COMMON HEALTH Coalition
Together For Public Health

More Illness, Greater Cost:

The consequences of public health cuts for the health care system

Executive Summary

This report analyzes how cuts to public health infrastructure will ripple through the U.S. health care system – leading to sicker patients, higher costs of care, and added operational burdens. The interconnectedness of public health and clinical care means that weakening one part of the system threatens the stability and performance of the other. While modernization is needed across public health and health care, the scale of the proposed cuts risks eliminating vital programs outright, rather than making them more effective. In parallel, the proposed disinvestment in Medicaid and the Affordable Care Act (ACA) now under debate in Congress would compound these effects.

The report outlines three primary categories of impact:

1. **Fewer services available to patients and clinicians** – Cuts to services like tobacco quitlines, newborn screenings, and public health laboratories (PHLs) will directly affect what clinicians can offer and what patients can access.
2. **More patients arriving sicker and at higher cost** – Eliminating prevention programs will result in delayed diagnoses, increased disease prevalence, and costly outbreaks, such as current HIV and measles outbreaks.
3. **Health care forced to fill gaps or go without** – As public health functions like contact tracing, mental health support, or tuberculosis treatment diminish, health systems and health plans will face difficult decisions: whether to backfill services on their own dime or leave them unaddressed.

Across all three categories, consequences will fall most heavily on underserved communities, rural areas, and people already facing barriers to care.

Losses from cutting public health extend far beyond one agency or department – they will be borne by hospitals, clinics, and ultimately, patients. Rather than viewing public health as separate from health care, this moment calls for renewed partnership, joint investment, and a reimagined model that centers on preventive care. State and regional coalitions are particularly valuable for shared stewardship of critical services.

Through this analysis, the Common Health Coalition aims to equip policymakers and health leaders with evidence, urgency, and a call to action: investing in effective public health infrastructure is not just sound policy – it's fundamental to the delivery of care and the health of the nation.

DISCLAIMER: *This report was compiled by the Common Health Coalition, a nonpartisan, not-for-profit organization. The report summarizes consensus-based findings and insights that were informed by dozens of leading experts in public health, health care, and forecasting. The views and opinions expressed in this report do not necessarily reflect the views or positions of the Common Health Coalition's Steering Committee, funders, or 250+ member organizations.*

Public health and health care: A common goal

Public health and health care delivery organizations in the U.S. have long served as the right and left hands of an interconnected system responsible for protecting and improving health. While the health care sector strives to deliver high-quality care to individuals, public health plays a vital and complementary role by working to prevent disease, monitor community health, and address the broader environment helping keep people healthy.

Today, much of the U.S. health care system prepares for reductions and operational deficits from currently proposed changes to Medicaid, Medicare and the ACA. At the same time, the public health system, too, is facing roll backs in funding, workforce reductions, and operational restructuring.

While improving the public health system has been a bipartisan priority, these recent reductions are notable for their unprecedented scale. Reductions in public health infrastructure are certain to reverberate across the health care sector – and unless new solutions emerge in their place will harm patients and drive up costs (**Figure 1**).

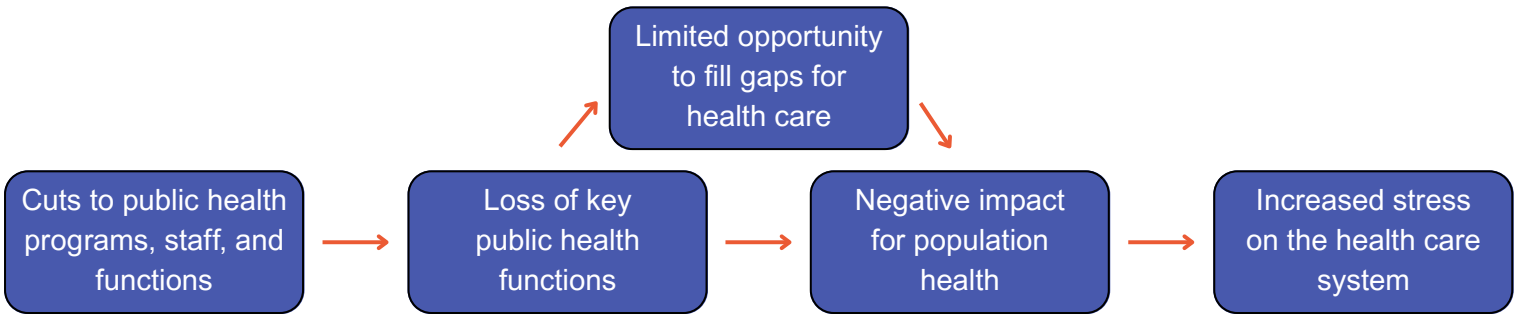

Figure 1. Impact flow of public health cuts to health care

This Special Report from the Common Health Coalition outlines in three categories how recent and proposed cuts to public health infrastructure impact health care delivery:

1. Fewer services available to patients and clinicians
2. More patients arriving sicker and at higher cost
3. Health care forced to fill gaps or go without

Section 1: Fewer services available to patients and clinicians

Clinicians routinely connect patients to services run by public health agencies that exist beyond the four walls of the clinic. A number of these services have been eliminated or threatened by funding and operational cuts.

Patient supports

Offices that address tobacco use at both CDC and FDA have been drastically downsized or eliminated. Thus, clinicians working to support their patients with smoking cessation will no longer have ready access to well-utilized tobacco quitlines, which receive over half of their funding from CDC (**Table 1**).

Clinicians also rely on public health programs that support patients who would otherwise fall through the cracks. For instance, newborn babies who fail their hearing screens are swiftly connected to care through the Early Hearing Detection and Intervention (EHDI) program. However, the EHDI and other newborn screening efforts were defunded as part of federal cuts.

Community health workers (CHWs) are cost-effective and high-value members of America's health workforce. Sustainability of CHW organizations across the country is at risk due to cuts to key public health funding streams and uncertain Medicaid reimbursement. The result is that fewer CHWs will be available to bridge gaps between clinics and community services, which may lead to delayed and costlier care. For example, in a program in Washington State, a mom repeatedly delayed a time-sensitive surgery because she lacked any care options for her child – until a CHW stepped in to connect the patient to both surgery and childcare, averting costlier medical interventions. Weakening such programs threatens the substantial return on investment already demonstrated by CHWs: one program returned $2.47 to the average Medicaid payer for every dollar invested, by reducing hospitalizations.

Table 1. Calling it Quits on Smoking Cessation Services

Cut: Budget cuts have eliminated all staff for the CDC's Office on Smoking and Health, which provides $240 million in funding for state initiatives like quit lines and the Tips from Former Smokers Campaign.

Impact: Free quitlines, once available in every U.S. state, are at risk – especially in states heavily reliant on federal funding. South Dakota has proposed cuts to quitline counseling, and North Carolina furloughed 75% of its tobacco control staff. Without federal support, quitlines may no longer offer nicotine-replacement therapy (like patches or gum), which nearly doubles quit rates, nor provide multiple counseling sessions for each caller. Compounding this impact is the loss of funding for the Tips from Former Smokers Campaign, which has been shown to save $7.3 billion in health care costs in just its first six years – a 15:1 return on investment. Increased costs for medications, emergency room visits and hospitalizations are likely to be disproportionately borne by governmental payers.

Background: Smoking is the leading cause of preventable death in the United States, and is responsible for the deaths of over 480,000 Americans each year. According to the CDC, 68% of the nation's nearly 30 million smokers express an interest in quitting in 2022. Across the country, a robust public health system supports tobacco cessation and control, including:

- **Creation of quit lines**. Over 10 million Americans placed calls to Quit Lines (1-800-QUIT-NOW and state-specific numbers) from 2004 to 2019.
- **Funding for health education campaigns**, like Tips From Former Smokers which is estimated to have supported 1 million Americans in quitting.
- **Protecting children**, by issuing warning letters and penalties to retailers who illegally sell tobacco to minors.

Laboratory and response services

Reductions in funding to national and state PHLs will delay diagnosis and care for patients in several ways (**Figure 2**). Clinicians regularly order “send out” tests to identify less common pathogens like H5N1, polio, and Mpox – as well as for routine services such as infant genetic screening, Hepatitis C testing, and Tuberculosis (TB) drug susceptibility. In some states like Alaska, they are the sole provider of toxic alcohol testing. Delays in testing mean delays in treatment and response efforts. For instance, during the 2024 measles outbreak in Chicago, an analysis showed that "if case notification to public health had occurred earlier…the chance of an outbreak of 100 or more cases would have been zero…."

Use of PHLs is an everyday occurrence: state laboratories like those in Texas and South Carolina perform over 1 million tests annually. Across the country, most commercial and hospital-based laboratories lack the expertise and financial incentive to maintain these specialized tests, and if they do, the turnaround times are usually slower than those from PHLs. PHLs are also responsible for many tests not currently covered or reimbursed by health insurance.

The impacts of reduced PHL capacity are potentially even greater if PHLs are no longer able to develop diagnostic tools for novel threats, as seen with Mpox, COVID-19, Zika and Ebola. Reduced lab capacity can also lead to preventable in-hospital transmission and delayed discharges — ultimately reducing bed availability and slowing admissions for other patients.

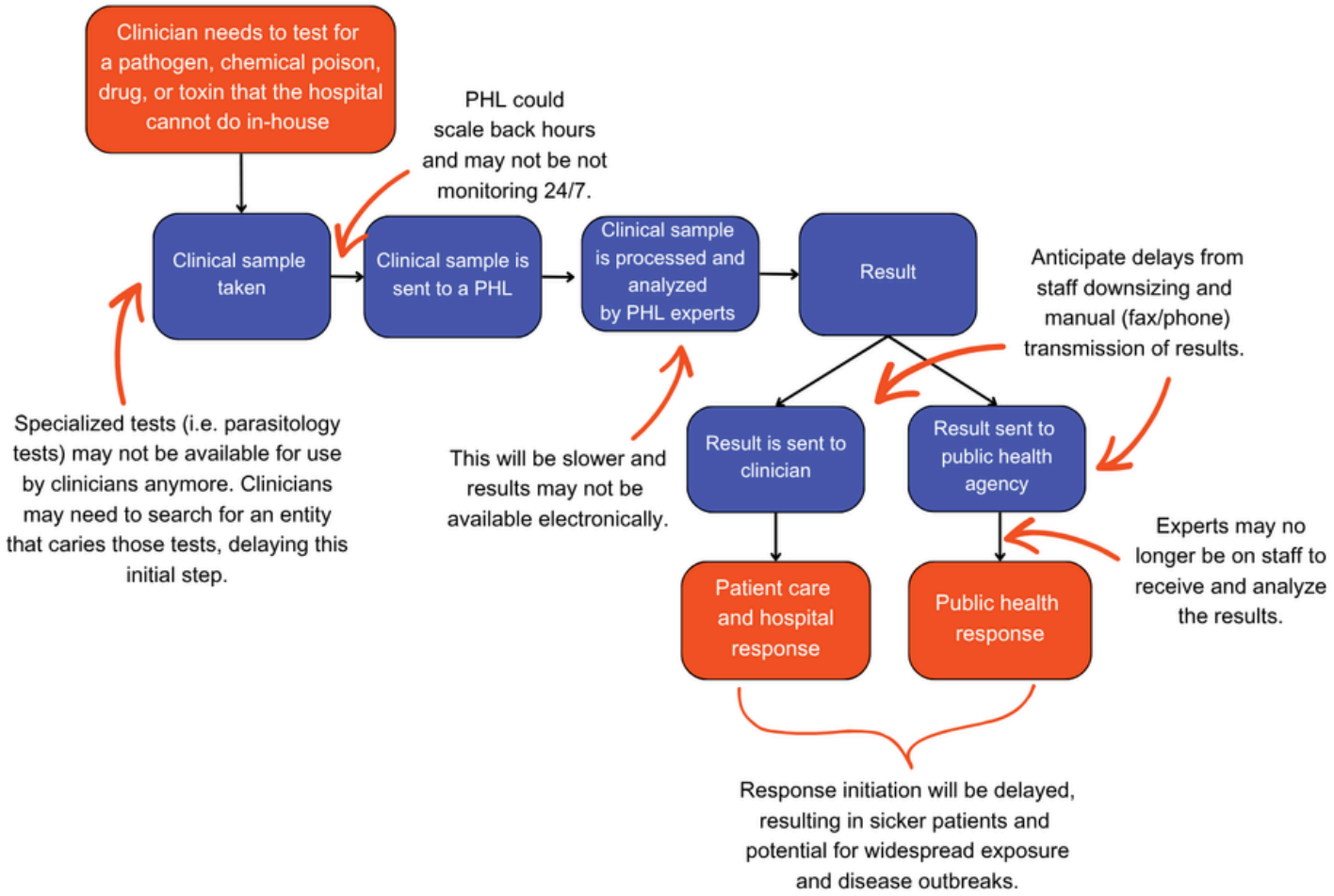

Figure 2. PHL cut impacts to health care delivery - Common Health Coalition

Exacerbating these laboratory gaps are budget reductions for emergency response capabilities. The proposed elimination of the $240M Hospital Preparedness Program (HPP) would dismantle support for stabilizing medical and PPE supply chains, coordinating bed capacity, and conducting joint emergency drills. During Hurricane Harvey, HPP-funded coalitions enabled patient evacuations, mobile medical deployments, and uninterrupted access to emergency care-actions that saved lives and reduced strain on overwhelmed hospitals. Similar risks come with the proposed elimination of HRSA's Emergency Medical Services for Children and a more than 50% reduction to the Public Health Emergency Preparedness (PHEP) grant. In addition to funding the country's Laboratory Response Network, states like North Carolina, used PHEP to fund equipment, supplies, and staff for COVID-19 and Mpox response, all while ensuring the state could maintain readiness capabilities for threats like Ebola and Marburg. Local and state preparedness efforts will be hamstrung by these reductions – and less able to keep critical threats from reaching the doorstep of health care systems.

Section 2: More patients arriving sicker and at a higher cost

When preventive and health promotion services are cut, more patients require health care – often later, sicker, and at a higher cost.

HIV detection and treatment

Over one-third of HIV diagnoses in the U.S. are made through public health-funded programs, including locally-operated sexually transmitted infection (STI) clinics that perform nearly 2 million HIV tests annually and provide confidential treatment and partner services, often at no cost to the patient nor health insurers.

Since 2018, a 12% drop in new HIV infections has saved the U.S. more than $5.1 billion (**Table 2**). Substantial proposed or enacted reductions to HIV and STI programs – including significant staff reductions within HIV units at CDC, the cancellation of HIV-related research grants at NIH, and reductions in the Ryan White HIV/AIDS program – threaten to reverse this progress. Such proposed cuts to HIV prevention programs are expected to lead to significantly more people with HIV, costing the health system an estimated $52.4 billion over patients' lifetimes.

In Maine, the largest HIV outbreak in state history is unfolding among young people in the southeastern area, straining local health systems. Limited resources have hindered testing, treatment access, and outbreak containment. The federal CDC has been unable to provide technical assistance due to recent staffing eliminations.

Table 2. Consequences of Shuttering STI Services

Cuts: In states like Mississippi, cuts have shuttered mobile testing clinics, reduced outreach, and limited free STI and HIV services. Proposed cuts to the National Center for HIV, Viral Hepatitis, STD and TB Prevention would eliminate HIV prevention divisions, data and communication branches, and many staff at the national lab for STIs, which performs surveillance, monitors resistance, and guides clinical protocols. Proposed reductions to the Ryan White HIV/AIDS program, which serves over half of all people diagnosed with HIV, will leave some people without treatment entirely.

Impact: Elimination or reduction of local and state public health services to curb the spread of STIs will result in higher rates of infection and more severe infections among patients. One analysis estimates that the 26 million new STIs acquired in 2018 will cost the American health care system nearly $16 billion in health care costs.

Background: Sexually transmitted infections are common, with more than 2.4 million cases of syphilis, gonorrhea, and chlamydia in 2023 alone. Congenital syphilis cases in the U.S. continue to climb – with over 3,800 babies infected in 2023. Notably, congenital syphilis hospitalizations have an average cost of $58,000 per hospitalization. Public health plays several roles in detecting, treating and preventing STIs:

- **Contact tracing:** Outreach when a patient tests positive for an STI to identify and notify sexual partners
- **Tracking resistance patterns:** National laboratories collect and analyze specimens to identify antibiotic resistance
- **Writing clinical guidance:** National STI screening and treatment guidelines used broadly as standard of care by clinicians and administrators
- **Outreach and screening for high-risk populations:** Serving as the first touchpoint for STI screening

Immunizations

Disinvestment will also impact vaccination infrastructure – like outreach programs and immunization information systems – essential to health care operations. In states like Arizona, families can no longer access free or low-cost immunizations for influenza or COVID-19 through public health-run programs. In Maryland, residents can no longer view their vaccination records digitally or receive reminders for future immunizations. If this weakening of the immunization infrastructure continues, clinicians may need to return to the days of manually checking vaccine cards and records.

The ongoing 2025 measles outbreak should be heeded as a harbinger for other vaccine-preventable diseases (**Table 3**). As a very contagious disease, measles cases often crop up before other diseases such as polio, rubella, or pertussis (whooping cough).

Table 3. The Health Care Costs of Fall/Winter Respiratory Virus Surges

Cut: Significant reductions in federal public health funding have weakened vaccination infrastructure and outreach programs. In addition to these funding cuts, the federal systems that shape immunization policy are undergoing rapid changes. Recent developments – including the removal of vaccine experts from CDC's Advisory Committee on Immunization Practices and the reversal of COVID-19 vaccine recommendations in pregnancy – directly impact how health care systems and insurers plan for supply, reimbursement, and guidance for the season, and also whether patients can expect their vaccines to be covered by insurance.

Impact: Declining immunization rates increase the risk of transmission and of severity of disease, as we have seen with this year's historic measles resurgence, and heighten the potential for simultaneous viral surges - like the seasonal waves of influenza, COVID-19, and RSV that strain health care systems each year. Higher immunization rates don't just prevent individual illness – they reduce overall health care utilization and help preserve system capacity. For example:

- Over 10 years, high-dose flu vaccines for older adults prevented more than 1.3 million flu illnesses, 520,000 hospitalizations, and 74,000 deaths–saving $4.6 billion in health care costs.
- Unvaccinated adults were 10 times more likely to be hospitalized for COVID-19, contributing to $13.8 billion in preventable costs in just six months.
- RSV is the number one reason infants are hospitalized in the US; RSV prevention (maternal vaccination or nirsevimab) reduced infant hospitalizations by 43%.

Background: Flu, COVID-19, and RSV remain the leading causes of fall/winter respiratory hospitalizations, especially among infants, older adults, nursing home residents, and those with chronic conditions. Seasonal system preparedness depends not only on immunization rates but also on clear, timely, and trusted public health guidance to enable providers, insurers, and health systems to plan vaccine supply, distribution, and coverage. As financial and policy uncertainty grows, the loss of public health capacity threatens both clinical care and operational readiness for respiratory viral surges.

The consequences of more, sicker and costlier patients in these use cases are not inevitable – timely investments could be made in new solutions.

Section 3: Health care forced to fill gaps or go without

From lead poisoning to suicide prevention, health care will need to make the critical decision of whether to fill gaps in public health functions or go without them.

Care in the community

Without Directly Observed Therapy (DOT) for tuberculosis (TB), patients are more likely to miss treatment doses, drug resistance emerges, and hospitals may face an influx of higher-acuity TB cases than they've seen in decades. With drastic proposed cuts to tuberculosis funding, hospitals and outpatient clinics may have to decide whether it's possible to expand services to include programming like DOT traditionally in the realm of public health. Public health efforts are particularly cost effective for TB: estimates from California assert that preventing a single case of TB costs $857, compared to $43,900 for diagnosing and treating an active TB case. With mixed coverage for DOT across payers, hospitals would need to consider filling both workforce and reimbursement gaps.

Lead poisoning prevention and care is also under threat due to budget and workforce reductions. A child with lead poisoning often presents with subtle symptoms, like language delays and difficulty learning. Lead can directly damage neurons, with cognitive effects that persist into adulthood. Preventing lead poisoning and swiftly acting upon elevated blood lead levels are therefore vital services delivered by state and local health departments. Public health workers perform home inspections, case management, and environmental interventions to mitigate the harmful effects of lead, often with federal resources and support. However, it has been more challenging for cities like Milwaukee to respond to community lead threats without the usual backing from CDC, raising the specter of more children showing up in clinics with lead toxicity.

Behavioral health

The U.S. is facing a behavioral health workforce shortage, with impacts felt across the health care system. These pressures are increasingly visible in emergency departments (EDs), where patients in crisis board in EDs for weeks to months due to limited inpatient psychiatric care.

Many of the proposed cuts will further strain emergency rooms and hospitals. Resources for localities to hire school-based counselors, psychologists, and social workers were withdrawn from the Substance Abuse and Mental Health Services Administration (SAMHSA). Suicide prevention services routinely recommended by clinicians, like mental health hotlines are slated for elimination. $56 million in funding for naloxone – the opioid overdose reversal agent – has been cut for paramedics and EMS, threatening fledgling progress on the overdose crisis. When behavioral health services such as these disappear from our neighborhoods, patients in crisis are more likely to show up in our emergency rooms and hospitals.

What can health care organizations do to prepare for the impacts of reduced investment in behavioral health prevention services? Regional coordination to expand inpatient capacity is possible, but past efforts have faced challenges, and Medicaid cuts would further complicate expansion. Health systems with integrated outpatient and inpatient care could mitigate strain by strengthening community-based and primary care behavioral health supports within their catchment areas.

Clinical guidance

Clinicians, payers, and policymakers rely on public health-generated guidance to shape clinical care (e.g., infection and prevention control, STI treatment, and contraception) and insurance coverage. These recommendations help the health sector apply emerging evidence to routine care and ensure that clinical guidelines can be adapted swiftly during public health emergencies. The U.S. Preventive Services Task Force (USPSTF), staffed and supported by Agency for Healthcare Research and Quality (AHRQ), has issued evidence-based recommendations on 90 topics, like cancer screening and preventive medications. Under federal law, insurers and Medicaid programs must cover USPSTF “A” and “B” grade services without cost-sharing – for patients, this can mean the difference between a covered test and an out-of-pocket bill. Proposed AHRQ funding cuts jeopardize the USPSTF’s ability to deliver and disseminate rigorous, evidence-based recommendations, putting at risk the trusted standards that guide patient care.

As we have seen during recent health emergencies, gaps in guidance while public health threats loom can be especially dangerous. During COVID-19, even brief delays or ambiguities in federal public health guidance – such as around vaccine eligibility and prioritization – left health care organizations without the clarity needed to plan staffing, distribution, and outreach strategies. When the first U.S. Mpox case was confirmed in May 2022, public health and health care systems were again in uncharted territory, confronting a disease rarely seen in the U.S. Moments without clear guidance were pain points in the response, making local Health Action Network (HAN) advisories and Dear Colleague letters especially welcome among frontline clinicians struggling to navigate complex patient counseling amidst vaccine shortages.

Without expert clinical guidance in preparation for – or in response to – both seasonal disease surges and unanticipated outbreaks, health care entities are left unprepared. These challenges underscore the critical role of timely public health expertise in guiding health care organizations clinical and operational decisions, and the need for replacement systems that can carry forward this essential advisory function.

Public health and health care are integral for each other's success

The U.S. health system – with its redundancies, siloes, and high costs – is undeniably in need of reform. But in its current form, it functions as a delicate web woven from both public health and health care threads, where pulling one thread risks unraveling many others. Just as public health cannot deliver individual-level care, health care cannot succeed in its goal of delivering high-quality care without a robust public health infrastructure. Reductions to vital public health services and personnel degrade that infrastructure, weaken our health ecosystem as a whole, and compound additional threats to health care – including potential Medicaid reductions.

Health leaders can consider how to prepare for the impact of these public health cuts on their patients and workforce – might staff need to be reassigned or trained in tasks like contact tracing or new lab services? Might certain clinic-based screening programs, like for HIV, need to be expanded? In addition, is it worth reinvestment – or possibly new investments from previously untapped sources – to reinstitute some of the public health services that have been dismantled?

Health care can't fill the public health gap alone – but it can't afford to ignore it, either. As the stakes only heighten, hospitals, payers, and public health leaders should explore ways to temporarily sustain essential public health services together. Going without them could cost far more – in both dollars and lives – than bridging the gap. These higher costs would be borne by health systems, payers, and ultimately patients and their families. State and regional coalitions offer a path forward, coordinating across sectors to steward critical services. Now is the time to align around shared priorities, act quickly to close urgent gaps, and invest in bold, collaborative solutions to improve and save lives.

The Common Health Coalition encompasses more than 250 organizations committed to strengthening the health system through local, state, and regional collaboration across sectors. Pursuing such partnership affirms the deep interconnectedness of public health and health care – and our shared commitment to the health and well-being of communities.