

FOUNDATIONAL PUBLIC HEALTH SERVICES WORKGROUP

JUNE 2013 UPDATE

Since November 2012, the work group has had four full day work session (11/30/12, 3/29/13, 4/10/13, 5/30/13) with the contractor to review the model, data submitted, results and policy questions raised by the model. The conclusions from the most recent work session on 5/30/13 include:

1. The model is flexible and able to provide information for different assumptions. Two key examples are:
 - o Elasticity – Elasticity relates to the amount of the total costs that are not ‘fixed costs.’ Common assumptions ranges from 70-90% elasticity which means that 70-90% of the cost of producing something or delivering a service is ‘fixed’ and 30-10% of the cost is variable. The model allows us to apply different elasticity assumptions. The workgroup felt that 70% elasticity seemed most in line with the realities of public health practice.
 - o Scaling or Scaling Factors – Scaling relates to identifying cost drivers or denominators for different services. For example, the primary cost drive or denominator for restaurant inspections is the number of restaurants or similarly, permitting of temporary food vendors is the number of temporary food vendors or events that have temporary food vendors. For communicable disease investigations, it is the number of cases that need to be investigated; for many other activities, it is population (per capita). The model allows us to use different cost drives for different services so that we can more appropriately determine cost of each services or activity.
2. While the contractor is still following-up with a couple of agencies to finish validating their data, the workgroup felt that the cost data that has been collected and is being used to extrapolate for statewide costs is quite solid and reasonable.
3. The ‘revenue data’ that is included in the model provides information on how these services are currently funded. It is grouped as follows: grant/contract, fee, all other. The revenue source ‘all other’ is assumed to represent ‘flexible’ funds – for LHJs this includes local government contribution / county-city general fund and state flexible funds (LCDF, 5930, MVET Replacement); for DOH this includes state general funds. For costs that are not currently funded, as an estimate, the contractor applied the same percentage of grant/contract, fee, and other funding from related activities to the currently unfunded costs / activities.

One use of the revenue data in the model that it allows us to set aside costs that currently have grant/contract or fee funding and identify the remaining costs that should be funded by state and local tax dollars. One initial observation on this is that it appears that half of the

local and state flexible funds currently available to LHJs are being spent to provide FPHS. It is assumed that the remaining flexible funds are being spent to provide additional important public health programs that are locally determined.

4. As illustrated by the above point, the model is and will be a good tool for discussing, exploring and better understanding our current funding system and determining options for (including pros/cons of each option) and a recommendation for a model of predictable and appropriate levels of funding for the state and local public health system in Washington state.

By the end of June, the contractor will provide the Workgroup with a final report that includes technical information on the cost model, descriptive analysis of the current funding system, and policy issues highlighted by the model. The report will include an executive summary and other communication tools like a PowerPoint presentation, FAQs, and a 1-page brochure will also be provided.

With the approval of the PHIP Partnership, Phase 2 of the FPHS Workgroup will be launched this summer directly under the auspices of the PHIP. Leadership and membership in this workgroup are yet to be determined. Please contact Barry Kling, Jennifer Tebaldi or Marie Flake if you are interested in participating.

In preparation for the 2015 legislative session, the next time the biennial state budget will be determined, the goals for Phase 2 are to provide a model for sustainable funding, including providing technical information on options, including pros/cons of each option and recommendations on a funding model and providing technical support to policy makers in designing sustainable funding models. Milestones along the way include having a clear description of our current funding situation and future funding options to discuss with public health professionals and key partners (July – December 2013); in collaboration with local government partners, clearly describe options, pros/cons, and agree on a recommendation for a funding model (January – June 2014); and assisting in the introduction of a broadly supported proposal to partners and policy makers (July – December 2014). The FPHS Phase 2 workgroup will also address related issues around improving BARS data and working with other PHIP workgroup to develop accountability for FPHS.

BACKGROUND

The Agenda for Change (A4C) Foundational Public Health Services (FPHS) Workgroup's goal is to develop a long-term strategy for predictable and appropriate levels of funding. The first step is addressing two questions – funding for what? And how much funding is enough? Along these lines, the Institute of Medicine (IOM) published the report in 2012 titled 'For the Public's Health: Investing in a Healthier Future,' which among other things recommended defining a 'minimum package of public health services.' In Washington State we are calling this package 'Foundational Public Health Services' (FPHS). We believe that the word foundational appropriately conveys the concepts of 'minimum' and something to build upon. Like public safety (police, fire), public utilities (power, water) and public infrastructure (roads, sewers), FPHS must be in place everywhere in order to work anywhere.

The FPHS Workgroup set about defining the foundational public health services that must be present everywhere, in order to work anywhere and should be funded with state and local tax dollars. These FPHS include cross-cutting capabilities like assessment, emergency preparedness, communication, policy development, community partnership development and business competencies, and a basic level of programs like communication disease control, chronic disease and injury prevention, environmental public health, maternal-child-family health, access-linkages with clinical health care, and vital records. The FPHS are not all that public health should provide, they are just the foundation, so the workgroup also provided ‘examples of other important programs’ to communicate that a) these programs were specifically considered and deemed “not foundational” and b) to provide examples of other important public health services that each local community and agency will determine the need for, how to deliver, and how to fund (frequently these services are funded by grants). Draft versions of the definitions were widely vetted and discussed with local public health leaders via WSALPHO and its forums in 2012. Input was received, considered and revisions were made.

The Workgroup hired BERK & Associates to conduct a review of current work around the country on this issue and to develop a model for estimating the cost of delivering the FPHS statewide here in Washington. To develop the cost model, the Workgroup selected DOH and 9 LHJs representing a cross section of LHJs statewide (large/small, east/west, department/district) to provide detailed financial data that would then be used to extrapolate to statewide costs. (The participating LHJs, from largest to smallest are: Public Health – Seattle-King County (PHSKC), Spokane, Clark, Whatcom, Chelan-Douglas, Grant, NE Tri, Walla Walla, Lincoln).

Using the FPHS definitions and current financial data, each agency provided estimates of what it would cost to deliver the defined services for their jurisdiction/population size – whether or not they are currently being provided and how these costs are currently funded. Current financial information served as a guide to estimate what it would cost to provide the FPHS. To achieve higher validity of the data and a more consistent interpretation of overhead and in-direct costs, the foundational capabilities and program definitions, costs and current funding source, numerous discussions were had within the workgroup and with each agency that contributed data. Detailed documentation was kept about which specific activities were included or excluded in the cost estimates.