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Restoring Health to Health Reform

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Restoring Health to Health Reform

Peter D. Jacobson, JD, MPH

Lawrence O. Gostin, JD

THE PUBLIC HEALTH SYSTEM IS IN SERIOUS TROUBLE. With declining public investments and an aging workforce, the system is under severe stress. Public health services previously taken for granted, such as immunizations, surveillance, and environmental health, can no longer be guaranteed. Reforming the public health system is therefore imperative. The Patient Protection and Affordable Care Act (PPACA) (Pub L No. 111-148) will improve state and local capacity, but not nearly enough to safeguard the public's health.

The public health system is badly frayed and needs to be rebuilt structurally and redesigned conceptually.¹⁻³ Public health departments lack modern information technology, surveillance capacity, a well-trained workforce, and a clear vision of their essential role. Their organizational structure has barely changed, with some states having literally hundreds of dysfunctional local departments. Leadership is needed to define the optimal mission, size, scale, and geographic area of local departments; the skills required of public health professionals; the services that must remain a governmental responsibility; and the relative roles of local, state, and federal agencies.

Although the health care system is embracing performance measurement, public health departments have not adopted similar reforms.^{4,5} Services are not routinely evaluated, health outcomes are not adequately defined or measured, and the evidence base for public health practices is just now emerging. Improved performance will require rigorous research for evidence-based practices that can be measured, with a feedback loop to continuously improve quality.^{6,7}

The field is divided over whether to focus on the immediate causes of population morbidity and premature mortality or the deeper, underlying determinants, including race and socioeconomic status. Public health departments must do both. They have direct responsibility for discrete public health interventions but also must assess the health impacts of public policies such as agriculture, energy, urban design, and transportation.⁸ That is why a "health-in-all policies" approach is vital to the public's health. Public health departments also have a responsibility to engage with the private sector and civil society, which have powerful effects on the population's health.

These key objectives—infrastructure, workforce, performance measurement, social justice, and health-in-all policies—simply are unachievable without innovative leadership, planning, and sustained investment. Yet the system is chronically underfunded, with less than 5% of total health spending allocated to population-based services.⁹ Making the transition from a sick care system to one that produces health should be a major political goal.

Prevention and Wellness

Consistent with previous Institute of Medicine recommendations,³ the PPACA creates a Prevention and Public Health Fund, along with a federal Preventive Services Task Force and a Public Health Council, to expand the nation's investment in prevention and wellness. The legislation allocates \$1.5 billion in fiscal year 2014 and \$2 billion for each subsequent year to prevention programs. It also establishes a "Creating Healthier Communities" flexible grant program for health departments to implement, evaluate, and disseminate evidence-based community prevention initiatives to reduce chronic disease and health disparities. Placing community health at the center of the public health enterprise,¹⁰ Creating Healthier Communities will fund innovative programs to prevent injury and disease and promote healthy lifestyles.

Similarly, the PPACA offers incentives for prevention and wellness by eliminating cost sharing for primary care services in Medicare, Medicaid, and qualified health plans, and establishing state grants to devise and evaluate Medicaid initiatives that encourage behavioral changes such as reducing weight and blood pressure. The act focuses on primary care, encouraging more physicians to enter the field and increasing funding for community health centers serving low-income populations.

Infrastructure

The PPACA's infrastructure provisions are limited and primarily address the future public health workforce. Facing serious budget constraints, states cannot invest in informa-

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tion technology, surveillance, laboratories, or the next generation of public health workers. The PPACA offers significant federal investments in a loan repayment program for public health practitioners and a public health sciences track within the US Public Health Service, but otherwise does not provide sustainable and scalable resources to revitalize the public health infrastructure.

Performance Measures

The act creates demonstration programs that require robust evaluation and mandates research funding for evidence-based practices and translating the research into effective programs. In a field that has often failed to rigorously evaluate its programs, this will create an evidence base if public health departments obtain the resources to embrace new and effective performance measures.

Reducing Health Disparities

The *raison d'être* for this legislation is to increase access to health care, which will improve the public's health. Enhanced access will help low-income individuals receive more timely and effective clinical prevention and treatment. The PPACA provides for extensive data collection and analysis to identify and monitor trends in health disparities. Nonetheless, the legislation seems limited to data collection instead of developing strategies to reduce disparities.

Limitations and Future Directions

Although the act represents a major advance in restoring public health to the national agenda, it fails to truly innovate. First, it does not adequately fund public health departments for the long term. As long as funding is categorical and time limited, public health departments cannot plan, build enduring programs, and hire permanent skilled workers. Notably, the PPACA does not clearly specify sources of funding (eg, "out of any monies in the Treasury not otherwise appropriated") or funding levels (eg, "such funds as may be necessary for each fiscal year").

An important indicator of success will be the willingness to fund state and local programs, not just federal efforts. In the PPACA, Congress authorized a maximum of \$500 million for health education outreach and media campaigns, but requires the Centers for Disease Control and Prevention to fund these activities instead of giving direct grants to states. The implementing regulations should focus on community health prevention rather than individual preventive services and invest in future needs instead of simply restoring existing programs.

The legislation does not explicitly improve the deteriorating public health infrastructure. Without federal funds, few states, and even fewer localities, are fiscally able to meet critical infrastructure needs. To correct this deficiency, Congress should enact the Public Health Investment Fund that was included in the House bill. The investment fund would

award grants to state health departments to meet core needs, including workforce, laboratories, information technology, and organizational restructuring.

What is most controversial is the expanded federal role in public health without a clearly defined rationale for what that role should be vis-à-vis traditional state and local control over public health delivery. Instead of dedicated investments in state and local programs, the legislation subtly shifts away from local control toward a greater federal presence. One example is requiring nutritional labeling at chain restaurants. This requirement is vital but does not apply to retail food establishments with fewer than 20 locations, and more importantly, preempts any conflicting state or local nutrition labeling laws.

Despite its innovations in health care access, prevention, and wellness, the PPACA takes the existing system as a given and does little to change the fundamental dynamic of how public health is organized, financed, and delivered. Going forward, it is urgent to devise a clear vision for public health. The federal government—together with its partners in the tribes, states, and localities—must create sustainable funding sources, support modern technologies, ensure a competent workforce, and introduce rigorous on-going evaluation of services.

Congress and the president have focused intently on the health insurance system. They should now make the same commitment to transforming the public health system because nothing is as important for society's health and well-being.

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REFERENCES

1. French M. *Shifting the Course of Our Nation's Health: Prevention and Wellness as National Policy*. Washington, DC: American Public Health Association; 2009.
2. Lurie N. The public health infrastructure: rebuild or redesign? *Health Aff (Millwood)*. 2002;21(6):28-30.
3. Institute of Medicine. *The Future of the Public's Health in the 21st Century*. Washington, DC: National Academy Press; 2002.
4. Kindig D, Stoddart G. What is population health? *Am J Public Health*. 2003; 93(3):380-383.
5. Hemenway D. Why we don't spend enough on public health. *N Engl J Med*. 2010;362(18):1657-1658.
6. Jacobson PD, Neumann PJ. A framework to measure the value of public health services. *Health Serv Res*. 2009;44(5 pt 2):1880-1896.
7. Murray CJL, Frenk J. Ranking 37th—measuring the performance of the U.S. health care system. *N Engl J Med*. 2010;362(2):98-99.
8. Gostin LO, Powers M. What does social justice require for the public's health? public health ethics and policy imperatives. *Health Aff (Millwood)*. 2006;25(4):1053-1060.
9. Sensenig AL. Refining estimates of public health spending as measured in national health expenditures accounts: the United States experience. *J Public Health Manag Pract*. 2007;13(2):103-114.
10. Galarneau CA. Health care as a community good: many dimensions, many communities, many views of justice. *Hastings Cent Rep*. 2002;32(5):33-40.