Financing Mechanisms for Reducing Adversity and Enhancing Resilience Through Implementation of Primary Prevention

Sarah M. Steverman, PhD, MSW; David L. Shern, PhD

From the Substance Abuse and Mental Health Services Administration, Department of Health and Human Services, Rockville, Md (Dr Steverman); Department of Mental Health, Bloomberg School of Public Health, Johns Hopkins University, Baltimore, Md (Dr Shern); and Mental Health America, Temple Terrace, Fla (Dr Shern)
The authors have no conflicts of interest to disclose.
Address correspondence to David L. Shern, PhD, 11009 Theresa Arbor Dr, Temple Terrace, FL 33617 (e-mail: dshern@mentalhealthamerica.net).

Abstract

The experience of adversity and toxic stress in childhood is associated with the development of chronic health and behavioral health problems. These problems contribute substantially to health care expenditures and the overall burden of disease. Although a strong scientific literature documents the effectiveness of primary prevention in reducing childhood adversity, promoting well-being and lessening the incidence of negative outcomes, funding for these interventions is highly fragmented across multiple government agencies as well as private and philanthropic sectors. It is becoming increasingly clear that improving population health will require a concentrated public health effort to improve access to and the accountability of these interventions as well as the development of novel financing schemes. In this perspective we review existing financing mechanisms for funding interventions known to reduce adverse childhood experiences and discuss innovative financing approaches that use insurance as well as pay-for-success funding mechanisms. The latter require that cost savings associated with primary prevention be quantified and that these savings be used to offset program costs, sometimes with a return on investment for private investors. We provide a series of recommendations regarding better coordination and strategic oversight of existing resources as well as the need to further develop and validate methodologies for estimating the societal costs and benefits associated with the varying social policies that are designed to ameliorate the effects of adversity and to build resilience.

Keywords: adverse childhood experiences; adversity; financing; prevention; societal costs

Academic Pediatrics 2017;17:S144–S149

Current health delivery system reform efforts aim to address root causes of the major drivers of chronic illness, disability, and health care expenditures. The burden of chronic disease, including mental health and substance use conditions (referred to as behavioral health disorders), has increased emphasis on preserving and strengthening population health. Because of the well documented, long-term effects on the prevalence of chronic diseases associated with adverse childhood experiences (ACEs),[1] reducing exposure to adversity and enhancing protective factors will lessen this burden and strengthen population health. Fortunately there are several primary prevention interventions that have been shown to reduce the incidence and mitigate the effects of ACEs, as well as to provide long-term benefits for mental, emotional, and behavioral health.[2] Currently underfinanced, these interventions have the potential to prevent the occurrence of ACEs (eg, parenting interventions that reduce rates of abuse[3]) as well as mitigate the effects of ACEs (eg, provide children with self-regulation skills to help cope with parental divorce[4]), leading to improved behavioral health. In this report we concentrate on challenges and opportunities in financing primary prevention interventions including universal (population-wide), selective (for those at risk), and indicated (for individuals with signs and symptoms) as well as some secondary prevention (treatment) interventions, which address ACEs and improve behavioral health.

In this article we will briefly outline the existing array of funding that support these interventions to reduce and mitigate ACEs and highlight emerging financing trends that might be used to increase investment in efforts to reduce ACEs and promote population health.

Current Landscape

Since the 2009 Institute of Medicine report,[5] primary prevention of mental, emotional, and behavioral disorders has gained traction in public discourse. In 2011, the Substance Abuse and Mental Health Services Administration made the prevention of substance abuse and mental illness its first priority[6] and has prioritized trauma reduction and trauma-informed care as a related strategic priority. The Affordable Care Act prioritized prevention as a reform strategy in addition to its goal of universal insurance coverage.[7]

Unfortunately, health care financing in the United States traditionally has not prioritized health promotion and illness prevention. The 2014 Centers for Medicare and Medicaid Services (CMS) summary of health expenditures reported only 3% of health spending was on public health.[8]

Compounding this meager investment, the fragmented public funding and administration of primary prevention addressing ACEs led to differences in language/terminology, financing sources, policy/administrative structures, delivery systems and settings, data systems, and desired outcomes. For example, although mental health and substance use systems are seeking improvements in mental health and reductions in substance abuse, education systems are concerned with outcomes related to academic achievement. ACEs are common risk factors undermining problems in each of these sectors and desired outcomes for both of these systems might be achieved by reducing ACEs through primary prevention interventions focused on strengthening families, schools, and communities. Unfortunately, the 2 systems do not often consider their converging goals and work together to achieve them. Additionally, categorical funding structures make it difficult to track outcomes and appropriately allocate cost savings to sectors. Reducing ACEs might result in reductions in special education, juvenile justice, and/or child welfare expenditures, but documenting societal savings and reinvesting them into ACEs prevention rarely occurs. Therefore, collaboration between sectors, alignment of incentives, development and evaluation of sustainable interventions, and reinvestment of system savings to support prevention of ACEs could be high-leverage strategies to mitigate the risk factors associated with ACEs, and enhance well-being at all levels. This paper details the range of traditional and innovative funding mechanisms to support preventive interventions that reduce the incidence or mitigate the effect of ACEs.

TRADITIONAL FINANCING MECHANISMS

Funding for primary prevention has historically come from federal discretionary and block grants, state and local revenue, and foundations.

FEDERAL BLOCK GRANTS

The federal government provides block grants to states in many different human services sectors that can be used to reduce ACEs incidence and effects. The block grant funding identified in the Table summarizes some federal investment. Many of these interventions have direct relevance to reducing adversity (eg, abuse and neglect, violence reduction) and others target known outcomes of ACEs (eg, increased use of elicit substances, antisocial behavior). Funding spans several federal agencies and outcome areas, showing the challenge of aligning and coordinating federal investment in prevention.

TAXING AUTHORITY

Excise taxes are federal, state, or local taxes levied on alcohol, tobacco, gambling, and marijuana that generate funds to reduce problems associated with these activities/substances and/or to accomplish other public good.[9] State and local tax levies also can fund prevention efforts through property, sales, or income taxes with funding dedicated to targeted prevention/promotion activities. For example, in 1990, Seattle voters approved a 23-cent tax on each $1000 in property value to be used for children's services. Among other investments, funds have been used to provide nurturing preschool environments for children from low-income families with the hope of improving outcomes for children who are at increased risk of ACEs.[10]

FOUNDATIONS

Foundations are major sources of public health funding and critical state and community implementation partners. In particular, health conversion foundations are major funders of primary prevention in many communities.[11] Federal law requires the sale proceeds from nonprofit health systems to be used for charitable purposes such as the creation of foundations dedicated to improving population health.[11] The Colorado Health Foundation has funded Invest in Kids, a purveyor of Incredible Years, an evidence-based preventive program that includes parenting interventions to reduce the likelihood of abuse-related ACEs and improve outcomes for children who have experienced adversity.

EMERGING FINANCING INCENTIVES AND MECHANISMS

The health care system is changing in many important ways, including innovative financing mechanisms that support interventions to reduce and mitigate ACEs. Some are new government programs and incentives whereas others leverage private investment for public good.

INSURANCE MECHANISMS

Insurance models have historically focused on individual beneficiaries and medically necessary care, which is a barrier to providing a service to an entire family, classroom, or community. However, with a move toward universal coverage and elimination of preexisting condition exclusions, insurers have greater incentives to promote population health because they are at risk for enrollment of any beneficiary from their service area.

As a small state moving toward universal insurance coverage, Vermont exemplifies the incentives for a population focus. To improve quality and access and reduce costs, Vermont insurers pay a per-member per-month fee that is pooled to finance community health teams (CHTs) that work independently of any insurer to link residents with primary care, regardless of their insurance status. CHTs have flexibility to identify individuals in various settings (eg, homeless shelters, emergency departments) and address their needs regardless of traditional medical