



A Shot In the Arm

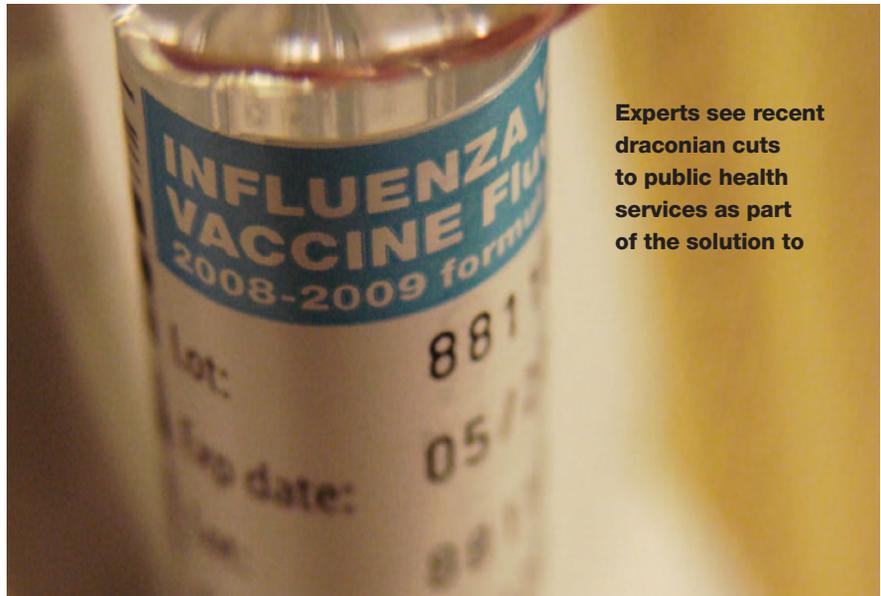
Revamping the way we pay for public health systems could be a game changer.

When you hear “public health,” you probably think of flu shots. That’s the visible—and briefly painful—side of public health services. But if you’ve enjoyed tobacco-smoke-free air, thought twice about ordering a cheeseburger after seeing its calorie count on a menu or not worried about tuberculosis in your community, you’ve also “used” public health services. These services are essential, ubiquitous and usually unnoticed.

They’ve also been hit hard by the recession. Since 2008 about 17 percent of the state public health workforce and 22 percent of the local public health workforce have been eliminated, according to a 2011 report from the Association of State and Territorial Health Officials. Several reports have enumerated how, as a result of these cuts, we’re more vulnerable to communicable diseases, water-borne infections and other health concerns.

Rather than lament, some of public health’s leading thinkers have seized the opportunity buried in this crisis. To them, these draconian cuts aren’t just the problem, but also part of the potential solution to a much bigger issue with how we fund public health systems. Their efforts offer an intriguing, possibly prescient, lesson on the future of fiscal federalism.

The issue is that funding for public health services is siloed and fragmented. For example, the Centers for Disease Control and Prevention pays for vaccines for Medicaid-eligible children, but does not necessarily fund the intergovernmental coordination, records management, public outreach and other components of a bona fide local vaccination program. Many local health jurisdictions use local tax dollars to build these components around the federal and state money. During the recession many of the siloed state and federal revenue streams dried up.



Experts see recent draconian cuts to public health services as part of the solution to

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To address this, public health leaders are rebuilding some of their core assumptions. For about five years, the field has grappled with a fundamental question: What’s the minimum package of essential public health services that every citizen should expect? To answer that, they’ve had to agree on common definitions and tactics about how to deliver these services. This is a huge challenge, given that the roughly 3,000 local public health districts around the U.S. often deliver the same services in very different ways. Nevertheless, several iterations of expert panels have reached some tentative conclusions. They’ve developed a shared set of foundational public health services and capabilities—like communications and policy development—needed to deliver these services.

Here’s the catch: They believe the capabilities are as important as the services. You can’t provide a minimum level of an essential service unless you can assess whether it’s working, build community partnerships around it and communicate with the public about it.

With this framework, public health can start to answer crucial questions about money. What does it cost to deliver foundational services and capabilities? Can local health districts reduce costs by sharing staff? Can we develop uniform budgeting and accounting systems to compare local spending on essential services around the country? In fact, the Institute of Medicine, the Robert Wood Johnson Foundation and other institutions are now funding research into precisely these types of questions.

If they can answer them, public health will change the intergovernmental fiscal relations game. Instead of angling for more money for the same system, they’ll offer state and federal legislators the chance to fund a package of services where the benefits and costs are clear, uniform and comprehensive. In a crowded field with other services funded the same way—homeland security and job training come to mind—this could be a shot in the arm for public health. **G**

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