

FOUNDATIONAL PUBLIC HEALTH SERVICES POLICY WORKGROUP

Meeting Five Summary

The fifth meeting of the Foundational Public Health Services Policy Workgroup was held on August 20, 2014 at the Spokane Regional Health District.

MEETING OBJECTIVES

- Come to understanding and agreement about the scope of the solution.
- Begin identifying potential ways for funding responsibility to be divided.

WELCOME

Fauna Larkin of BERK welcomed all work group members to the meeting and reviewed the meeting agenda and objectives. She stated that the next meeting on September 17th will be at the Port Gamble S'Klallam reservation.

John Wiesman welcomed everyone to the group, and thanked everyone for attending in person or on the phone. John stated that the right people were present at the conversation, and that he was excited to start some important conversations about the different ways the state, LHJs and Tribes can collaborate.

Marilyn Scott expressed that she appreciated the opportunity for the tribal contribution and explained the importance of visiting the Port Gamble S'Klallam tribe..

SOLUTION BOUNDARIES

Logic Model: Government Public Health in Washington State

Fauna reviewed the government public health in Washington state logic model. She explained that the idea of the logic model was to clarify the role of the FPHS policy workgroup.

Scoping Tool for Government Public Health

Fauna reviewed the scoping tool for FPHS. The term “government public health” means the public health work done by the Washington State Department of Health (DOH), tribal health departments, and local health jurisdictions. She explained that in certain counties, certain services are being delivered by public health partners such as Washington State Department of Social and Health Services (DSHS), the Department of Ecology and nonprofit organizations.

Workgroup members said that it was important to have more discussion about certain FPHS definitions and non FPHS services. Some participants said that there were a lot of services that are provided by other agencies and nonprofit organizations.

Charter

Fauna presented the charter problem statement as the third way of clarifying the role of the policy workgroup.

There was discussion regarding the second sentence in the problem statement: governmental public health agencies cannot adequately confront 21st century challenges. Some workgroup members did felt the words outdated and inequitable seemed judgmental, and other work group members felt the words were important to discuss the inequalities across the tribes and the LHJs. Another work group member suggested adding behavioral health and mental illness as examples of chronic disease.

A workgroup member suggested that it was important to think about communication as a part of the charter.

LOOKING AT THE NUMBERS

Emmy McConnell from BERK presented the different ways FPHS is funded. There are three types of funding: fees for services are paid for a user to cover the cost of the service; categorical funding is money dedicated to a purpose; flexible funds are money raised by the state or local governments that are not for a specific purpose. Fees included: fish tax as a tribal example, a license for accreditation at the state level, and restaurant inspections at the local level. Categorical funding included the New Beginnings program at the tribal level, epidemiology funding at the state level, and county tuberculosis funding at the local level. Flexible funds included the fuel tax at the tribal level, and a public health block grant at the local level.

Technical workgroup representatives pointed out that flexible funding and FPHS funding will be different, and it is important not to equate flexible funding with FPHS funding. A policy workgroup member stated that if the FPHS definitions are not defined, it is difficult to determine how to fund FPHS. Public health's role in overseeing health professional's licensing was briefly debated and then tabled until the following meeting when a full discussion of the definitions is part of the planned agenda.

FUNDING RESPONSIBILITY IDEAS

Workgroup members at the meeting participated in a gallery walk and visited three different work stations in small groups. The participants on the phone had a small group discussion with Fauna. Each work station described a different FPHS funding responsibility idea: at Idea 1) The State funds 100% of FPHS; Idea 2a) The State funds 75% and tribes and locals fund 25%; 2b) The State funds 50% and tribes and locals fund 50%.

Idea 1a

Advantages for Idea 1 included: easier budgeting and accounting; better data collection with tribes; a single entity is responsible. Disadvantages included: loss of local control; locals could lose significant revenue resources that support flexible programs. Questions included: how the state would fund and deliver services; if locals would fund all Additional Important Services (AIS); how to set boundaries and local objectives and priorities?

During the whole group discussion, participants pointed out that this idea may be attractive but it also may not be politically realistic. One participant explained that there would be a problem at the local level with the state funding 100% of FPHS because counties will pull their local funding for public health and fund other non-public health priorities.

Idea 2a

Advantages for Idea 2a included: if counties are paying more than 25% currently, that money could be freed up for AIS; this maybe the best political idea. Disadvantages included: small counties and LHJs may not be able pay 25%; counties that contribute more than 25% might reduce overall public health contributions to be at 25%; the possibility of the state making changes at county levels in order to pay 75%. Questions included: where will the state get the money to fund 75%; could there be a base for small counties; how will that affect the complexities of tribal revenues from the federal government?

During the whole group discussion, participants pointed out there would have to be an agreement on how local jurisdictions would collect fees at the local level, and the state would help the LHJs and tribes negotiate. Participants expressed concern about small LHJs being lumped together for cost efficiencies. A participant stated that the county pressures already exist, so if FPHS is funded, the county can try to fund AIS.

A technical workgroup representative stated that the per capita contribution for LHJs range from \$3per capita to \$100 per capita. That is a multiple of 30. He felt that if one believes in the idea that there should be minimum public health protection, one must stop believing in a certain level of impoverished independence.

Idea 2b

Advantages for 2b included: establishes ongoing shared responsibility; might maintain more local autonomy/ flexibility than 100% state funded. Disadvantages included: local variation in feasibility options; replicates too closely what is going on today that is not working; the complexity of implementing and tracking these responsibilities. Questions included: what strings come with the state funding; would the 50/50 split be mandated?

During the whole group discussion, participants expressed that if FPHS is mandated it could potentially work, but if it is not mandated a lot of LHJs will not support it. Participants expressed that it would be difficult to get counties to pick up 50%.

Fauna closed this discussion by pointing out that there are multiple variations of Idea 2a. The 75% and 25% split could go in different ways, and there could also be a different percentage split that breaks in other ways.

Preferred Alternative

Many workgroup members felt that their preferred alternative was to have the state responsible for fully funding FPHS. Some felt that idea should be amended by excluding federal funding and locally supported fees from state responsibility. Participants in the conversation were wary about the implications of the idea on local funding for non-FPHS as well as service delivery.

ROUNDTABLE

Comments during the roundtable included: the need to focus on what is politically realistic; a feeling that mechanism discussions are not helpful at this point in the process; a request that a discussion about professional licensing and public health's role in that happen; a suggestion that cities need to play a more significant role in public health funding; and a reminder that participants are in this workgroup because of the public health funding crisis.

Workgroup members also commented that the facilitation of the meetings has been effective and that they liked the gallery walks, which allowed them to have more in-depth conversations in smaller groups.

CLOSING REMARKS

Marilyn explained some of the ways that the tribes around the state are all very unique. There will be differences in the way tribes fund and deliver FPHS.

John expressed that the conversations the policy workgroup had in this meeting were very important due to the diversity of perspectives throughout the state. FPHS are the base level services that everyone in the state deserves. He stated that he excited for the next meeting and that if anyone has ideas between meetings, please address them to Karen or reach out to the Co-Chairs or the facilitators.

NEXT STEPS

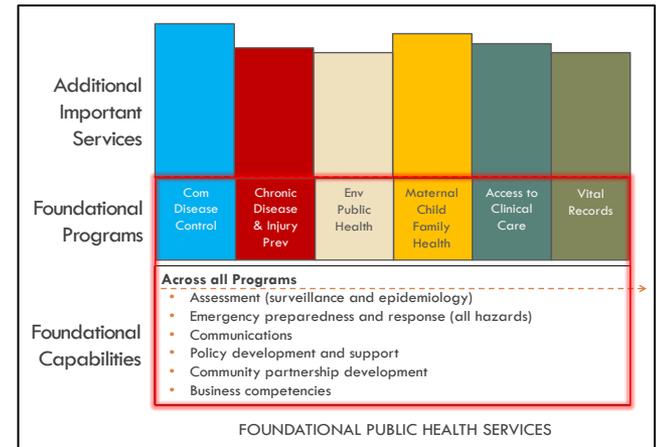
The next meeting will be hosted on September 17th, 2014 by the Port Gamble S'Klallam tribe. The Port Gamble S'Klallam reservation is located near Kingston, north of Bremerton. This meeting will be held in a long house space, and attending in person is strongly encouraged. It will be a great opportunity to see what tribal public health looks like.

FUNDING RESPONSIBILITY DISCUSSION

Introduction

Who should be responsible for funding FPHS?

- This discussion is focused on who should be responsible for funding the services in the “red box” of the foundational public health services framework.
- This discussion is about who raises the money to pay for FPHS.
 - It’s important to remember that whether we identify the state or local jurisdictions as responsible for raising funding, the taxpayers of our state are ultimately the same set of people paying into these services.
 - For example, if the state implements a 0.1% sales tax, all taxpayers in the state would pay it. If the counties all implemented the same tax, the impact on taxpayers (in the affected county) would be the same. The difference is in who is collecting and distributing that funding.



Key terms in this discussion

- “The state funds” – this phrase means that Washington State takes responsibility for raising and distributing funding
- “Locals fund” – this phrase means that local jurisdictions (all counties and a few cities) take responsibility for raising and distributing funding
- “Federal government funds” - this phrase means that the federal government takes responsibility for raising and distributing funding

Background on Fees and Federal Funding

Fees

- Fees are services paid for directly by the users (i.e. restaurant inspections, birth certificates).
- Except for vital records, fees collected by DOH are generally set by DOH and fees collected by LHJs are generally set by LHJs.
- There is legislation regarding the types of costs that can be recovered by fees, usually restricting fees to paying solely for the services being paid for.
- Overall, fees support about 24% of all current governmental public health spending.*
 - FPHS is heavily fee supported – 50% of spending on FPHS today is from fees.
 - Other public health spending is only about 11% supported by fees.

Federal Funding

- The federal government provides funding in the form of categorical funds – meaning funds restricted to specific activities.
- Federal funds are usually provided in the form of program-specific grants that can only be used to support those services, with some allowance to cover indirect and overhead costs.
- Overall, federal funding pays for about 45% of all current governmental public health spending.*
 - FPHS is less reliant on federal funding – 19% of spending on FPHS today is from federal funds.
 - Other services are more reliant on federal funding – 60% of services not included in the foundational definition is paid for by from federal funds.
- There is a high likelihood that some federal funding will decrease or be reprioritized in the future. However, this analysis assumes the majority of federal funding currently spent on FPHS will continue.
- This assumption may have risk going forward if federal funds for FPHS decrease. At that point it would be necessary to decide how state/local funding responsibility would apply to these services

Introduction to Funding Ideas

Discussion Topics

- The following sections present different high-level ideas for who should take responsibility for funding FPHS.
- For background, after removing the influence of federal funding the state currently pays for 62% of FPHS (\$151 million) and locals currently pay for 38% (\$92 million). Therefore, the current state/local split is 62%/38%.*
- For each idea, we will:
 - Review the idea
 - Identify implications
 - Discuss the advantages and disadvantages of the idea.

FUNDING RESPONSIBILITY DISCUSSION

Idea 1: The State Funds FPHS

Under a model where the state funds FPHS, the cost of providing all FPHS statewide would be funded by state dollars – including services at DOH, LHJs, and Tribal Public Health Departments.

Questions

What are your questions about having the state fund FPHS?

- Why isn't the state doing it now?
- Would there be a loss of local regulatory flexibility?
- Does the state fund, or fund and deliver?
- How do funds get allocated to locals?
- Does this imply locals fund all "AIS"?
- How would you set boundaries & local objectives/priorities?
- How much loss of local control if funded by state?
- Would state contract back to locals, or just provide leadership?
- What can learn from how tribes are already doing this (tribal, B/A, IHS splits & assumptions?)

Member Responses

Implications

What are the implications of having the state fund FPHS?

- The state would take full responsibility for funding the portion of FPHS not supported by federal dollars. This could involve moving state funding to FPHS from other activities and/or raising new state revenues
 - Locals would no longer have to pay for FPHS. This would likely free up some money that locals currently use to pay from FPHS that could be flexible funding to be shifted toward other local priorities.
 - Tribal Health Departments would no longer have to pay for FPHS. The funding they currently use for FPHS could be shifted toward other tribal priorities.
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- Risk of political will to continue the model on-going (e.g. Legislator sweeping tobacco \$\$)
 - Legislators need to answer to local priorities
 - States and locals collect fees
 - Loss of local input & flexibility

Member Responses

FUNDING RESPONSIBILITY DISCUSSION

Idea 1: The State Funds FPHS

Under a model where the state funds FPHS, the cost of providing all FPHS statewide would be funded by state dollars – including services at DOH, LHJs, and Tribal Public Health Departments.

What are the advantages of having the state fund FPHS?

Advantages

- State-wide coverage for services that are foundational
- Easier budgeting & accounting
- Possible opportunities for economy of scale
- Tribes are not currently included in data currently. If state was responsible → better data collection
- Simple mechanism to assure it is actually happening
- Single entity is accountable
- From equitable...

Member Responses

What are the disadvantages of having the state fund FPHS?

Disadvantages

- Loss of local control
- Possible less innovation: local/tribal incubators for new ideas
- Locals could lose significant revenue resources that support flexible programs
- Have to rely on a single agency
- Would the source actually be stable? Should not be dependent on legislative action
- Could take additional resources beyond what is currently estimated if really including tribal data
- Diversity of funding would go away → problematic because makes it an unstable situation

Member Responses

FUNDING RESPONSIBILITY DISCUSSION

Idea 2a: The State Funds 75%; Tribes and Locals Fund 25%

Under a shared funding responsibility model, the cost of providing all FPHS statewide would be funded by a mix of tribal, state, and local dollars – including services at DOH, LHJs, and Tribal Public Health Departments .

Questions

What are your questions about having the state fund 75% of FPHS and tribes and locals fund 25%?

- Concern: where will the state get \$\$ to fund 75% - will that come from – a sweep? A change in sales tax to local, goes to state?
- Set level for County/City contributions to get 25%
 - Who distributes the \$\$? The treasury or DOH?
- Is there a base that can be set for small counties?
 - Covering gap?
 - Would that be mandated?
- Locals need to mean cities & counties
- What is the difference in local control, from 50% to 75%?
- This mirrors state education funding model
- What level of control do jurisdictions expect with this breakout?
- Could there be a shared pool to get the overall 25%?

Member Responses

Implications

What are the implications of having the state fund 75% of FPHS and tribes and locals fund 25%?

- The state would fund 75% of the portion of FPHS not supported by federal funding. To do this, the state would need to shift nearly all movable state funding currently spent on other services to FPHS, raise new state revenue, or a mix of both.
- Locals would be responsible for funding 25% of the portion of FPHS not supported by federal funding. Since locals are already supporting 27% of this amount, there may be some local flexible funding that could be reprioritized to support other local priorities.
- It is unclear what this shift in responsibility would mean for Tribal Health Departments, as the current mix of state and tribal funding is unknown.

- Will want to set levels for city/county contributions to get 25%
- State might want more control if they fund 75%
- Base level will be critical
- To be successful, cities need to be expected to contribute to 25% local contribution
- For tribes: complications from the complexities of revenues for tribal governments. The responsibilities for these funds is very specific.
- It would have to be mandated by the state
- Tribes would also be required to participate
- Counties should have a levy → will not be equitable, may not pass in certain areas

Member Responses

FUNDING RESPONSIBILITY DISCUSSION

Idea 2a: The State Funds 75%; Tribes and Locals Fund 25%

Under a shared funding responsibility model, the cost of providing all FPHS statewide would be funded by a mix of tribal, state, and local dollars – including services at DOH, LHJs, and Tribal Public Health Departments .

Advantages

What are the advantages of having the state fund 75% of FPHS and tribes and locals fund 25%?

- If: some counties that are paying more \$ than 25%, can ~~get~~ have \$ freed up to fund AIS or other programs – local priorities
- If: cities contribute to local fund, it will even the playing field
- For tribes, if the state is responsible for 75% (?) - that is clear. The tribes would know that their responsibility is 25%. It would give tribes the opportunity to pool their other tribes to cover FPHS responsibilities
- Best political idea

Member Responses

Disadvantages

What are the disadvantages of having the state fund 75% of FPHS and tribes and locals fund 25%?

- Fiscal possibility of state will make changes at county level in order to pay
- Unstable state budget; there is no \$
- Risk to make the ask
- Small counties & LHJs might not be able to pay for 25%
- State may dictate service areas and make structural changes, population minimums
- Counties might reduce overall public health contributions to be at 25%, if that's all that is required
- What if the counties could not raise this?

Member Responses

FUNDING RESPONSIBILITY DISCUSSION

Idea 2b: The State Funds 50%; Tribes and Locals Fund 50%

Under a shared funding responsibility model, the cost of providing all FPHS statewide would be funded by a mix of tribal, state, and local dollars – including services at DOH, LHJs, and Tribal Public Health Departments .

What are your questions about having the state fund 50% of FPHS and tribes and locals fund 50%?

Questions

- What strings come with the state funding?
 - Health care plans surcharge
 - Mechanisms is what matters
 - State collects, local and state figure out how to distribute/allocate funds
- Are we counting local fee revenues as local money?
- Are we subsidizing local fees with other local funding? Do we need a consistent level of cost recovery?
- Would 50/50 be mandated → locals required to rake the 50% as a match?
 - *Would state portion be mandated?
 - Is each LHJ responsible for 50% or would there be pooling or redistribution to address disparities?
- Would the 50% state be dependent on amount locals put in?

Member Responses

What are the implications of having the state fund 50% of FPHS and tribes and locals fund 50%?

Implications

- The state would fund 50% of the portion of FPHS not supported by federal funding. To do this, the state would need to shift some state funding currently spent on other services to FPHS, raise new state revenues, or a mix of both.
- Locals would be responsible for funding 50% of the portion of FPHS not supported by federal funding. This would require a significant increase in the level of local funding. This may include shifting local funding that is currently used for other services to pay for FPHS and generating new local revenues.
- It is unclear what this shift in responsibility would mean for Tribal Health Departments.
- If at every LHJ, some locals would pay less and others would pay more
- If 50/50 at each LHJ, doesn't address disparities
- Potentially reduced levels of local autonomy under a shared model
- Tribes, for foundational, have a shared responsibility approach today
- Might work if backfill for smaller jurisdictions
- Cities would need to contribute, not equal "city" pop in all jurisdictions
- Local jurisdictions need authority to raise more money
- Needs to be room to fund other important services – require funding for AIS

Member Responses

FUNDING RESPONSIBILITY DISCUSSION

Idea 2b: The State Funds 50%; Tribes and Locals Fund 50%

Under a shared funding responsibility model, the cost of providing all FPHS statewide would be funded by a mix of tribal, state, and local dollars – including services at DOH, LHJs, and Tribal Public Health Departments .

What are the advantages of having the state fund 50% of FPHS and tribes and locals fund 50%?

- Does establish ongoing shared responsibility
 - For tribes, would clarify what the 50% the state would be responsible for vs. what tribes would be responsible for
 - Might maintain more local autonomy/flexibility than 100% state funded
- Member Responses

Advantages

What are the disadvantages of having the state fund 50% of FPHS and tribes and locals fund 50%?

- Local variation in feasibility of local options
 - Unlikely all locals will or would be able to raise more money isn't working
 - Replicates too closely what's going on today that isn't working
 - Local jurisdictions can't generate enough funding*
 - Complexity of implementing/tracking these responsibilities
 - Would be less straight forward than 100% state, hard for locals to get from local perspective, would shift burden more to locals
- Member Responses

Disadvantages