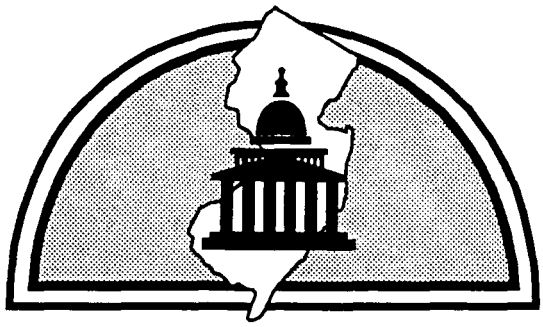

**THE CAPITOL FORUMS**
On Health & Medical Care

# PUBLIC HEALTH AT THE CROSSROADS: PAST, PRESENT, FUTURE
# PART I: NATIONAL, STATE, AND LOCAL OVERVIEW

Background information for the discussion at the

**CAPITOL FORUM**
**on Wednesday, June 26, 1996**
**9:00 am - 1:00 pm**
**Masonic Temple Library**
**Trenton, New Jersey**

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The League Of Women Voters of New Jersey

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# PUBLIC HEALTH AT THE CROSSROADS: PAST, PRESENT, FUTURE
# PART I: NATIONAL, STATE, AND LOCAL OVERVIEW

**ISSUE: How will the complex system of public health, whose structure is comprised of national, state, county and local municipality administrative units, negotiate the changes of the evolving health care system, with its call for efficiency, streamlining and elimination of administrative excess? In what ways with public health agencies balance core public health functions with the delivery of direct services?**

Our evolving health care delivery system, with its emphasis on preventative care and case management, has as one of its primary goals improving the health of the public it serves. This goal has long been the cornerstone of America's public health system through its efforts at disease prevention and health promotion. As managed care organizations are fast becoming a primary source of health care for both private insurers and public programs (Medicaid and Medicare), how will the public health system be affected, especially in its role as provider of direct services? Should its primary function be framed by a population-based model to improve the health status of the overall population, should it be as a provider of direct services, or some combination of both functions?

## INTRODUCTION

Ask an uninsured mother what she thinks public health is, and she will probably answer that it means a measles vaccine for her child; ask a chiropractor from Hunterdon County and she will probably talk about the deer tick she sent into the laboratory for Lyme disease analysis; ask a teacher from the inner city, and he may talk about the local board of health's lead screening program or asbestos abatement efforts in his school building; ask a local resident of Salem County and he may talk about well water testing.

Public health means many things to many people. Throughout history, from Old Testament edicts about the preparation of certain foods such as pork and dairy products, to Thomas Mann's novel *Death in Venice* (set in 19th century Italy during a cholera epidemic), when the Minister of Health assures the people and tourists in Venice that "nothing is wrong, the fever is just being caused by the warm winds blowing up from northern Africa," the public has believed that those in charge of public health will protect them from disease and illness, through surveillance, research, monitoring and public education and outreach. Historically, most times their beliefs were supported.

By the turn of the 20th century, with medical breakthroughs and understanding of the nexus of communicable and infectious diseases related to improving sanitary conditions and nutrition, a new era of disease surveillance and control was established in the American public health system. Public health has contributed to a majority of the major improvements in the health of the American public, through such public health activities as its control of epidemic diseases, the monitoring of safe water, food and sanitary conditions, and the oversight and provision of maternal and child health services. As we move toward the end of the 20th century, the traditional assertion that the "successes of the public health system are invisible, but its failures are not" continues to hold true, as exemplified by the re-emergence of medication resistant Tuberculosis (TB), the Cryptosporidiosis (caused by Cyptosporidium, an infectious organism found in water sources) outbreak in Milwaukee, Wisconsin, from which some 400,000 people became ill from the drinking water, and the cases of hantavirus (a virus that had not been found in the United States until the 1980s) in the Southwest in the 1990s (McGinnis, 1995).*

Since the 1960s when infectious diseases were believed to be all but eliminated in the United States and with the establishment of the Medicaid and Medicare pro-

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*The Appendix of this issue brief includes background information on the mission, structure and core functions of the public health system in the United States.

grams, the activities of public health agencies have shifted from providing core public health functions, such as surveillance of communicable and chronic diseases, environmental protection and public education, to providing clinical services to uninsured and other disadvantaged populations. Events during the 1980s and 1990s. with the emergence and proliferation of managed care organizations (MCOs) in the health care delivery system and the reduction in public health funding, have created a public health "identity" crisis. At the same time, between 1980 and 1992, age-adjusted mortality from infectious diseases (such as TB and pneumonia) increased by 39 percent, creating a need for more sophisticated active and passive surveillance by public health agencies (National Health Policy Forum, 1996). Currently, one quarter of all physician visits in the United States are related to infectious diseases, and antimicrobial medications (such as antibiotics) are the second most commonly prescribed type of drugs (Ibid).

## CURRENT STATUS

The primary challenge facing public health officials on all levels is how public health activities should change in the context of a managed care environment. Specifically , should the provider of public health services continue to provide clinical services and contract as a provider with the managed care health plan; should it partner with the MCO, drop its clinical provider role and instead focus on delivering health promotion, prevention and surveillance activities; or should it provide some combination of both? Such decisions are further complicated when the issue of funding comes into play. The Institute of Medicine at the National Academy of Sciences reports that almost 75 percent of state and local health department funding goes to clinical care. While public health agencies have become reliant on Medicaid reimbursement for providing direct services to clients, their role as "provider of last resort" may disappear, in light of the likely reductions in Medicaid and other health care spending and the increase in numbers of uninsured and medically indigent members of their communities.

### Core Functions of Public Health

- Surveillance of Communicable and Chronic Diseases (Data Collection)
- Control of Communicable Diseases and Injuries
- Environmental Protection
- Public Education and Community Mobilization
- Assurance of Quality and Accountability in the Delivery of Health Care
- Operation of Public Laboratory Services
- Training and Education of Public Health Professionals

In testimony before the U.S. Senate, the Assistant Secretary for Health, Dr. Philip R. Lee asserted that the "shift of public spending at the state and local level toward personal medical care has been at the expense of its essential role in keeping communities healthy" *(State Initiatives in Health Care Reform, 1994).* The Committee for the Study of Future of Public Health at the Institute of Medicine is due to publish a progress report this summer (1996) as a follow-up to its 1988 report, "The Future of Public Health." The Committee found that American public health agencies are faced with the impossible responsibility, "to served as stewards of the basic health needs of entire populations, but at the same time avert impending health crisis, as well as provide health care services to persons who do not have access to health care by any other means." (Institute of Medicine Report at 2; 1988).

NATIONAL INITIATIVES-HEALTHY PEOPLE 2000

In 1990, the United States Department of Health and Human Services, through its U.S. Public Health Services, released *Healthy People 2000: National Health Promotion and Disease Prevention Objectives,* a report which set forth the nation's health goals for the year 2000. The report was the result of cooperation among principal health officials of the 50 states, the National Academy of Sciences' Institute of Medicine and representatives from over 300 professional and voluntary national membership organizations. *Health People 2000* sets forth 300 measurable objectives in 22 areas of priority for health promotion, health protection and clinical prevention services to be accomplished by the year 2000. New Jersey is one of many states to develop state-specific goals and objectives for its individual needs and conditions. New Jersey's individual state document, *Healthy New Jersey 2000* and its 1996 update, monitor and assess New Jersey's status towards meeting the goals set forth in the national document regarding health status and preventive health services.

In a 1994 study conducted by the University of Illinois at Chicago School of Public Health, researchers looked at the objective set forth in both *Healthy People 2000* and *Healthy Communities 2000* (comprised of model standards at the community public health level) that 90 percent of the population be served by a local health department effectively carrying out the three core functions of public health; assessment, policy development, and assurance. Using a stratified random sample from the National Association of County Health Officials (NACHO) data base, the study group found that less than 40 percent of the U.S. population was served by a local health department effectively addressing the core functions of public health (Turnock et al, 1994). The group asserted that "considerable capacity building" within the public health system is needed to achieve the year 2000 target goal of 90 percent.

In a 1995 Journal of the American Medical Association (JAMA) article, Drs. J. Michael McGinnis and Philip Lee of the U.S. Public Health Services reported progress towards the goals and objectives of the national plan at mid-decade. One of the primary challenges of meeting the goals was identified as the erosion of the public health infrastructure at the community level; another

challenge was that critical obstacles to good health status remain for the most vulnerable populations, with an increase of financial barriers to medical care and preventive services for African-American, Latino and native American populations (JAMA, April 12, 1995).

In 1996 the New Jersey Department of Health published its *Healthy New Jersey 2000 Update, A public Health Agenda for the 1990's,* to report on " how the state is doing" in terms of goals and objectives of its plan developed in 1991. At the beginning of the 1990's, New Jersey set goals in eleven priority areas: access to health care; maternal and child health; adolescent health; cancer; cardiovascular disease; HIV/AIDS; sexually transmitted diseases (STD's); vaccine-preventable illnesses; injuries; occupational and environmental health; and substance addictions. In general, the state is following along the national lines in terms of grappling with the problem of closing the gap between minority and white health status. i.e., there continues to be substantial disparities in the health status between New Jersey's total population and its minorities. In its 1996 *Update,* the department analyzed these priority areas in terms of the likelihood of achievement of its Year 2000 objectives. The priority areas of public health in which the likelihood of achievement of goals was strong was in reducing the mortality rate for adolescents from motor vehicle accidents; in annual mammography screening; in the prevention, detection and control of cardiovascular diseases; and in the prevention and control of addictions. those areas in which the objectives are unlikely to be achieved are in the areas of health access; maternal and child health; cancer; AIDS and HIV and occupational and environmental health. Nutrition objectives for women and children, however, are likely to be met, via the accomplishments of the Women, Infants and Children (WIC) program.

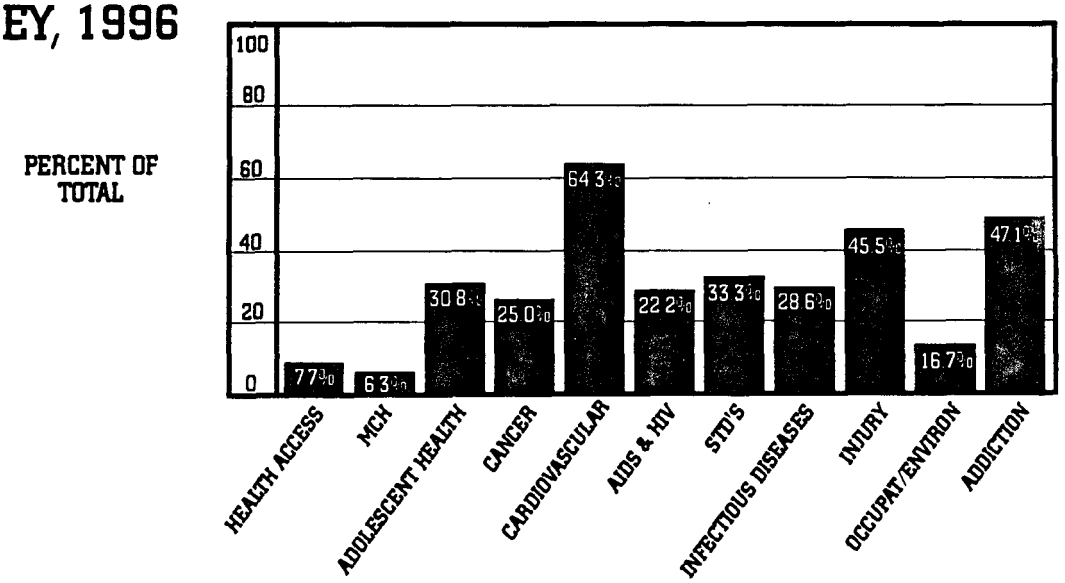
## PUBLIC HEALTH IN NEW JERSEY-AN OVERVIEW

### State Level

At present, the Department of Health in the state of New Jersey is itself "in transition"; as it brings "under one roof" services for New Jersey's senior citizens, the Department will become the Department of Health and Senior Services. Within the Department, Public Health Services is comprised of separate Divisions for AIDS Prevention and Control; Alcoholism, Drug Abuse and Addiction services, and Family Health Services. In further actions to improve its public health activities, the Department is in the process of re-organizing its epidemiology and public health laboratory activities into three divisions and two smaller programs. The three divisions will be: (1) Public Health and Environmental Laboratories; (2) Environmental and Occupational Health and (3) Epidemiology and Communicable Diseases. The two smaller programs are the Office of Cancer Epidemiology and the Office of Local Health.

While the Department does provide direct services through its Laboratories and is involved in four major data initiatives (Health Information Network (HINT) project; electronic birth certificate registry; the statewide immunization network project and the state cancer registry), its role is primarily as administrator. Through its labs, the

## YEAR 2000 OBJECTIVES LIKELY TO BE ACHIEVED TOTAL STATE OBJECTIVES, BY PRIORITY AREA NEW JERSEY, 1996




Source: New Jersey Department of Health, 1996

Department provides an array of services to state and Federal agencies, physicians, clinics, hospitals and local health departments. Public health activities within the divisions include epidemiological research, the publication and dissemination of fact sheets and reports on diseases such as TB and Lyme disease, and environmental health problems such as mercury and hazardous chemicals. The Department is currently working with the Department of Environmental Protection to develop a statewide water system data base to ensure water safety.

Each division has its own fiscal and administrative units, which award Federal and state grants for public health activities to local health departments, hospitals, not-for-profit agencies and any other entity that provides public health systems. Federal block grants include the Maternal and Child Health Block Grant, the Preventive Health Block Grant and the Drug Abuse and Mental Health Block Grant. A number of other Federal grants for specific public health projects come into the Department and its Divisions. Through its Request for Proposals (RFP) process, the block grant funds are distributed to a variety of local agencies. In addition, the local public health agencies may also apply for and receive Federal funding support directly, without using the state Department as an administrator.

## New Jersey Department of Health -Fiscal Year 1995 Expenditures

A recent report of the Department's Fiscal Year 1995 Expenditures in the area of public health breaks out expenditures including state funds, state appropriations, block grants, other Federal grants and contracts and private and other funds. Total expenditures from these areas was approximately $353 million. Public health categories include the following expenditure totals (from all sources):

| | |
|---|---|
| •Family Health Services | $181,171,992 |
| •Alcohol, Drug Abuse & Addictions | $90,424,706 |
| •AIDS | $35,039,703 |
| •Epidemiology, Environmental & Occ. Health | $32,671,774 |
| •Public Health & Environmental Labs | $11,868,273 |
| •Vital Statistics & Registration | $1,649,095 |
| Total | $352,825,543 |

Within each of these budgets, various programs are operated and supported by multiple sources. For example, FY 1995 expenditures for the Prevention Services program within the Division of Alcohol, Drug Abuse and Addictions totaled $12,835,599. This total was comprised of $796,051 from State funds, $253,979 from the federal Preventive Health Block Grant, $10,822,219 from the federal Drug Abuse and Mental Health Block Grant and $963,350 from other federal grants and contracts.

As another example of the complicated funding streams involved in federal, state and local levels of public health, we can look to how the Federal Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 funds are awarded and distributed. The Act makes funds available through four titles to states, eligible metropolitan areas (EMA) and nonprofit entities for developing, organizing, coordinating and operating service delivery systems for individuals and families with HIV disease. Nationally in FY 1994, over $579 million in CARE Act funds were appropriated. About 56 percent (or $326 million) of the funds were appropriated for Title I, which provides emergency assistance to EMAs, metropolitan areas disproportionately affected by the HIV epidemic. In New Jersey, approximately $5.5 million was awarded to Newark; approximately $2.4 million was awarded to Jersey City and $1.4 million was awarded to Bergen-Passaic counties directly fromm the Federal government.

Nationally, Title II of the CARE Act included $184 million in FY 1995, or approximately 32 percent of the total CARE Act funds. Title II provides funds to states to improve the quality, availability, and organization of health care and support services for people with HIV. New Jersey received approximately $8.9 million in FY 1995 for Title II public health activities. In Fy 1995, Titles III and IV monies were approximately $48 million and $22 million, respectively; Title III funds, which are awarded competitively, are intended for early intervention programs and Title IV funds are intended for pediatric AIDS programs. Tracking of such funds from the Federal, to the state, down through a multiple of local levels is a complicated task. And this represents just one single slice of a complex area of departments, divisions, and agencies on Federal, state, and local levels.

## Local Public Health

Beginning in 1887, every municipality in New Jersey has been required to have a local board of health. According to the New Jersey State Health Plan, the boards of health have a statutory mandate "to provide policy direction for and oversee the operation of public health activities within the municipality." Departments of health at the local level, however, are not required under law; each municipality is free to contract with other health departments, join a county health department, or join with other municipalities to form a regional health commission.

In the mid-1970s, there were 291 local health departments in New Jersey. In 1975, when the state's Local Health Services Act was promulgated, it required that each local health department be administered by a full-time, licensed health officer. Consequently, the number of local health departments was significantly reduced; according to a 1994 Department of Health report on local health, there are now 115 local health departments in New Jersey. There are eleven Federally Qualified Health Centers located in medically underserved areas in New Jersey, which service approximately 40,000 beneficiaries by providing primary care and preventive services. Of this total, 55 are individual municipality health departments, and 15 are

county health departments. There are 39 contracting arrangements and six regional commissions. Under New Jersey's Health Care Cost Reduction Act of 1991, these six Local Advisory Boards (LABs) were established throughout the state to coordinate local health planning.

New Jersey's contribution equals approximately 20 percent of their total funding to local budgets, while the bulk of their funding comes from Federal grants and other public and private sources. In FY 1995, the state distributed approximately $3 million in these Public Health Priority Funds to the locals. New Jersey is one of several states (e.g., Connecticut, Iowa, Missouri and Wisconsin) with populations of under 8 million people, which have decentralized public health systems and low levels of state funding. According to 1991 figures from the Centers for Disease Control, per capita state funding in these states range from $0.53 in Wisconsin to $2.07 in New Jersey. New Jersey's decentralized public health system creates a wide range of variability in public health services and is supported by complex funding streams. The 1994 Report of "The Commissioner's Working Group on Public Health" strongly recommended that a more regional approach to the provision of local public health services be undertaken in New Jersey. Currently,the Department of Health is working to develop a public health infrastructure in new Jersey. The Department points to reduced funding and the growth of managed care as "forcing the issue" to develop a coordinated infrastructure of public health activities in the state.

The Commissioner's 1994 report cited the state of Georgia (with a population of approximately 6.5 million) as an example of successful regionalization in public health activities. While each of Georgia's 159 county-based local health departments are also decentralized, the primary difference between New Jersey and Georgia's public health system is that Georgia has Lead Districts throughout the state, which are compromised of between one to sixteen local health departments. These Lead Districts are responsible for coordinating surveillance and reporting activities, program development and service delivery. While the local departments still retain flexibility to design services appropriate to their communities, there is coordination of programs such as communicable disease surveillance at a regional level. The state contribution to Georgia's local health departments averages $7.10 per capita.

The state of Maryland has developed a strong relationship between its state and local health departments to provide coordinated health services at the community level *(Commissioner's Working Group on Local Health, 1994)* Support for local health varies; on average, the state and localities provide 50 percent of the funding to local health departments; wealthier counties contribute up to 80 percent to their departments, while poorer counties contribute as little as 20 percent (Ibid). The state provides an estimated $8.00 per capita to local health departments (Centers for Disease Control, 1991).

As an example of recent local planning efforts, the New Jersey Hospital Association has a Community Health Assessment Committee to assist members in administrating a community health needs assessment. Through a survey distributed to hospital's CEO's, local health departments, health planners, Local Advisory Boards and community agencies (e.g, Visiting Nurses; YMCAs; YWCAs) in order to gather information about current initiatives being undertaken by health care organizations concerned with improving the health status of the communities they serve. The 1995 survey found that community health Assessments were accomplished by organizations partnering with other organizations in order to obtain health and health status data. Based on responses, 53 percent of the hospitals, 28 percent of the local health departments, 11 percent of the LABs and 8 percent of the community agencies have conducted Community Health Assessments.

## THE FUTURE OF PUBLIC HEALTH -CURRENT STRATEGIES

### FEDERAL LEVEL ACTIVIES

Both the Clinton Administration and Republican leaders are in agreement that the maze of categorical public health grant programs should be simplified through consolidation and that the states should be given broader discretion as to how the funds are utilized. Currently, Senator Nancy Kassebuam (R.-Kans.) (Chair of the Senate Committee on Labor and Human Resources) has introduced a bill that would consolidate all 12 Centers for Disease Control (CDC) categorical funding streams into a single block grant, to be allocated among the states based on factors related to population, health status and financial capacity. A Clinton Administration proposal seeks to consolidate 32 separate CDC categorical grant programs into three areas: (1) immunization; (2) HIV/STDs/TB and (3) chronic diseases and disability. Both proposals are currently pending. While state and local public health officials generally support merging categorical public health grants, advocates are concerned that block grants may reduce appropriations.

In planning for the future of public health in a managed care environment, the CDC has created an agency-wide Managed Care Working Group, which believes that "managed care organizes health care into delivery systems with potential for prevention related surveillance, monitoring, intervention and health services research." The working group reports found that the electronic information systems being developed by MCOs may be utilized as sources of data for a new national health information system. Also, as enrollment of Medicaid and Medicare beneficiaries continues to grow in MCOs, there will be data collected on these two important high-risk groups. In other activities, a collaborative effort with the Group Health Association of America, the HMO national trade association and the CDC's National Immunization Program is the formation of a nationwide alliance to improve the vaccination status of preschool children. As a result, individual HMOs are working with public health agencies on local levels around the country.

## STATE LEVEL ACTIVIES

Decisions concerning the future of public health within the states are inextricably tied in with health reform issues, in particular with initiatives concerning the uninsured population, insurance reform and managed care enrollment for Medicaid populations. As states continue with efforts to provide health coverage for uninsured and underinsured citizens, states like Washington are planning to enroll their uninsured population in managed health plans. As a consequence, public health agencies will be relieved from providing clinical services and will be freed up to focus on population-based prevention and health promotion and education. In the state of Florida's plans, local public health units will have the discretion to decide the best direction for their activities: they may work with Medicaid managed care providers, become HMOs themselves, or focus on population-based activities and core public health services, such as control of communicable diseases, environment protection and public education.

## PRIVATE SECTOR PARTNERSHIPS IN PUBLIC HEALTH

A recent piece in *American Medical News* asserts that the long standing difficult relationship between public health and the private medical profession has contributed to the public health system's weakness *(American Medical News, 1996)*. It stresses that this rift has to be mended to facilitate consistent disease reporting, prevention and health education from private physicians and medical practitioners.

New potential partners in infectious disease surveillance and prevention are managed care organizations (MCOs), such as HMOs. While the traditional view of public health is that it is responsible for populations, not individuals and the traditional view of medical care is responsible for individuals and not populations, the emergence of managed care in the health care system is initiating a concern with the health of populations, in addition to the health of individuals. At the present time, concurrent functions of public health agencies and managed care organizations include: wellness and prevention programs, immunization, the identification and treatment of sexually transmitted diseases (STDs) and HIV/AIDS; case finding and surveillance; school-based health care; chronic mental illness, maternal and child health, case management, home health care and quality assurance.

In the most recent edition of *State Initiatives in Health Care Reform* (May-June 1996), discussion focused on the question of collaboration between public health and managed care organizations. Research has indicated that the likelihood of collaboration is "tied to market maturity and managed care penetration," putting Minnesota and West Coast locations in the forefront of such collaborations in areas such as preventive health. In Minneapolis-St. Paul, managed care organizations, public health agencies and other health care delivery organizations have formed the Center for Population Health to serve as a forum for developing public-private health promotion initiatives. In other activities, the state of Oregon is using school-based projects for public-private cooperation. While still in its planning stages, the plan would tie in Blue Cross-Blue Shield, the state's largest managed care organization, with establishing public health clinics in the schools. The report identified a trend that many public health agencies are responding to budget reductions and cutbacks "by focusing their resources on their traditional mission of overseeing the health of the whole community."

## CONCLUSION

New Jersey is not alone in confronting the challenge of creating a public health infrastructure which can provide core public health functions in this era of dynamic changes within the entire health care delivery system. The direction which the state will take at the current crossroads is inextricably tied in with our policies and programs concerning the core functions of public health and its organization and funding. In addition, the corollary issues of insurance and welfare reform, and managed care delivery systems in both the public and private sectors must be addressed. Cooperation and coordination among all players and at all levels of public health are critical to its future.

## QUESTIONS FOR DISCUSSION

### ORGANIZATION AND FUNDING

• Public health means many things to different people; how can a cohesive identity for public health be created so as to ensure adequate funding and resource allocation? Is the vision for public health in New Jersey one framed by a population-based model focused on providing core public health functions to the community, a direct services model, or a combination of both?

• The Department of Health at the state level is developing a public health infrastructure in the state to most effectively serve its constituents. How will the state handle the delicate task of "re-organizing" its de-centralized public health activities without alienating its local public health organizations which are critical in delivering community services?

• Managed care organization are rapidly becoming major players in New Jersey's health care delivery system. How will New Jersey strategize working cooperatively with managed care organizations to effect public health activities in the state?

• In our evolving health care system, if New Jersey's public health officials decide to focus on population-based public health core function activities, and shift the provision of direct services to managed care organizations and private health facilities, how will funding support be continued? In the current environment, much funding comes from Federal and state sources to support the provision of direct services. Will traditional funding sources continue to be supportive?

• What is the role of other executive departments within state government, such as the Departments of Insurance, Human Services, Environmental Protection and Community Affairs, in the evolving public health system?

### AT-RISK GROUPS

• In a recent piece in *The Milbank Quarterly*, social researchers discuss the coming crisis of public health in the suburbs as a result of the deterioration of urban public health. By analyzing the social and health problems in neighborhoods such as the South Bronx and the central ward of Newark, they stress that the increase in communicable and infectious diseases in these communities are not only "inner-city" problems, but suburban problems as well, because of the likely diffusion of contagious diseases from inner city to suburbs. Only through an integrated system of initiatives, programs and policies can living and working conditions in urban areas be improved. What is New Jersey's commitment to funding such public health initiatives in inner cities, so as to enhance the quality of life for all its citizens?

• All too often in the history of public health, political exigencies and interference have driven public health decision-making and strategies, often delaying actions which created serious health consequences. For example, the Federal government refused to act on urgings by the Center for Disease Control in the early 1980s to act rapidly to deal with an emerging disease now known as AIDS. Such hesitancy, based on political conservatism, led to loss of lives and trust in the nation's blood supply. How do we in New Jersey guard against public health decisions being compromised by political agendas? How do we regain the loss of trust that the public holds in government to protect and ensure its health?

• In its report on the future of public health, the Institute of medicine highlighted the weakness in public health activities concerning environmental health, mental health and care of the indigent. Many states continue to administratively and programmatically isolate these services from general public health, creating fragmentation in services, policy development and fiscal accountability. The report calls on involvement at all governmental levels; national, state, and local, to integrate services to these traditionally "isolated" population needs. What are New Jersey's plans in developing a public health infrastructure to integrate services to these populations?

• Across the country, states are challenged by the issue of whether or not to provide health care services for their "illegal alien" populations. While short-term savings may be accomplished by denying health services, such as immunizations, to this population, the long term consequences, such as the re-emergence of infectious disease such as TB, will have considerably more significant health and monetary impacts. Where does New Jersey stand on such complex public health issues?

### RESEARCH

• Disease surveillance is the basic public health strategy against infection. The activity of surveillance is significantly labor-intensive and costly. As a result, most state and local public health agencies rely primarily on passive surveillance, depending on reports from physicians, community providers, hospitals, laboratories and other health care facilities. Infectious disease reporting is decentralized, diffuse and largely discretionary. The states are left on their own in paying for surveillance of other diseases. As a result, there are major deficiencies in the surveillance infrastructure. For example, 24 states had fewer than one staff person performing surveillance of food and waterborne disease per million citizens. Yet, there is growing evidence that public water supply infrastructure is deteriorating and that we are importing more foreign-produced foods, which is posing new threats. At the recent annual conference of the New Jersey Public Health Association, a paper was presented which identified weaknesses in surveillance capacity in New Jersey and pointed out that while the current infectious disease surveillance system is focused on known identified diseases, it is unprepared to identify and respond to emerging infections, similar to Hantavirus. What resources do New Jersey's state and local health departments have for effective surveillance of infectious diseases in New Jersey? Can continued reliance be kept on federal funds?

• The questions of data collection and the development of accurate, current and comprehensive health information databases are critical in the formation of public health policy. Projects such as the birth certificate registry, the statewide immunization database and the cancer registry require consistent support, both fiscal and technical. How will New Jersey ensure continued support for these projects, which are so sensitive to changing political climates?

# APPENDIX

## PUBLIC HEALTH-ITS MISSION, STRUCTURE AND CORE FUNCTIONS

The development of public health activities in the U.S. evolved along with how the American people as a whole viewed social and health problems. Once poverty and disease were understood and accepted as societal as well as individual problems, both private and governmental interventions were implemented (Synder, 1994). In 1873, Stephen Smith, a physician and commissioner of the Metropolitan Board of Health in New York, founded the American Public Health Association as an organization for health officials and interested citizens. In the previous year, only three states and the District of Columbia had established boards of health and only two states had "accurate" registrations of birth, death and marriages.

### THE MISSION AND CORE FUNCTIONS OF PUBLIC HEALTH

The Committee on the Future of Public Health found that while most agree that the overall mission of public health "is fulfilling the society's interest in assuring conditions in which people can be healthy," the implementation of that mission has broad variability across national, state and local lines. This variability is reflected by a "system" with extreme varieties of organizational arrangements, funding mechanisms and available services.

Historically, the core functions of public health have involved assessment, policy development and assurance. These functions include:

- Surveillance of Communicable and Chronic Diseases (Data Collection)
- Control of Communicable Diseases and Injuries
- Environmental Protection
- Public Education and Community Mobilization
- Assurance of Quality and Accountability in the Delivery of Health Care
- Operation of Public Laboratory Services
- Training and Education of Public Health Professionals

Public health experts agree that public health agencies, through inter-governmental and interagency cooperation, should collect, assemble, analyze and make available information on the health of the community, including statistics on health status, community health needs and epidemiologic and other health problems (Institute of Medicine Report, 1988). In addition, "agencies should be involved in the development of comprehensive health policies by using a coordinated scientific knowledge base to make appropriate decisions." Finally, public health agencies should be assure their constituents that services necessary to reach public health goals are provided, either by working with other agencies to provide such services, or providing them directly (Ibid). This assurance function means to assure access to environmental, educational and personal health services. The ways in which this last function are implemented are particularly dynamic, with the emergence of managed care organizations and their commitment to provide preventive care services.

Historically, disease surveillance, health assurance, health promotion and health policy development had been designated as core public health functions and were the primary functions of most public health agencies. With the "abeyance" of infectious and communicable diseases, especially during the period from 1970s to the 1990s, public health took on the expanded role of the direct delivery of services. Given the limited public health budgets, there is currently much debate as to whether or not both types of these functions can continue to be performed by agencies.

### FEDERAL, STATE AND LOCAL GOVERNMENT ROLES IN PUBLIC HEALTH

#### FEDERAL GOVERNMENT'S ROLE

The Federal government's role in the public health system includes surveying the population's health status and health needs, setting policies and standards, helping states and local agencies to finance personal health services, delivering personal health services, providing technical assistance to state and local health systems, and supporting international efforts to ensure global health and protect against health threats. The primary Federal unit responsible for public health is the United States Public Health Service (in the Department of Health and Human Services). The administrator of the Medicaid and Medicare programs - the Health Care Financing Administration (HCFA) (in the Department of Health and Human Services) also has a significant role in national public health activities. The Food and Nutrition Service in the Department of Agriculture, and the Environmental Protection Agency are also involved in public health activities.

Organizationally, the U.S. Public Health Services is comprised of: (1) the Centers for the Disease Control (assessment and epidemiologic unit); (2) the National Institutes of Health; (3) the Food and Drug Administration; (4) the Health Resources and Services Administration; (5) the Alcohol, Drug Abuse and Mental Health Administration, and (6) the Agency for Toxic Substances and Disease Registry. In addition, the Office of Health Promotion and Disease Prevention and the Office of Planning and Evaluation are involved with health management, planning, education, and evaluation. For example, the Centers for Diseases Control provides technical support for disease prevention and control through approximately 800 public health advisors and other specialists who are assigned to state health departments, at an average yearly cost of $40 million dollars (United States General Accounting Office Report, January 1996). In recognition of the changing role of these advi-

sors, which continue to evolve, the evaluation of the role of public health advisors is one of over 25 "active" assignments that the General Accounting Office is investigating in the area of public health and health financing in the evolving national and state-based health care systems.

Technically, Federal public health activities fall into two broad categories: activities conducted directly by the Federal government, such as assessment, research and some delivery of personal health care, and activities contracted by the Federal government to states, localities and private organizations. These contracted activities represent the bulk of direct service programs and are through contracts and grants. For example, the Department of Health in the state of New Jersey receives block grants from the Federal government in such areas as maternal and child health, preventive health, drug abuse and mental health, and primary care. These grants are support for localities to provide such services as prenatal and obstetrical care, family planning, immunizations, mental health, alcohol and drug abuse care and services for chronic diseases.

STATE LEVEL RESPONSIBILITIES

The states carry the primary responsibility for ensuring the public health in this country. There are 55 state health agencies in the United States, each directed by a health commissioner or a secretary of health. Currently, there are two models by which state health agencies are organized: as a free-standing independent agency, or as a component of a "superagency". There is wide variation as to the oversight responsibilities of state health agencies throughout the country; some also are responsible for environmental concerns, mental health concerns and act as the state Medicaid agency.

Primary similarities among state health agencies are that most states have programs for vital statistics and epidemiology, conduct planning, have regulatory responsibilities (including inspection and licensing), conduct environmental safety programs (sanitation, air and water quality, occupational health, waste management) and are involved in personal health services. The resources for public health activities come from a variety of sources, including state funds, Federal contracts and grants, fees and reimbursements (e.g., state laboratory fees); local funds and other private sources.

LOCAL LEVEL RESPONSIBILITIES

Great variability exists at the local public health level. While there are an estimated 3,000 local health departments across the United States, most of them are county-based. In states like Pennsylvania and Nebraska, there are no local health agencies and reliance is upon state and federal government for public health support. States such as Maryland, Missouri and New Jersey have local health departments in every county. In each state, the number of local health departments varies from 0 in states like Rhode Island and Vermont, to close to 160 in the state of Georgia. New Jersey currently has 115 local health departments.

Local health departments across the country are in fact the "front line" agencies for public health activities. Activities in these local health departments may include the provision of screening and immunizations; the operation of communicable disease control programs; the collection of health statistics; direct services, such as maternal and child health services, mental health, public health nursing services and other ambulatory and home care services. The Committee for the Future of Public Health found that similarities among local health departments include that most are involved in providing health education, personal health services, environmental health services and conducting inspections. However, there remains significant variation in services rendered among the thousands of local health departments around the country and their capacity to provide services varies greatly. According to a recent Centers for Disease Control (CDC) survey, 42 percent of the nation's local health departments have fewer than 10 full-time staff members and 21 percent do not provide well-child clinic services.

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