

PUBLIC HEALTH IMPROVEMENT PARTNERSHIP

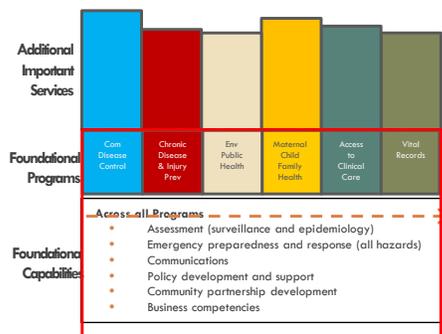
Foundational Public Health Services (FPHS)

Summary Update, October 2014

For more than a decade in Washington State, Public Health Improvement Partnership (PHIP) finance committees have tackled the issue of public health funding more than a couple of times. Approaches have included estimating the costs of delivering public health services in compliance with the public health standards (2002); developing white papers that explained how public health funding is structured and how it is underfunded (2004); developing principles for allocating funds among LHJS (2004); and in response to the 4410 Joint Select Committee on Public Health Funding, identifying and prioritizing where to spend any new investments in public health and what types of services would be provided at different investment levels (*Creating a Stronger Public Health System* 2006). The later work was part of a legislative process that resulted in an additional investment of \$20 million/biennium of state general fund dollars in local public health. That new revenue stream was later reduced to \$10 million/biennium.

In 2008 concern that the erosion of public health funding was threatening the most basic public health services led to the formation of the Reshaping Government Public Health Workgroup which published *An Agenda for Change* in 2010. The workgroup concluded that 'public health in Washington is at a crossroads' and as a part of public health reform agenda identified the need to 'develop a long-term strategy for predictable and appropriate levels of financing.'

FUNDING FOR WHAT?



FOUNDATIONAL PUBLIC HEALTH SERVICES

- **Foundational Capabilities** – cross-cutting services that support all other services
- **Foundational Programs** – a defined basic level of service that is necessary in each program area

The FPHS framework was published in the 2012 Public Health Improvement Partnership report.

Definitions were developed for each FPHS with the goal of being specific enough to estimate the cost of providing the service statewide while not naming specific programs that may come and go over time. Criteria used to identify and define the FPHS included:

- Important population-based health service (without individually identifiable beneficiaries)
- Governmental public health is the only or primary provider of the service
- Service if mandated by law or contingent on the legal powers granted only to the local health officer/board of health

For each of the foundational program areas, the definitions identify the primary role of governmental public health as:

- Working with data (collection, analysis, and sharing)
- Working with community partners to identify assets, planning, advocating for high-priority initiatives
- Coordination among programs and community partners

Additionally, a limited set of specific conditions or issues are called out because they are of high priority.

The FPHS are not everything that public health should and could do to keep the public healthy, but provide a solid foundation onto which additional important services (AIS) can be added depending on local needs and priorities and availability of funding.

During summer 2012, the draft FPHS definitions were circulated widely among public health and health care partners. Input was considered and revisions were made. The FPHS were then published in summer 2013.

In 2012, PHIP formed an *Agenda for Change* Workgroup and a subgroup to develop a long-term strategy for predictable and appropriate levels of financing. The subgroup, later named the Foundational Public Health Service (FPHS) Technical Workgroup, first addressed the question 'funding for what?' by defining a core package of services that people rely on government to provide and that no community should be without. These Foundational Public Health Services define what must be present everywhere for the public health system to function anywhere.

The FPHS framework is composed of two components:

WHAT WOULD IT COST?

With the aid of consultants, the FPHS Technical Workgroup developed a model that is flexible and can be used to explore the cost of different scenarios for providing a uniform level of FPHS statewide. Steps included:

- Estimating what it would cost to provide a uniform level of FPHS statewide given the current delivery system
- Estimating how much money is currently spent on foundational and what the revenue sources are for this spending
- Estimating the difference between current spending and the estimated cost of providing a uniform level FPHS statewide and identifying the gap.

Details of the methodology and initial results can be found in Foundational Public Health Services Preliminary Cost Estimation Model Final Report (September 2013). Next the workgroup refined

the cost estimate by taking a closer look at selected areas to assure that cost estimate was complete and acute: tobacco prevention; healthy eating and active living, and the non-fee supported environmental health work like land use planning and built environment.

Program	Service Delivery	(1)	(2)	(3)	(4)		(5)
		FPHS Cost Estimate	FPHS Current Spending Estimate	Preliminary FPHS Gap	FPHS Gap Adjustments (a) Exclude LHJ Spending Above Estimates	(b) Exclude Uncertain Revenue	Estimated FPHS Gap
Foundational	DOH	\$ 27.8 M	\$ 26.2 M	\$ 1.6 M	-	\$ 0.0 M	\$ 1.6 M
Capabilities	LHJs	\$ 47.9 M	\$ 36.3 M	\$ 11.6 M	\$ 1.6 M	\$ 1.9 M	\$ 15.1 M
Environmental	DOH	\$ 35.2 M	\$ 30.3 M	\$ 4.9 M	-	\$ 0.0 M	\$ 4.9 M
Public Health	LHJs	\$ 69.5 M	\$ 64.6 M	\$ 4.8 M	\$ 7.8 M	\$ 0.0 M	\$ 12.6 M
Communicable	DOH	\$ 9.0 M	\$ 5.0 M	\$ 4.0 M	-	\$ 0.0 M	\$ 4.0 M
Disease	LHJs	\$ 24.8 M	\$ 19.4 M	\$ 5.4 M	\$ 0.9 M	\$ 0.8 M	\$ 7.1 M
Chronic Disease & Injury Prev.	DOH	\$ 27.9 M	\$ 8.7 M	\$ 19.2 M	-	\$ 0.0 M	\$ 19.2 M
	LHJs	\$ 40.3 M	\$ 6.8 M	\$ 33.4 M	\$ 0.0 M	\$ 0.0 M	\$ 33.4 M
Access/Linkage to Clinical Health Care ⁶	DOH	\$ 62.1 M	\$ 62.1 M	\$ 0.0 M	-	\$ 0.0 M	\$ 0.0 M
	LHJs	\$ 3.4 M	\$ 0.0 M	\$ 3.4 M	\$ 0.0 M	\$ 0.0 M	\$ 3.4 M
Maternal/ Child/ Family Health	DOH	\$ 13.8 M	\$ 9.0 M	\$ 4.7 M	-	\$ 0.0 M	\$ 4.7 M
	LHJs	\$ 11.4 M	\$ 9.4 M	\$ 2.0 M	\$ 2.0 M	\$ 2.1 M	\$ 6.0 M
Vital Records	DOH	\$ 3.6 M	\$ 3.6 M	\$ 0.0 M	-	\$ 0.0 M	\$ 0.0 M
	LHJs	\$ 3.5 M	\$ 4.4 M	(\$ 0.9 M)	\$ 1.2 M	\$ 0.0 M	\$ 0.3 M
Laboratory ⁷	DOH	-	\$ 12.6 M	(\$ 12.6 M)	-	\$ 0.0 M	(\$ 12.6 M)
	LHJs	-	-	-	-	-	-
DOH Total		\$ 179.4 M	\$ 157.6 M	\$ 21.8 M	\$ 0.0 M	\$ 0.0 M	\$ 21.8 M
LHJ Total		\$ 200.8 M	\$ 141.0 M	\$ 59.8 M	\$ 13.4 M	\$ 4.8 M	\$ 78.0 M
Total Statewide		\$ 380.2 M	\$ 298.5 M	\$ 81.6 M	\$ 13.4 M	\$ 4.8 M	\$ 99.9 M

NATIONAL EFFORTS

The work in Washington dovetailed national work sponsored by the Robert Wood Johnson Foundation (RWJF) including the 2012 publication of *For the Public's Health: Investing in a Healthier Future* by the Institute of Medicine (IOM). The report's ten recommendations including that:

- Public health should endorse a minimum package of public health services
- Expert panels should determine the components and cost of the minimum package

RWJF is now funding four national workgroup to:

- Define Foundational Public Health Services
- Estimate the cost of these services
- Discuss the federal role in funding FPHS
- Develop a model chart of accounts

Representatives from Washington State are members of these workgroups and the national efforts are drawing heavily on the work already completed in Washington State. More information can be found at www.resolv.org/site-healthleadershipforum/.

A LONG-TERM STRATEGY FOR PREDICTABLE AND APPROPRIATE LEVELS OF FUNDING

In April 2014, The Secretary of Health John Wiesman convened a Foundational Public Health Services (FPHS) Policy Workgroup. He recruited two co-chairs who represent different parts of the governmental public health network – Todd Mielke, Spokane County Commissioner and Marilyn Scott, Vice Chairman, Upper Skagit Tribe. Membership on the workgroup was by invitation of the Secretary and includes representation of the key sectors or groups that influence the structure and funding of governmental public in Washington – elected officials from municipal, county and tribal governments. Membership also includes representatives from the Governor's Health Policy Office, the state Office of Financial Management, public health officials from county, state and tribes and key health associations. State legislators and federal partners will be briefed periodically throughout the process.

The purpose of the FPHS Policy Workgroup is to propose governance and financing solutions that ensures appropriate funding for FPHS statewide. This is likely to include but not limited to:

1. Identify a reasonable share of state and local responsibility for funding a uniform level of FPHS statewide
2. Re-prioritize or reallocate current state and local funding that is being used for non-foundational services to FPHS
3. Identify additional or other governance/organizing or shared services principles and options for the delivery of a uniform level of FPHS statewide
4. New funding options
 - a) Identify new sources of public funds
 - b) Identify other new or non-traditional sources of funds (e.g., funds from capital markets; reallocation of health care savings from health care reform)
5. Some combination of the above or other approaches

The FPHS Policy Workgroup is meeting monthly and will publish recommendations in December 2014.