Advance The Public Health System

The public health system — composed of federal, state and local departments — must be modernized and maintained at a level that allows the field to focus on activities it is uniquely qualified to deliver in the most effective way. In order to do this, 1) health departments at the federal, state and local levels must establish foundational capabilities to ensure consistent, basic levels of protection across the country; 2) federal public health programs need to be restructured; and 3) public health departments at all levels must receive adequate funding.

DEFINE “FOUNDATIONAL” CAPABILITIES OF PUBLIC HEALTH DEPARTMENTS

Current Status:
Public health departments around the country have the unique role and responsibility for improving health in schools, workplaces and neighborhoods, through identifying the top health problems and developing strategies for improvement.

As of 2012, however, the field of public health faces a new set of challenges and opportunities, including:

- Changes in the overall health system that emphasizes cost containment and improved health, and expansion of the number of individuals with insurance coverage for direct preventive services;
- Massive budget and workforce cuts at all levels of government;
- A growing focus on accountability, with higher expectations for demonstrating a return on investment in terms of cost and health improvement. This includes a movement toward accreditation to ensure that all health departments meet and can demonstrate a standardized set of core capabilities; and
- Adoption of new technologies, including electronic health records, which could allow public health to integrate and analyze data with the health system and other sectors to better identify health patterns, causes and cures for health problems, and “hot spot” areas with high rates of chronic diseases and costs.

Why Public Health Departments Matter:
- Where you live shouldn’t determine how healthy you are, and public health departments serve as the unique and essential component of an integrated health system that looks out for the population as a whole, rather than focusing on the health outcomes of individuals alone.
- Public health is responsible for identifying the biggest, highest cost health problems and developing the most effective strategies for improving health.
Public health departments bring together partners in states, counties, cities and communities around the country to assess community-specific needs, and to plan and implement activities designed to improve health outcomes and reduce health care expenditures.

Public health plays an essential role in protecting Americans’ health from threats ranging from bioterrorism to infectious disease outbreaks to extreme weather events.

Recommendations:

▲ Strengthen the role of Health Departments as the chief health strategist in communities: In response to the new challenges and opportunities confronting our nation in 2013, public health departments must assume greater accountability for the design and development of the overall strategic plan for improving health in communities. To do this, health departments must clearly establish their value and role in a reformed health system — especially in the identification, implementation, coordination and evaluation of cost-beneficial prevention programs and activities. Strengthening this role will also require a greater focus on efficient, effective practices for structure, organization, finance and delivery of public health, including on-going public health services and systems research to identify new evidence-based practice and approaches.

▲ Define, prioritize and fully fund a set of foundational capabilities for public health departments at all levels of government: Public health departments need the tools and skills that are necessary to provide basic public protections while adapting to and effectively addressing changing health threats. The Institute of Medicine (IOM) and the Transforming Public Health project, funded by the Robert Wood Johnson Foundation (RWJF), identified some of these foundational capabilities as developing policy, using integrated data assets, communicating with the public and other audiences to disseminate information, mobilizing the community and forging partnerships, cultivating leadership skills, demonstrating accountability and protecting the public in the event of an emergency or disaster.1,2 Ensuring these foundational capabilities should become a primary focus of federal, state and local funding, even if it means restructuring some categorical funding streams, and funding must be maintained at a level to guarantee these capabilities can be effectively maintained and delivered.

▲ Prioritize accountability for achieving and maintaining foundational capabilities through accreditation and other mechanisms: Accreditation, continuous quality improvement and transparency are important parts of ensuring these foundational capabilities are met and maintained. Specifically, achieving voluntary accreditation from the Public Health Accreditation Board (PHAB) is a process where governmental public health departments can begin to demonstrate core competencies and accountability. In the future, accreditation could also be used as an important mechanism for states and localities to more easily and efficiently demonstrate that they have met the capabilities required for federal funding opportunities.

▲ Integrate with health care providers to contain costs and improve health: Public health departments must adapt to work with new entities and financing mechanisms in the reformed health system, such as by working with Accountable Care Organizations (ACOs) or within new capitalized care structures and global health budgets, to help improve health beyond the doctor’s office.

▲ Partner with other sectors and members of the community to make healthier choices easier in our schools, workplaces and neighborhoods: Public health officials must work with other sectors, such as education, transportation and housing, to capitalize on the many opportunities to promote health and wellness where Americans live, learn, work and play.

▲ Develop a public health workforce to meet modern demands: The future public health workforce should be more versatile and better equipped to handle various public health challenges or threats. This workforce should have policy development skills, management/administrative skills, technological skills and communications skills needed to create the foundational capabilities that all health departments should have. Public health workers also must be able to draw from and work with other fields and overlapping disciplines such as education, transportation and the environment and receive continued re-training and professional development opportunities to meet evolving needs. In addition:

• The public health workforce measure in the Affordable Care Act (ACA) must be fully funded and implemented;

• Public health curricula and job re-training must include developing skills in Health Information Technology (HIT), policy and legal areas, and cross-sector management; and
Training programs for health workers, including community health workers and HIT professionals, and in other sectors where programs impact health must emphasize the need for multiple sectors to work in coordination.

Use modern technology to improve the ability to identify top health problems in a community and determine their causes and cures: New data systems and electronic health records (EHRs) have the potential to revolutionize health tracking by making it possible to collect and analyze health data in real-time and allow interactive communication among providers, health departments and other sectors. Instead of continuing to have a series of siloed systems to track different diseases and other health problems, connecting different sources of data so they are interoperable and available in real-time could lead to breakthroughs in identifying health trends and patterns. In addition, public health must monitor a range of factors — from educational attainment to employment — that impact health outcomes even if they are not under the direct purview of public health.

Public health departments should only pay for direct services when they cannot be paid for by insurance: Some public health departments provide direct services in their community along with other preventive programs. Since the ACA will expand the number of individuals with coverage and expand what services are covered by many insurance providers, public health departments should reassess their role in the direct provision of medical services (including the option of becoming a Federally Qualified Health Center), to ensure that they do not use their public health budgets to pay for services that could be billed to insurers or could be paid for through health center dollars.
In their April 2012 report, *For the Public’s Health: Investing in a Healthier Future*, the IOM called for increased focus and prioritization among governmental public health agencies. They identified a set of “foundational capabilities” that included:  
- Information systems and resources;  
- Health planning;  
- Partnership development and community mobilization;  
- Policy development analysis and decision support;  
- Communication; and  
- Public health research, evaluation and quality improvement.

Following the IOM report, a group of leading public health experts participated in the Transforming Public Health project, an initiative funded by RWJF to develop guidance for public health officials and policymakers to prioritize vital public health functions in a shifting political landscape. They summarized the foundational capabilities of public health as:  
- Developing policy to effectively promote and improve health;  
- Using integrated data sets for assessment, surveillance and evaluation to identify crucial health challenges, best practices and better health;  
- Communicating with the public and other audiences to disseminate and receive information in an effective manner for health, including health promotion opportunities, access to care and prevention;  
- Mobilizing the community and forging partnerships to leverage resources (funding and otherwise);  
- Building new models that integrate clinical and population health;  
- Cultivating leadership, organization, management and business skills needed to build and sustain an effective health department and workforce to effectively and efficiently promote and improve health;  
- Demonstrating accountability for what governmental public health does directly and for those things that it oversees through accreditation, continuous quality improvement and transparency; and  
- Protecting the public in the event of an emergency or disaster, as well as responding to day-to-day challenges or threats, with a cross-trained workforce.

The project also identified a set of additional important issues for public health departments to consider, which include:  
- Maintaining a culture of continuous quality improvement;  
- Improving coordination across all levels of government to foster synergy and efficiency;  
- Building a better and cross-trained workforce that is more versatile and well equipped to handle a range of public health needs;  
- Bolstering research, by capitalizing on improved technology to access and analyze data, to better demonstrate the value of public health and prevention services and programs; and  
- Ensuring sufficient, stable and sustainable funding for public health, including leveraging resources from non-traditional sources that also have an interest in improving health, such as across government agencies and from the health care sector, private industry, non-profit fundraising and community development.

The project stressed that “prioritizing is the only way to take on new challenges in a time of declining resources.” To be successful in the future, public health should focus on:  
- Ensuring what is being done is being done as well and as efficiently as possible;  
- Coordinating across all levels of the governmental public health system and other government agencies and jurisdictions to maximize impact; and  
- Cultivating and/or training a workforce that can deliver foundational capabilities when implementing programs.
PUBLIC HEALTH ACCREDITATION

The PHAB, created in 2007, has created a voluntary public health accreditation program for state and local public health departments. This accreditation process is a major effort to improve and standardize core capabilities of health departments.

The PHAB administers the national public health department accreditation program for public health departments operated by Tribes, states, local jurisdictions and territories. PHAB accreditations include domains (groups of standards that pertain to a broad group of public health services), standards (the required level of achievement that a health department is expected to meet), and measures (evaluation tools for meeting standards).

There are 12 domains. The first ten domains address the 10 Essential Public Health Services; domain 11 addresses management and administration, and domain 12 addresses governance.

The 12 domains include:

**Domain 1**: Conduct and disseminate assessments focused on population health status and public health issues facing the community.

**Domain 2**: Investigate health problems and environmental public health hazards to protect the community.

**Domain 3**: Inform and educate about public health issues and function.

**Domain 4**: Engage with the community to identify and address health problems.

**Domain 5**: Develop public health policies and plans.

**Domain 6**: Enforce Public Health Laws.

**Domain 7**: Promote strategies to improve access to health care services.

**Domain 8**: Maintain a competent public health workforce.

**Domain 9**: Evaluate and continuously improve health department processes, programs and interventions.

**Domain 10**: Contribute to and apply the evidence base of public health.

**Domain 11**: Maintain administrative and management capacity.

**Domain 12**: Maintain capacity to engage the public health governing entity.

Standard 5.4 focuses specifically on preparedness and requires that public health departments maintain an all hazards emergency operations plan. In order to become accredited, a health department must:

- Participate in the process for the development and maintenance of an All Hazards Emergency Operations Plan (EOP);
- Adopt and maintain a public health EOP; and
- Provide consultation and/or technical assistance to Tribal and local health departments in the state regarding evidence-based and/or promising practices/templates in EOP development and testing.
RESTRUCTURE FEDERAL PUBLIC HEALTH PROGRAMS

Current Status:
Federal health agencies are responsible for protecting the health of Americans. Key public health functions include setting national priorities and goals for the country’s health and providing funding and other support to states and communities that carry out prevention programs and services aimed at improving health.

Based on budget and scale, delivery of health care services dominate the time and attention of the senior leadership at the U.S. Department of Health and Human Services (HHS) and dramatically overshadow public health. For example, more than 80 percent of the HHS budget is devoted to the Centers for Medicare and Medicaid Services (CMS). With only four percent of the HHS budget, the budget for the National Institutes of Health (NIH) is still more than the combined budget for the agencies focused on public health and prevention, including Center for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA) and the U.S. Food and Drug Administration (FDA). Currently, there is only one Deputy Secretary to manage all health care, biomedical and public health agencies and offices.

Many of the existing public health agencies have a broad range of responsibilities and functions, from funding and overseeing direct providers of health services to public health science and research. It has been decades since changes have been made to the way the federal government structures its health care roles and programs outside of Medicare and Medicaid. With the passage of the ACA and the increase in insurance coverage of direct prevention services, it is time to consider restructuring and realigning federal public health agencies.

Why Restructuring Matters:

- The current federal structure for handling public health issues is not coordinated and lacks clear, strong leadership. The Assistant Secretary of Health (ASH) does not have line or budget authority over public health programs across HHS.
- At CDC, programs are often siloed and based on diseases and conditions, such as type 2 diabetes and heart disease, rather than integrated and focused on the prevention strategies that can help improve health overall, such as promoting better nutrition and increased activity.
- Currently, there are more than 300 different health surveillance systems or networks supported by the federal government.\[11\]

Recommendations:

- Improve efficiencies of programs at CDC through strategic realignments and integration: CDC has undertaken a series of efforts to find ways to better coordinate and align interrelated health issues, activities and prevention strategies, but implementation of this approach and vision has only been carried out to a very limited extent. For instance, efforts to realign chronic disease programs at CDC based on the most effective prevention strategies rather than by categorical diseases have not been realized and the implementation of a vision for program collaboration and service integration (PSCI) for the National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention has been limited.

- Evaluate the possibility of increased integration and flexibility of CDC’s grants to state and local health departments in exchange for increased accountability: Currently, state and local health departments often have cumbersome and duplicative administrative requirements for multiple grants they receive from CDC. An evaluation should be conducted to determine how different CDC grants could be integrated, and whether more flexibility could be provided to grantees to cut down on red tape if state and local health departments meet certain accountability standards. CDC officially recommends increasing grant funding flexibility along with creating standard approaches and quality improvement measures to be defined in collaboration with State, Tribal, Local and Territorial (STLT) health departments.\[12\]

- HRSA, SAMHSA and CDC should become payers of last resort for direct services: All grantees of federal public health agencies that provide direct services that can be billed to a client’s insurance (private insurance, CHIP, Medicare or Medicaid) should be required to do so. Only those services not covered by insurance — or services provided to those who remain uninsured — should be paid for with scarce discretionary dollars from the public health program budgets. Some health programs may need assistance in instituting reimbursement procedures.
**Consolidate federally-supported public health surveillance systems:** New data systems and EHRs have the potential to revolutionize epidemiology by making it possible to collect and analyze health data in real-time and allow interactive communication among providers, health departments and other sectors. Instead of continuing to have a series of siloed systems to track different problems, connecting different sources of data so they are interoperable and available in real-time could lead to breakthroughs in identifying health trends and patterns, and identifying causes and health problems. The federal government should clarify and promote mechanisms for exchange of data between the private sector and public health departments in a way that is permissible under the law and maintains appropriate individual privacy protection.

**Appoint an independent group of experts, such as by creating a committee at the IOM, National Academy for Public Administration, and/or think tank initiative, to evaluate possible ways to restructure public health agencies to improve and align functions and services.** This evaluation should consider all of the below options to determine which changes, if any, would create improvements and cost savings. The evaluation should include recommendations for the timing and coordination of the different possibilities, so any transitions would be carried out as effectively as possible.

- **Assess the need for an Undersecretary or Deputy Secretary for Health:** There should be an evaluation of whether the creation of an Undersecretary or Deputy Secretary position to oversee a strategic approach to prevention, preparedness and public health would help increase coordination and accountability among agencies. This review should determine whether all Public Health Service agencies, the Assistant Secretary for Preparedness and Response (ASPR) and CMS should report to this official. This position is not meant to disempower agencies or add another bureaucratic layer, but to help coordinate and provide leadership. Further, the person in this position and the Secretary should have integrated budget and policy analysis staff to avoid duplication and multiple layers of review.

- **Evaluate if restructuring of agencies based on functions would be more efficient and effective:** An evaluation should explore if restructuring based on alignment of functions would help agencies better fulfill their missions. Currently, a number of different agencies provide support for delivery of health services and also oversee public health research and programs. Aligning agencies based on functions and core competencies could potentially lead to increased efficiencies and improved capabilities. One high priority would be SAMSHA and HRSA, which have different, but very related responsibilities for direct service delivery. SAMSHA focuses on reducing the impact of substance abuse and mental illness in America’s communities, while HRSA focuses on improving clinical and related supportive services for vulnerable populations, especially the poor, uninsured, mothers and children, and people living with HIV/AIDS. While they focus on different health problems, the two agencies have many overlapping functions and serve overlapping populations. In addition, philosophically the health care system is moving toward closer integration and equity between clinical and behavioral health care. An evaluation could examine if it would improve efficiencies and quality by merging the delivery services functions of the various public health agencies.

- **A similar assessment should be conducted regarding the public health science, practice research, and workforce development functions that cut across CDC, HRSA, SAMHSA and the Agency for Healthcare Research and Quality (AHRQ).** An integrated approach to this work could help close the gap between prevention and health promotion and direct health care services within the department.

- **Determine the most effective structure for protecting food and drug safety:** Many food safety advocates have long called for an independent, unified food safety agency to bring together the diverse regulatory activities related to food safety across HHS and the U.S. Department of Agriculture (USDA), in order to be able to singularly and effectively focus on carrying out an integrated, risk-based, prevention-focused strategy. As a first step, the food safety functions at the FDA should be unified and strengthened so that the agency can effectively carry out the improvements called for in the Food Safety Modernization Act. In addition, a government-wide assessment and plan with a specific timeline and sufficient resources to carry out recommendations should be developed to unify all regulatory food safety functions and to coordinate research and outbreak investigation activities to best inform regulation and policy development.
Define a modern role for the Surgeon General: Historically, the Surgeon General has held a strong public-facing position as the nation’s doctor to provide unbiased advice to the public. However, over time, the office has been severely diminished, both in stature and financing. Currently, the office primarily serves to oversee the Public Health Service Commissioned Corps, the National Prevention, Health Promotion, and Public Health Council and an Advisory Group on Prevention, Health Promotion, and Integrative and Public Health. A review committee should examine how to reinvigorate the role of the Surgeon General to ensure strong national leadership on the major health issues and epidemics facing the country.

ENSURE SUFFICIENT AND STABLE FUNDING FOR PUBLIC HEALTH DEPARTMENTS

Current Status:
Public health departments at all levels of government have been chronically underfunded for decades. Federal funds are distributed through a mixture of population-based formula grant programs, formulas based on disease rates, and a series of competitive grants which provide funding to some states but not others. In most cases, there is no officially defined mode of coordination for targeting or strategically focusing the funds.

According to a 2008 analysis by The New York Academy of Medicine (NYAM), there was a shortfall of $20 billion per year in spending on federal, state and local public health.13

At the federal level, the budget for CDC decreased from a high of $6.62 billion in 2005 to $6.32 billion in 2011 (adjusted for inflation). Between fiscal year (FY) 2010 through FY 2012, federal public health spending was reduced 8 percent — by $2.5 billion. In FY 2011, federal public health spending through CDC averaged only $20.28 per person. The amount of federal funding varied significantly from state to state, with a low of $14.20 in Ohio and a high of $51.98 in Alaska.

At the state level, 40 states decreased their public health budgets between FY 2009-10 and FY 2010-11; 30 states decreased budgets for a second year in a row; and 15 for three years in a row. In FY 2011, the median state funding for public health was $30.09 per capita, down from $33.71 in FY 2008.

At the local level, in July 2011, nearly half of local health departments reported reduced budgets, on top of the 44 percent that reported lower budgets in November 2010. More than half of local health departments expect further cuts to their budgets in the upcoming fiscal year.

Since 2008, state and local public health departments have lost a combined total of over 45,700 jobs.14, 15

Why Federal Public Health Funding Matters:
Federal, state and local public health departments’ ability to carry out many core functions that most Americans take for granted — including basic infectious disease prevention and food and water safety programs — have been hampered due to limited funds.

Chronic diseases are responsible for seven of 10 deaths among Americans each year and treatment for people with chronic conditions account for roughly 75 percent of the $2.5 trillion spent on annual U.S. medical care costs. In addition to the direct costs, indirect costs of chronic conditions, including productivity losses, compound the problem. The best way to avoid these costs is through prevention beyond the doctor’s office — changing the behaviors that result in these chronic conditions.

Recommendations:

Increase funding for public health at the federal, state and local levels: A number of independent evaluations have concluded that public health is severely underfunded in the United States. To carry out core capabilities as defined by the IOM and Transforming Public Health project, federal, state and local health departments must receive a sufficient level of funding, and some existing funding lines may need to be realigned. Even in tough budget times, funding must be increased to sufficient levels for current public health and prevention programs to be effective in improving health and lowering disease rates across the country, which, in turn, will help contain health care costs. The use of all federal public health funds, and the outcomes achieved from the use of funds, must be transparent and clearly communicated with the public. Accreditation can be an important tool to measure if states and localities are meeting foundational capabilities.
Ensure all Americans are protected by a minimum set of public health services: Through the ACA, as a nation, we have established ensuring a minimum set of essential health benefits for all Americans with health care coverage. Since so much of what impacts health happens beyond the doctor’s office where people live, learn, work and play, it is also important to make sure that all Americans are protected by a minimum set of public health services. An established set of minimal or baseline services could then be equated to costs to maintain those services on a per capita basis, which would help standardize and rationalize funding for public health.

Explore new funding models to guarantee sufficient levels of funding to support basic capabilities.

Evaluate the possibility of a model of shared federal-state-local-tribal responsibility for delivering foundational capabilities and maintenance of programs and funding: Currently, funding for governmental public health activities differs dramatically for every state, based on a combination of categorical federal funds and discretionary allocations from state and local governments, and there is no rational model for ensuring base-level support for public health. A 2008 analysis by NYAM found that approximately 60 percent of public health funding is federal and 40 percent is a blend of state and local funds, although the exact amounts are variable by state. According to the Association of State and Territorial Health Officials (ASTHO), federal funds are the largest source of state health agency revenue (approximately 45 percent in FY 2009) — around 60 percent of which goes to local health departments and community-based organizations. It is worth examining the potential of a funding system for public health that sets a basic standard that every state and locality must meet, such as demonstrating the ability to deliver the foundational capabilities, as verified through a process such as accreditation, while also providing flexibility based on the states’ decisions, need and governmental structure.

Medicaid provides one example for how the federal government and states can work together to set basic national eligibility and benefit standards. This model allows for flexibility in implementation as long as certain standards are met and provides special incentives for states that embrace new program elements by increasing the federal match. Such a system would have to 1) set standards for federal matches for state and local public health funding; 2) establish a maintenance of effort standard so that current levels of state and local public health funding — for every given state based on their existing funding structures — are set as a baseline as they are with Medicaid — and so states are not hit with new unfunded mandates; and 3) standardize federal match levels based on priorities, such as an 80-20 split for basic capacities; a 60-40 split for priority program areas; and a 50-50 split for other categorical efforts. New federal requirements would need to start with an initial 100 percent federal commitment that could be brought down into the existing splits over time. This system could be managed within CDC’s existing structure or through a restructured federal public health system. Given the diversity of approaches to public health across the states, CDC would need to establish a system that assures that any agreement between the CDC and a state includes concurrence from the participating local health departments.

Examine a new model that increases flexibility for state and local health departments that demonstrate core capabilities: One alternative option for stabilizing funding would be to assess the feasibility of moving away from CDC’s existing model of funding, which includes a series of categorical grants, and move toward a combination of foundational capability grants with strict performance measures that would be the building blocks for categorical and disease specific grants. Currently, for instance, grants for epidemiological, laboratory and surveillance support are administered separately and are also divided from grants for diseases or conditions they are working to prevent or control. Grants stressing flexibility and accountability should be structured to help all states reach and maintain the foundational capabilities defined by the IOM report and Transforming Public Health project.
ENDNOTES


5 Ibid.


8 Ibid.

9 Ibid.


12 State, Tribal, Local and Territorial Workgroup. STLT Workgroup Recommendations to the Advisory Committee to the Director, CDC. October 2011.


