CENTER for STUDYING HEALTH SYSTEM CHANGE

Issue Brief

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Tracking Changes in the Public Health System:

What Researchers Need to Know to Monitor and Evaluate These Changes

Just as the medical care system is changing in communities across the country, so too is the public health system. Reduced resources, fragmentation of traditional public health functions, the spread of managed care, and developing new partnerships are key among these changes. Two dozens public health officials and health policy researchers met in April at the Center for Studying Health System Change to discuss the changes in the financing and delivery of public health services and the research needed to monitor and evaluate the impact of these changes.

THE TRADITION OF PUBLIC HEALTH

The federal, state, and local agencies that constitute the U.S. public health system perform a host of functions and provide services that affect the lives of millions of people (see box on p. 2). The heart of the system is made up of some 3,000 local public health agencies, boards, and departments from coast to coast.

The popular image of a local health department is represented by New York City, Detroit, Los Angeles County, and other large metropolitan areas. But big city or county public health agencies represent only 4 percent of the nation's local public health departments. Most are in small cities, towns, and rural areas; half serve fewer than 25,000 people and two-thirds fewer than 50,000. it is on the local level, in large and small communities alike, that decisions made by public health departments are most likely to affect the public's health.

CHANGES IN PUBLIC HEALTH SERVICES

The changes taking place in the financing and delivery of medical care in the United States are having and will continue to have an enormous impact on the public health system. They affect the quality, accessibility, and organization of services traditionally provided by public health departments. In addition, the health of the people these departments traditionally serve is changing.

Foremost among the pressures on the system are the diminished levels of state and local funding and the increased fragmentation of public health responsibilities among non-traditional partners in the community. As a result of these and other pressures, the tools and strategies used to address the delivery of public health in the past may not be adequate or appropriate today or in the future.

For example, with the increased fragmentation public health departments find it increasingly challenging to coordinate and be held accountable for the services they are responsible for. Primary health care facilities and hospitals can take care of patients with tuberculosis, but the local health department remains responsible for overseeing contact tracing to find other people in the community with the disease.

The proliferation of health and safety programs in non-public health government agencies further challenges the coordination of public health functions. Many states have environmental health programs that are managed by their environmental protection agency. Food safety often comes under the direction of the state agriculture department. Drug awareness programs are housed in education offices. And highway safety programs are run by the department of transportation. Each of these agencies or departments tends to look at health problems from its own perspective. Fro example, when an environmental agency handles asbestos removal from buildings, the problem is seen primarily as an environmental one with environmental solutions, and not as a public health problem.

DWINDLING RESOURCES

Perhaps the most important change in recent years concerns the resources available for public health. Between 1981 and 1993, total U.S. health expenditures increased by more

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than 210 percent while funding for population-based health strategies, as a proportion of the health care budget, declined by 25 percent. In 1993, $8.4 billion, or less than 1 percent of the nation's health care dollars, went for public health, down from 2.7 percent in 1990.

Not only is less money available for public health, but also much of it is categorical, or set aside for specific programs or services. This makes it difficult to handle local emergencies or unexpected disease outbreaks, such as food poisoning or cryptosporidiosis from infectious agents in food and water. State and local health department administrators want more discretionary funding to give them flexibility in transferring money among public services when the needs arise.

Compounding the problem of dwindling resources is an increase in the number of uninsured people—including those with complex health problems such as AIDS and drug-resistant tuberculosis—who rely on public health facilities for their medical care. For people with inadequate or no health insurance, local health departments are among the few places in the community where they can go for health care. As an example, patients at one public health clinic for the indigent in Missouri have no health insurance, and most of the rest are on Medicaid.

CORE PUBLIC HEALTH FUNCTIONS

- Preventing epidemics
- Protecting the environment, workplace, housing, food, and water
- Promoting healthy behaviors
- Monitoring the health status of the population
- Mobilizing community action
- Responding to disasters
- Ensuring the quality, accessibility, and accountability of medical care
- Reaching out to link high-risk and hard-to-reach people with needed services
- Conducting research to develop new insights and innovative solutions
- Leading the development of sound health policy and planning

Source: For a Healthy Nation: Returns on Investment in Public Health, Public Health Service, U.S. Department of Health and Human Services, 1994

MANAGED CARE

Managed care plans represent a large and growing part of the public health system in the United States, as health maintenance organizations (HMOs) take on responsibility for some traditional public health functions for their enrollees, especially Medicaid beneficiaries. Missouri, for example, contracts with 14 HMOs both to provide population-based and personal health services under the state's Medicaid plan; this work had been done by the public health department. Services include programs for immunizations, sexually transmitted diseases, lead poisoning, tuberculosis, and HIV-AIDS.

Managed care has the potential to be more involved in providing these and other population-based services; however, it cannot be expected to replace completely the population-based functions of public health departments. For example, an HMO can identify a child with lead poisoning, but it is not responsible for removing lead paint from an apartment or school, monitoring other children in the neighborhood, or enforcing building codes.

The relationship between public health and managed care varies from place to place. In Los Angeles County, for example, the public health department competes with private health care providers to offer managed care under Medicaid. In San Diego County, however, the public health department only monitors care delivered in the private sector; it does not bid on or undertake contracts to provide managed health services.

The impact of losing income that Medicaid patients once provided to public health departments is significant in some areas because it supported vital public health services and programs that brought in little or no money. In fact, Medicaid reimbursements were 10 percent of the annual budget for some state health departments. The loss of this business has had a particularly large impact in states where Medicaid reimbursement is highest.

Where there are savings from Medicaid managed acre, public health departments want to make sure they are used to fund population-based work. There is widespread concern that the money will be allocated elsewhere in state and local government agencies.

Research Questions Raised by Changes in the Public Health System

- **Which indicators best track the effectiveness of public health activities? How are these indicators changing over time?**
- **How is the overall level of resources for public health changing? Do public health departments have the financial and human resources to carry out their functions?**
- **Has the proportion of public health dollars spent on personal care and other public health services changed?**
- **How many public health functions have been transferred to the private sector? What is the nature of the new public-private sector partnerships?**
- **What is the status of the managed care-public health connection? Will these systems grow closer or further apart? Are managed care organizations entering nontraditional areas of population-based care?**
- **How informed are communities about public health department activities and functions?**
- **How involved are local public health departments in decisions that affect the health of the community?**

NEW PARTNERSHIPS

A positive public health system change is that more community partners are involved in public health. New partnerships are developing between public health and private health care organizations as well as between and among public health agencies. In the past, public health departments were the main providers of services to improve a community's health status. Now, many such departments are developing partnerships with a broad range of public and private sector institutions to improve a community's health status.

In Texas, for example, Wendy's has instituted an MBA program—Mop, Bucket, and Attitude—to help protect food safety and prevent outbreaks of food poisoning. A Columbus, Ohio, business coalition developed a strategic plan that closely follows the public health department's plan. Called Community Health 2010, the coalition plan calls for improving the health status of residents by facilitating education and behavioral changes and providing access to basic health care and preventive health services.

In other communities across the country, local health departments are building linkages with private hospitals, managed care organizations, business groups, and others in the private sector to enhance public health services. For this to work well, the groups need to work as partners, not as competitors.

Looking at public sector partnerships, 98 of Missouri's 115 local health agencies have signed contracts with the state health department to assess their communities' health status and needs. In most cases, the local public health agency will act as a leader in convening teams of community health officials from the public and private sectors.

Another public sector partnership is the Centers for Disease Control and Prevention program to develop sentinel networks across the country, which will serve as early warning systems for potential public health problems. With a broader number of public and private sector partners, local health departments find it more challenging to coordinate and be accountable for the services delivered.

ACCOUNTABILITY

Public health departments increasingly are being asked to be accountable for the resources given to them to ensure that the money is being well spent. Both the government and the public want to know what public health dollars are buying and what effect these expenditures are making. For example, is there a reduction in a state, country, or city's percent of low-birthweight babies? Are there fewer cases of measles and other childhood diseases as a result of a well-managed immunization program?

Public health activities are not the only determinants of public health outcomes, however. Rates of infant mortality, for example, are affected not only by the delivery of prenatal services, but also by Medicaid eligibility, the rate of employment in a community, whether a pregnant woman is homeless, and so on. A public health department cannot accept the credit—or blame—for all measures involved in a community's infant mortality statistics.

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Thoughts from Public Health Experts

"The real money is not in public health budgets; it's in Medicaid. The question is whether savings from Medicaid are going to pay for public health or for roads and prisons."

"The local public health systems that are keeping their heads above water are the ones that are deeply involved in their local communities."

Is anybody's surveillance really monitoring what is going on? Is anybody looking at a community's public health structure over time? Some claim they are trying to do that, but are they really?"

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In any case, health goals are needed to measure outcomes and ensure the accountability of public health programs. In some cities, public health goals include an increased awareness of sexually transmitted diseases and improved immunization rates. These goals are a clear reflection of the ultimate public health outcome of reducing disease in the population.

Public health agencies can develop a series of indicators to track whether the goals are being met and, if so, how they affect medical outcomes in the community. In doing so, however, they should be aware of which indicators are most likely to change and how those changes are likely to affect the delivery of public health services.

MEASURING PUBLIC HEALTH FUNCTIONS

To better assess how changes in the delivery of medical care affect the public health system, researchers need to track those changes and how local agencies respond to them. A number of studies are underway to track public health functions.

Since 1989, the National Association of County and City Health Officials (NACCHO) has sponsored the National Profile of Local Health Departments. The latest profile will look at changes in how many dollars go into public health, what those dollars cover, and who is providing public health services.

Another NACCHO project, APEX, is designed to assess a public health agency's organizational capacity and work with local residents to assess and improve the community's health status. About 45 percent of local health departments have used APEX.

Under the Illinois Process for Local Assessment of Needs (IPLAN), every local health department in Illinois has examined its community needs and organizational capabilities. The study provides a score for specified public health indices.

North Carolina has been tracking changes in public expectations of services performed by local public health agencies. Researchers are tracking these agencies' progress toward meeting the goal of 90 percent of the public being served by a local health department as set out in Healthy People 2000.

Traditional methods and tools for tracking public health functions have focused on describing and assessing the local health department's infrastructure, capacity, and organization. As public health activities move outside the walls of the local health department, these tools are falling short in their ability to track public health activities in the community. New methods and tools need to be developed that can:

- Describe how public health responsibilities are changing in communities and how responsibilities are distributed among the public and private sector;
- Assess the impact of public health activities on improving community health outcomes; and
- Identify what communities want from or expect of public health agencies.

LOOKING AHEAD

Unlike the medical care system, there is little research and relatively few measures for studying how well the public health system operates. Public health and health policy researchers have been challenged to develop new tools. The following are some of their ideas for tracking changes in the public health system, which were generated at the Center's meeting:

- Measure local health department involvement in decisions affecting the community, including looking at the department's role in forming partnerships and other collaborative efforts, its resources available for and expenditures on population-based services versus personal care, and its role in overseeing or providing managed care.
- Follow over time how much money public health agencies have to spend, how much leeway they were given in deciding what to spend it on, and changes in state and local laws governing the responsibilities of local health departments.
- Track the number of uninsured patients seeking treatment at public health facilities and the kind of care they receive, including preventive and primary care for infants and children.
- Monitor how local agencies define their core public health functions by examining what services they offer today and who provides services that were once offered only by public health agencies. ■