements and their accreditation implications have been the subject of regional think-tank groups and pilot efforts (see Matthews and Baker, 2010). Places like New Hampshire have been exploring partnerships with contract providers for many years, and lessons from these efforts can be brought to bear on the kinds of

new reforms necessitated by continuing budget pressures. Dispersed, regionalized authority structures with strong leadership from the capital have been in place for many years in Nebraska, South Carolina, and many states in the West. These regionalized organizations are well placed to lead consolidation and shared service arrangements as a result. Their experience provides model programs for other states.

One place where such innovation has been most energized is Colorado, due to its 2008 of the Public Health Reorganization Act there. The Act provided specifically for shared service plans among LHAs and their community partners within defined geographical districts. Critical to the Act's strategy is the necessary state-level vision for planning and coordination. The state health board was tasked with developing new fund allocation formulas agile enough to accommodate redrawing the jurisdictional map and administering some areas jointly among LHAs. Consolidated operations will proceed according to mutually arranged program priorities, and here the Colorado Department of Health and Environment sets the tone for local efforts. The Colorado strategy, if successful in garnering cost savings over time, may provide a useful model for other states where only centralized leadership and thoughtful enabling authority can make regionalization successful.

VI. Conclusions

The shortage of resources has long been a fact of life for community health. While resource constraints are not a new reality for the field, states and localities, and their partner agencies and organizations, are reeling under continue pressures from the legacy of the Great Recession, the sluggish recovery, and the impending threat of a possible "double-dip." Yet exciting policy innovation remains robust, as a substantive matter. Approaches to chronic disease, obesity, and other conditions are propelling new energy and vibrancy in this work. While the commitment of public health professionals is a nearly inexhaustible resource, however, there are daunting challenges. Programs have been cut, pilots for new approaches have been upended midstream, and the federal and state juggernauts of austerity have taken a real toll on the field.

This report has described a series of smart practices should bear in mind, including:

- Revenues gained via property tax approaches, including health districts
- Social-impact bonds, where programs and investors are paid for by the taxpayers only when specific outcomes are attained
- Community development corporations and finance institutions, familiar in the nonprofit real estate industry and its redevelopment activities in disadvantaged neighborhoods, and now applied toward such health-specific activities as supermarket construction in "food deserts" lacking health access
- New sales and excise taxes on dangerous products like sugar sweetened beverages, to provide consumers and their families the correct signals regarding these products' risks and their role in the child obesity epidemic
- The burgeoning "Health and All Policies" movement and its effort to involve a broad swath of government agencies (and their budgets) in renewed, coordinated, collaborative community-health programming
- Federal health care reform and its investment approach toward reducing health care costs via invigorated disease prevention and health promotion
- The community benefit requirements imposed upon nonprofit hospitals under the tax code, and methods for increasing the net contribution of this regulated industry toward population health programming, education, and services
- Surcharges on public and private health plans to facilitate greater capture of savings on care expenditures healthy communities programs can produce
- Collaborations between educational institutions and public health agencies and organizations, in which the academy's resources are brought to bear in advancing public health initiatives
- Public "entrepreneurship" and savvy pursuit of business-style opportunities, sales, and property management
- Regionalization and shared service arrangements, generating resources via savings and efficiency gains while attempting to limit reduction of service

The stories and examples discussed in this report are quite difficult to summarize adequately. Their approaches vary significantly, and none comes close to sufficing as a one-size-fits-all solution to the fiscal problems facing community health these days. Yet a number of possible conclusions emerge here.

First, when substantial infusions of new moneys grow unlikely, the field responds. Necessity indeed begets inventions. Efficiencies in production can be found in many circumstances, most often in

the economies of scale available via partnership and coordination (or even consolidation and shared service), and economies of scope in the adaptation toward health of strategies familiar in other fields. States and agencies emerging strongest from this time of trouble will be those who vigorously sought out the savings and were not afraid to confront the institutional and jurisdictional hurdles lying in the way.

Second, in a selective manner, such as in the case of local investment in facilities which boost both public health and aggregate property values, taxpayers may be interested in improving the quality of life of the places where they reside and where they work. Once the health aspects of amenity enhancement are highlighted, the willingness of households to pay, for benefits their children and future generations will enjoy, may perhaps be summoned anew. The emphasis on community benefit – providing common ground for numerous devices discussed in this report, from property taxes for bike trails to redevelopment finance for health clinics, from nonprofit hospitals complying with the tax code to the potential for social impact bonds – is one which will resonate more and more in the years to come.

Finally, the direction of state and federal leadership concerning the basic economics of prevention and promotion – namely, the slowing of the growth of costs in the health care services sector – has never been more resolute. This fact bodes well for cultivating new fiscal resources throughout the health policy system. Local invention should be communicated to state and national thought leaders, who should continue to reward innovators and fund the most promising public health and public policy approaches. Perhaps more importantly, whenever policy reaches some level of maturity in its development, bringing recognized practices to scale ought to become a more pressing need than continuing to pilot new ones.

Happily, some quite exciting work is being done on this report's topics at high-levels of practice and leadership. At IOM, the Committee on Public Health Strategies to Improve Health [CPHS] (within the

Board on Population Health and Public Health Practice) is engaged in the third part of a three phase study convened in 2009, exploring transformations in measurement, law and governance, and finance. CPHS characterizes its upcoming charge as follows:

> The committee will develop recommendations for funding state and local health systems that support the needs of the public after health care reform. Recommendations should be evidence based and implementable. In developing their recommendations the committee will:
> - Review current funding structures for public health
> - Assess opportunities for use of funds to improve health outcomes
> - Review the impact of fluctuations in funding for public health
> - Assess innovative policies and mechanisms for funding public health services and community based interventions and suggest possible options for sustainable funding.

While this report has culled from the field a number of provocative ideas for revenue enhancement and financial reorganization, key direction must come from the key leaders and organizations charged with stewardship during good times and bad. The field must maintain a careful eye upon promising new practice and innovation, as it charts enlightened paths towards greater efficacy and sustainability on behalf of America's health and well-being.

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