



The Forums Institute for Public Policy

# **New Jersey Public Health Financing in a Changing Environment: Implications for Policymakers**

Background Information for...

## THE NEW JERSEY POLICY FORUM

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9:30 AM to 12:00 PM

Registration begins at 9:00 AM

The Medical Society of New Jersey

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**ISSUE: The financing of our public health system is a critical component in its overall functioning and integrity. The ratio of public health funding support, however, continues to be disproportionate when compared to expenditures for personal medical care. Anticipated changes in the public health infrastructure include an emphasis on collaboration and cooperation among funders and providers, both public and private.<sup>1</sup> Against the backdrop of this changing environment, what challenges are faced by policymakers in their decision-making regarding funding and resource allocation for essential public health services?**

## INTRODUCTION

In this election year, several substantive areas of health and medical care policy have become high-profile, triggering policy proposals from both parties, specifically Medicare reform, health coverage for the uninsured, patients' rights in a managed care environment, prescription drug coverage for seniors and long-term health care. How does support for the integrity of the public health infrastructure "fit in" with the current policy focus on personal health care? In what ways can public policymakers identify the critical aspects of the public health infrastructure<sup>2</sup> that need to be addressed and how will the financing of these aspects become a priority for policymaking leadership at national, state and local levels?

According to the U.S. Public Health Service, during the past 100 years in America, the average life span has increased by 30 years. Population-based public health services have added 25 of the additional 30 years to our life spans; only 5 of those years were as a direct result of improvements in medical care ("For a Healthy Nation: Returns on Investment in Public Health," U.S. Public Health Service, 1993). Yet most estimates suggest that less than 1 percent of the nation's health care dollars are spent on supporting the essential public health services that have granted us those extra 25 years of life: cleaner water, monitoring and surveillance of environmental health threats, disease outbreaks, better sanitation and health education (Gostin and Hodge, 1999). When viewed on a per capita basis, estimates indicate that on average, Americans spend \$4,000 per capita each year on personal medical care, compared to an estimated \$44 for population-based public health services (Eilbert et al, 1996; Lamm, 2000).

A recent editorial by Richard D. Lamm, former governor of Colorado and now executive director of the Center for Public Policy and Contemporary Issues, underscores the critical importance of the interrelationship between good medical care and a well-supported public health system (ibid.). Quoting Stan-

ford health economist Victor Fuchs, he notes that three factors are important when we evaluate a health-care system:

- (1) medical training and technology;
- (2) people's access to the system; and
- (3) people's health – the outcome of the system.

Although the United States, when compared to other countries, leads in terms of the first prong of these criteria, it falls critically short on the second – owing to its high rate of uninsured and under-insured. Regarding the third prong – people's health – Lamm cites the World Health Organization's report on world health in the year 2000, which notes that the United States ranks 37<sup>th</sup> out of 191 countries in health care systems, falling behind most of the developed world (ibid.).

In concluding his analysis, Lamm proffers that it is critical to focus spending on the nation's overall health: "No successful public policy calculates need on the basis of one individual at a time" (ibid.). Dr. J. Michael McGinnis, speaking in the early 1990's on health reform efforts, offered: "[F]or health care reform to capture what is possible in improving the health of Americans, it must embody a population-based public health perspective."

## PUBLIC HEALTH'S IDENTITY CRISIS

"Health threats, even those caused by serious communicable diseases, are often practically invisible" (Gostin and Hodge, 1999).

When the public health system is working "right," we don't readily see its benefits. It is only when an outbreak – such as West Nile virus – or a breakdown in surveillance – such as an *E.coli* contamination of restaurant meals – occurs that public health activities become "seen" and recognized. In 1999, the Pew Charitable Trusts commissioned a survey regarding public





opinion about public health.<sup>3</sup> In general survey responses, over half (57 percent) of respondents could not define public health as either protecting the population from disease or policies and programs that promote healthy living conditions for everyone (*MMWR Weekly*, March 31, 2000). However, when asked if the United States should "do more" to protect public health, 65 percent said that it should do more (*ibid.*). In comparing public health as a priority with several other programs, most respondents said public health was more deserving of "additional funds" than building roads and highways, missile defense, and reducing taxes; only education was rated to be of greater priority for additional funding resources (*ibid.*). Survey responses show a clear "disconnect" in the public's perception of public health vs. their belief that it is deserving of additional funding and that policymakers should "do more" to protect public health.

In an editorial note accompanying the survey findings, it was reported that during the past two decades, financial support for public health infrastructure has decreased and national expenditures for health care services have increased. In 1998, Health Care Financing Administration data indicated that total national health expenditures (including health services and supplies and personal health care) exceeded \$1.2 trillion. Of this total, \$626 billion came from private sources and \$523 billion represented governmental expenditures (federal, state and local sources). Expenditures for government public health activities were \$36.6 billion, less than 3 percent of total health expenditures.

The editors of *Morbidity and Mortality Weekly* placed these figures in a policy context and observed that: "Societal support is critical for public health efforts, which target population-based disease prevention and collective action . . . [T]he diminishing resources for public health combined with increasing costs of medical intervention may indicate a failure to communicate the efficacy of public health practices and programs" [emphasis added] (*id* at 2).

The paradox of good public health's being "invisible," i.e., the absence of environmental health problems, outbreaks, improved health status, also has an impact on public policymaking in general. In an essay analyzing policymaking in the public health environment, public health expert Dr. Bobbie Berkowitz points out that the traditional methodology of public policymaking – problem identification, research, policy solution, implementation – may not apply to public health, a field where having the infrastructure in place to "anticipate" problems, e.g., a new outbreak of cholera,

leads in a convoluted path to the first step of traditional public policy development – identifying a specific problem. Without being able to use their traditional "problem identification" policymaking tools, how do policymakers respond proactively to address emerging public health issues, such as funding support for infrastructure?

## GENERAL ORGANIZATIONAL STRUCTURE IN PUBLIC HEALTH

The organizational structure of funding public health, its categorical funding streams, fragmented financing and leadership challenges continue to "shape" the identity of the public health system. In a 1990 Profile of State and Territorial Public Health Systems, the CDC identified four broad categories of state and local public health structures:

- (1) centralized systems, in which the local health department is operated by the state health agency and functions under its authority;
- (2) decentralized systems, in which local governments have "home-rule" or direct authority over local health agencies;
- (3) "mixed" systems, in which state and local health services are provided by a combination of state agencies, local government, and boards of health and health departments;
- (4) "shared" systems, in which the local health department operates under the shared authority of the state health agency, the local government and local boards of health (Fraser, 1998).

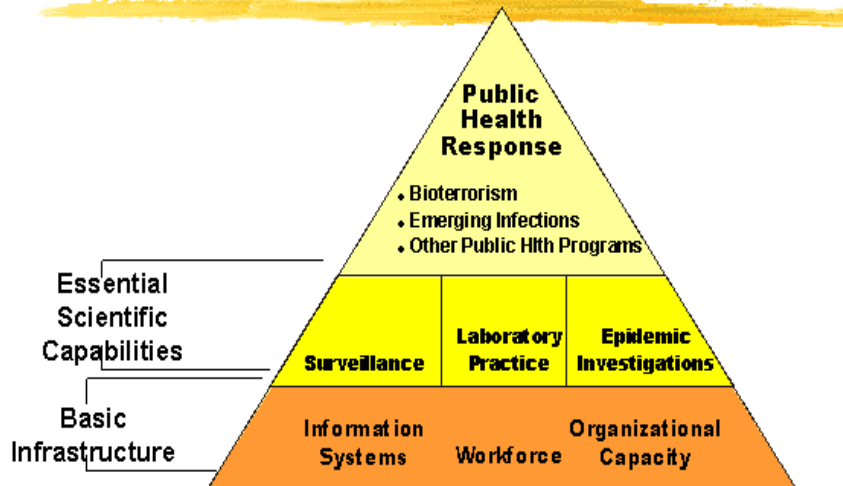
The National Association of County and City Health Officials (NACCHO) conducted a study to focus on state-local structure topology in 1997 (*ibid.*). In its findings, decentralized systems were the most common (50 percent or 26 states); 25 percent (or 13 states) reported centralized systems; 17 percent had mixed systems and 4 percent reported shared systems. An "other" category was created for the states of Hawaii and Rhode Island in that they each reported that they had no local health department equivalents. In most systems the lowest level of governmental infrastructure is at the county level.

There are broad policy implications related to the ways in which these systems influence not only funding allocations, but also broad organizational activities such as program design and evaluation and coordination of services.





## Public Health Infrastructure



Reference: Public Health Practice Program Office (PHPPO), CDC, 1999.

- A “devolution” by which more burden has been placed on state and local level programs for provision of core public health functions (assessment, policy development and assurance) and the ten essential public health services;<sup>4</sup>
- Shifts in Medicare and Medicaid reimbursements to the private sector, which have greatly affected reimbursement to public health agencies from both of these programs; although indigent caseloads continue to grow in these programs, the level of reimbursement for services has not;

### DECONSTRUCTING DEVOLUTION — NATIONAL, STATE AND LOCAL AUTHORITY IN PUBLIC HEALTH

In a report that focused on health care in America, researchers at the Institute for the Future observed that: “[A]t all levels of government, but particularly the local level, officials are hamstrung by limited funding . . . Although states have been given considerable flexibility in their use of block grants, this restrictive funding mechanism has often compromised the ability of local agencies to meet the particular needs of their communities, especially as the grants are not discretionary” (*Health and Health Care*, 2010).

As the well-known adage states, “all politics is local.” This statement is no truer than in the public health context where “all public health care is local” (*Health Care Financing Organization, News & Progress*, 2000). In a recent report on communities and health care markets that acknowledged this adage, it was noted that: “[I]t remains a challenge to communicate to public and private policymakers, through unbiased research, what is happening to health care delivery at the local level” (*ibid.*).

A “topography” of the current public health environment highlights the following issues:

- Shifts in resource allocation and in how financing is given, by whom and for what purposes;
- Increases in the delivery of health services in managed care contexts, which have also had a significant impact on the reimbursement mechanisms and financial support for public health agencies;
- Trends toward integrated services and coordination and collaboration among public health agencies and providers;
- Focus on infrastructure barriers and limitations in capacity;
- Emerging public health issues – implications of global public health practices and surveillance, pressures of demographic diversity and public health education;
- Limited data standardization – unreliability in tracking persons served and dollars spent, specifically among local agencies;
- Accountability and outcomes – the significance of evidence-based research within the current public policy environment;
- An absence of consistent funding support for long-term research activities;
- Challenges created by an identity crisis: there is a lack of public awareness regarding public health’s direct and indirect contribution to improved health and life expectancy.





Current obstacles to supporting public health functions and services include the following:

- a funding structure where core functions are inadequately funded and a disproportionate percentage of funding is targeted for direct provision of services;<sup>5</sup>
- competition for funding which compromises a shift towards collaboration and cooperation;
- fragmentation of the delivery system;
- poor integration of services;
- limitations of capacity on both technical and organizational levels;
- data limitations, resulting in unreliability in showing hard outcomes for core public health functions.

Workforce issues also carry their own set of challenges: according to the U.S. Department of Labor, governmental public health officials' average wages are half those in medical and health services management and are less than one-third those of physicians (1997). Such low salaries make it difficult to attract health professionals, including epidemiologists, policy analysts and technical information systems experts.

Historically, the financial model in public health is that funding sources drive the types of programs that are provided.<sup>6</sup> At present, many public health advocates are calling for a shift through which needs assessments are conducted and necessary and appropriate services are provided based on findings from these assessments. Such a shift is compromised by the absence of hard outcome data, which is commonly required by funders.

## THE "ECONOMICS" OF PUBLIC HEALTH IN NEW JERSEY

Just as the past 10 years have witnessed exponential changes in the health care environment in New Jersey and throughout the country, most pointedly in the areas of financing, delivery and insurability, the public health system has been undergoing its own evolution. Public health – what it is and how its services are financed and delivered – has had to adapt to its own shifts in health-related financing and technologies.

In discussing this particular topic with state and local public health experts – the "economics" of public health in New Jersey – there was great diversity in response to the question: "How would you identify the primary issues affecting public health economics at this time?" Where consensus did fall was that there

was no economic "model" per se which defined public health financing, and there is a need to address the significant issue that funding support for personal health care is disproportionate to support for the essential health services of public health.

A 1999 Institute of Medicine analysis of the viability of safety net providers also directly points out that the disproportionate allocation of public health resources to publicly funded medicine drains capacity and attention from community-wide public health service, assessment and policy development functions. Specifically, the report found that at the state level, two-thirds of spending is for personal health services, compared to spending for population-based health services, which is estimated to be only 1.0 percent of total health care expenditures. Of this 1.0 percent, the largest percentage (26 percent) is used for enforcing regulations and laws to protect public health and safety, while training and research activities (2 percent) receive the lowest amounts.

According to New Jersey experts, the goal of obtaining a consistent picture of public health financing is compromised because of its administrative and operational structure: each locality uses different definitions and forms of accounting structure. Research, however, has been conducted on the state's local health capacity and functioning which gives a clearer picture of local public health activities.

## NEW JERSEY — LOCAL PUBLIC HEALTH EXPENDITURES

New Jersey's public health system – which is a decentralized system comprised of activities and functions at state, county, and local levels – is strongest at the local level. There are an estimated 524 boards of health and 115 local health departments (Freund and Liu, 2000).<sup>7</sup> These public health agencies range in size from extremely large organizations (some 400 FTE's) to small agencies (2.5 FTE's); however, public health laws and regulations affect each of these entities in the same way.<sup>8</sup> Massachusetts, another decentralized state, operates its public health system through local boards of health in over 350 cities and towns.

In the broadest sweep, it is estimated that in New Jersey, approximately 3 percent of all health financing comprises the public health budget; of that percentage, an estimated 2.1 percent supports the delivery of medical services, leaving less than 1 percent of the state's health dollars supporting essential public health activities. In 1997, over \$184 million was budgeted





for public health services in New Jersey (*ibid.*). According to current DHSS estimates, New Jersey's total public health budget in 1998 was \$176.6 million (down 4 percent from 1997). These public health expenditures are fairly evenly distributed among five major categories: administrative services (including administration, nurse referrals, health education) receives approximately 20 percent; environmental health (covering food surveillance, recreational safety, etc.) is at 20 percent; communicable diseases receives an estimated 19 percent; maternal and child health services receives 19 percent and adult health services (including flu shots) receives approximately 23 percent (all 1998 figures). (See Appendix, Table 1, "New Jersey Local Health Department Expenditures, 1994; 1997; 1998").<sup>9</sup>

For all three years reported (1994, 1997 and 1998), local tax and other revenues supported the largest portion of public health services: 72 percent in 1994; 78 percent in 1997; and 76 percent in 1998. In comparison, in 1994, 27 percent was funded through federal and state sources (including Public Health Priority Funding); in 1997, 22 percent, and in 1998, 23 percent of public health expenditures were allocated from state and federal sources.

A recently reported survey of local boards of health in New Jersey indicates that between 1994 and 1997, local public health budgets in the state increased from \$124 million to \$184 million, or 48.4 percent (Freund and Liu, 2000). Local funding support for these budgets also increased during this period, from 72.6 percent in 1994 to 80 percent in 1997. During the period, state and federal support have remained relatively flat. New Jersey's state Public Health Priority Funding has experienced funding levels of between \$3 to \$4 million for several years. Current state support for Priority Funding is \$4.165 million (New Jersey Department of Health and Senior Services (NJ DHSS) Staff Interview, 2000). The distribution is by state formula to municipalities, with certain demographic criteria applied to each recipient (N.J.S.A. 26:2F). Within DHSS, the Office of Local Health administers the Public Health Priority Funds, under which some requirements for infrastructure have been set.

In order to ensure that the public health system operates efficiently and effectively, the coordination of multiple funders and providers is critical. The diversity of financial support in public health includes a range of entities: federal, state and local health agencies, foundations and insurers (See Appendix, Table 2, "Examples of Public Health Funding Streams"). Funding is used to support public health activities de-

livered by a range of community health providers including hospitals, home health agencies, visiting nurse agencies, local boards of health, drug and alcohol councils, and maternal and child health consortia (Freund and Liu, 2000). These public health services are provided by health professionals who include: physicians, public health nurses, social workers, health educators, environmental health specialists, laboratory scientists and other health professionals.

## NEW JERSEY'S PUBLIC HEALTH INFRASTRUCTURE — DEVELOPMENT AND SUPPORT

In its year 2000 report on the future of health care, the Institute of the Future highlighted several broad social, political and technological forces that will shape the future of public health in particular ([Health and Health Care 2010](#)). An example of such technological advances in New Jersey is represented by the state's Local Information and Communications System (NJ LINCS), which was implemented in 1997 via the Department of Health and Senior Services (DHSS), Office of Local Health, in cooperation with the state's local health departments. Using Internet-based technologies, LINCS works to improve the state's public health system; it is an electronic information system designed to support interactive reporting, health data analysis and the dissemination of public health information among state, federal (CDC), local public health and emergency service providers. In 1998, the system began in 24 local public health agencies (one per county and in three major cities – Jersey City, Paterson and Newark).

The long-range goal of LINCS is to integrate each of the state's 115 local health into the system ([www.state.us.nj/](http://www.state.us.nj/)). Funding and support for LINCS has come primarily from state and local sources. For state fiscal year 1999, an additional one half million dollars in Public Health Priority Funding (State Aid) was legislatively appropriated and has been made available to local health departments for the purpose of improving their information technology capacities (hardware, software, Internet service/e-mail, informatics training, etc.) to access and use LINCS (*ibid.*).<sup>10</sup>

Consistent or committed funding support for public health infrastructure continues to be a "weak link" in the public health financing construct. Although infrastructure goals are addressed in *Healthy New Jersey 2010*, there is no direct funding – either on federal or state levels – to support these goals. Historically, because categorical funding streams have in many ways





“carved” the public health environment, advocates for funding support for infrastructure development are in direct competition for funds for more visible and quantifiable public health concerns, such as disease control and surveillance. On a national level, the CDC, through its bioterrorism preparedness initiative, is addressing the priority of infrastructure development in pointing to the necessity of computers and information system networks for rapid reporting of potential bioterrorist activities.

At the state level, DHSS’ Office of Local Health is in the process of awarding up to three planning grants to local health agencies at the county level with the aim of assessing and building regional public health capacity. In evaluating the three-year business plans which will be one aspect of the planning grant process, administrators will be able to assess specific costs for infrastructure as delineated in the grantee’s business plans.

## **NEW JERSEY — PUBLIC HEALTH PRACTICE STANDARDS**

For the last two and a half years, the Department of Health and Senior Services (DHSS) and New Jersey public health professionals have been involved in a statewide initiative to revise its regulations: “Recognized Public Health Activities and Minimum Standards of Performance for Local Boards of Health in New Jersey,” N.J.A.C. 8:52. The public health practice standards for New Jersey had not been significantly amended since 1986, and the current process is being overseen by a public health task force.

In Freund and Liu’s study of local health department capacity and performance in New Jersey, the researchers analyzed data from 102 (of the state’s 115 local health departments, comprising an 88.7 percent response rate) from their survey dispatched in summer 1998.<sup>11</sup> They found that the organizational structure of New Jersey’s local health departments was primarily municipal (45.2 percent) or contractual (37.4 percent). Yet county health departments (14, or 12.2 percent of public health providers) serve more (40.2 percent) of the state’s population than any other group.

Significantly, research findings indicated that over half (58.8 percent) of the local health departments had annual budgets of less than \$500,000 and almost three-quarters of them (73.5 percent) administered their operations on annual budgets that totaled less than \$1 million. (For personnel size, number of population served and annual budget figures, see Appendix, Ta-

ble 3, “New Jersey Local Health Departments, Full-Time Equivalent (FTE) Personnel, 1998”).

In a state like New Jersey, where local rule is strong, the power of politics is equally robust. One expert asks: when the public health funding “pie” is sliced in such small pieces among so many public health agencies, does the money lose its effectiveness? Would collaboration and regional administration for some programs increase efficiencies and provide more “power” to dollars which are not so diluted? When competition for funding exists, how can such collaboration and cooperation best be achieved? Many interviewed public health experts agreed that there has been no more critical time than the present to address the public health infrastructure issues and collaborate on developing strategic remedies.

## **PUBLIC HEALTH IN PERSPECTIVE — CHALLENGES AND OPPORTUNITIES**

In its now-classic 1988 report on public health, the Institute of Medicine (IOM) characterized the history of the public health system in the U. S. as “a history of bringing knowledge and values together in the public arena to shape an approach to health problems.” It also expressed the view that the mission of public health will be achieved through organized community efforts that are aimed at the prevention of disease and the promotion of health. As defined by the World Health Organization, health is characterized as: “A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” When medicine and public health are in synergy, there is the best opportunity to come closest to this state of health across the population.

Twelve years ago, in its final analysis, the IOM called public health to a “shattered vision,” characterized by a lack of consensus on the mission of public health, organizational fragmentation on all levels, and limited and often inadequate capacity. Since that time, several infrastructure changes have taken place: federal government involvement has retracted and the responsibility of state governments has increased. It is the local level of government that is at the front line of public health at present as it acts as a liaison among the myriad of providers, funders and educators who contribute to public health practice. It is at this level also where collaboration and integration of services is most critical and where the achievement of these goals is most challenging. For example, in 1999, it was reported that the CDC was unable to contact nearly half of the local public health departments in







America within 24 hours (Gostin and Hodge, 1999). According to a CDC official: "Over several decades the capabilities of state and local health departments have waned. They don't have the resources to do what they can and need to do."

And while the coordination and management of public health activities and practice have moved to the local level, the broader "view" of public health in the next century involves the reality of external global forces affecting public health at all levels in this country. Various health risks are directly related to globalism, including new infectious diseases (through increased trade and travel), the spread of emerging and drug-resistant disease, bioterrorism and contamination of food and drinking water. According to the Centers for Disease Control, in 1997 39 percent of all patients with tuberculosis reported in the U.S. were foreign-born; since 1995, almost 50 percent of measles cases reported in America have been introduced from other countries. These statistics have significant implications in a state like New Jersey, whose demographics have been shifting dramatically in the past five years. The Institute for the Future report projects that during the next decade, the reality of public health concerns will be more embedded in a global health and economic context (2000). In a newly published book by journalist Laurie Garrett, she warns that the absence of a "functioning public health infrastructure" will lead to the collapse of global public health.<sup>12</sup>

**"SHOW ME THE MONEY" vs.  
"SHOW ME THE DATA" —  
HOW RESEARCHERS ARE TRYING TO  
MEASURE PUBLIC HEALTH  
EXPENDITURES**

As providers focus on the need for more funding support, policymakers focus on the need for more evidence-based research and data on population-based health. In his 1999 remarks at the opening of the University of West Virginia's Center for Healthcare Policy and Research, Dr. Claude Earl Fox underscored the importance of focusing on the issue of health care financing, noting that "dollars drive policy, but are, just as surely, a product of policy" (*HRSA News Room*, 1999). He also echoed U.S. Surgeon General David Satcher's belief that one of the core values in health policy research and decision-making is ensuring that interventions be evidence-based so that science may be translated into practice. Although there have been studies that attempt to achieve baseline estimates of expenditures for essential public

health services at federal, state and local levels, there is a critical need for continued intensive and comprehensive research.

Historically, public health expenditures have been "estimated" in various ways: from the Public Health Service's collection of data focusing on cities and categorical programs (since 1900) to the Health Care Financing Administration's (HCFA) reporting on national health expenditures (since 1965) using census, state and local data. HCFA data is not broken down to the state level, nor does it differentiate personal health services from population-based services (Eilbert et al, 1996).<sup>13</sup> In 1991 the CDC commissioned a study, "National Expenditures for Health Promotion and Disease Prevention Activities in the U.S.," as a means to estimate national health promotion and disease prevention expenditures. At that time, study results found that total public health expenditures represented approximately 3 percent of total health expenditures.

In December 1994, findings from a survey study conducted by the Public Health Service and the Public Health Foundation of eight states (Connecticut, Illinois, Iowa, Missouri, New York, Oregon, Rhode Island and Texas) with a combined 1990 population of 61.4 million were used to estimate core (essential) public health expenditures from October 1992 - September 1993.<sup>14</sup> Among the eight states, per capita expenditures for core public health functions ranged from \$31 to \$57 (mean: \$44). When aggregate data was analyzed, study researchers estimated that the combined (estimated) state, local and PHS expenditures on core public health functions were \$14.4 billion (range: \$11 billion - \$17 billion) in 1993. By comparison, HCFA data for the same year estimated that federal, state and local public health expenditures were \$24.2 billion, or 24 percent of total national health expenditures. This number contrasts sharply with the study's \$14.4 billion, or 1.6 percent of total health expenditures, and carried significant implications for funding decisions.

Because of identified limitations in the 1992-93 study, a second study was launched in 1995. One of the primary goals of the study was to "document public health expenditures to improve policymakers' and public health managers' understanding of what is spent on delivering public health services" (Eilbert et al, 1996). Six of the eight states in the first study - Illinois, Iowa, New York, Oregon, Rhode Island, and Texas - and three additional states - Arizona, Louisiana and Washington - participated in the Phase II study.





In November 1996, the Phase II study, entitled "Measuring Expenditures for Essential Health Services," was published by the Public Health Foundation. The study focused research on state and local public health, mental health, substance abuse and environmental health agencies in the nine states. Its purpose was to develop and test a methodology for estimating investments in the ten essential public health services (See Appendix, Figure 1, Public Health in America: "Essential Public Health Services").<sup>15</sup> These essential services include both personal health services (direct care services provided to individuals) and population-based health services (interventions that prevent disease and promote health among entire populations). Expenditures for personal health services were analyzed apart from all other essential public health services.<sup>16</sup>

Acknowledging data and reporting limitations in the study, the researchers argued that "the methodology, with the recommended improvements, provides an excellent starting point for states, localities and federal agencies interested in developing baseline estimates of public health expenditures for making important policy and program resource decisions" (Eilbert et al, 1996). Significant research findings for policymakers at all levels included the following:

- Population-based health services spending – \$2.7 billion, or \$36 per capita – was only one percent of total health care expenditures (\$3,342 per capita) in the participating states;
- Predominance of personal health services in the public health system – more than two of every three dollars spent by the nine states on essential public health services (\$6.1 billion of \$8.8 billion) went for personal health services;
- Of the \$2.7 billion spent on population-based services, the largest amount (26 percent) was for enforcing laws and regulations protecting the public's health and safety; training (4 percent) and research (2 percent) showed the smallest investments;
- States were the largest funders of population-based services, providing 50 percent of the funding for these activities; federal funding accounted for 32 percent and local and other sources (fees and reimbursements) supported the remaining 18 percent of population-based health expenditures;
- Thirty-four percent of the \$7.1 billion funded by the U.S. Public Health Service on essential public health services supported research efforts, indicating the federal government's strong role as researcher in public health.

The Public Health Functions Steering Committee, a collaborative body staffed by the Office of Disease Prevention, Department of Health and Human Services, has facilitated the development of a wide range of projects designed to study and describe the public health infrastructure (including those studies referenced above). The U.S. Public Health Service, as part of this overall research effort, has continued to fund research to develop, test and refine methods to document expenditures associated with the essential health services. The Public Health Foundation, the National Association of County and City Health Officials, the Association of State and Territorial Health Officials, and the National Association of Local Boards of Health have worked together to release studies on specific dimensions of estimating expenditures for essential health services. The overall goal of the collaborative project is "to enable the public health community to examine and understand its own strengths and weaknesses and to communicate to policymakers and other partners the need for maintaining and enhancing current public health infrastructure" ([www.phf.org](http://www.phf.org)).

Further recent studies include a report (published in April 1997) on personal health care services rendered by public health departments. This study focused on essential public health services function #6 – "Link people to needed personal health care services and assure the provision of health care when otherwise available" (1997). In testing health departments' ability to estimate expenditures for specific health care services categories and delivery methods, this pilot study (which was tested in state health departments in Arizona, Iowa and Rhode Island and local health departments in Austin/Travis County, Texas and New York City, New York) was seen as an initial step toward a method of characterizing personal health care services expenditures. Developing a knowledge and research base of such expenditure estimates could facilitate understanding of the impact of federal policy changes on state and local levels, such as moving Medicaid beneficiaries into managed care (*ibid.*).

A March 1998 joint study – "Where Do the Dollars Go? Measuring Local Public Health Expenditures" – looked at three sentinel sites – Onondaga County, NY; Northeast Tri-County, WA; and Columbus, Ohio – to "test the partitioning of local public health expenditures into the essential services framework and to assess key similarities and differences among the participating sites."<sup>17</sup> Several "lessons learned" from this study found that site participants felt the process of characterizing their expenditures within the essential services framework was worthwhile but empha-





sized that the comparability and reliability of data are problematic. The approach, methods and decision rules used by participants varied greatly, both across programs within a site and across sites (ibid.). In March 2000, the first statewide pilot study was released which analyzed health expenditures for the state of Maryland.<sup>18</sup>

## FEDERAL AND NATIONAL INITIATIVES

On the federal level, activity in the public health arena has included the implementation of a new program – the Community Access Program (CAP) – which Congress funded for Fiscal Year 2000. The program's purpose is to “expand access to the uninsured through increasing the effectiveness and capacity of the nation's health care safety net at the community level – where public health practice and services take place.”<sup>19</sup> Managed by the Health Resources Services Administration (HRSA), CAP funding is designed to assist communities and their safety net providers in developing integrated health care delivery systems that serve the uninsured and underinsured. During the FY 2000 grant cycle, CAP funds will support infrastructure development in communities that have already begun to reorganize and integrate their health care delivery systems.

One of the program goals is to assist communities in eliminating unnecessary and duplicative functions in service delivery and in administration, resulting in savings to reinvest in the system. The CAP program represents a significant dimension of the new Federalism in the public health system: direct federal funding support to communities for collaboration and integration of services. Such federal investment in local collaboration is the essence of devolution in public health.

The initial long-term plan of CAP is to fund 100 communities as part of a five-year, \$1 billion program. Recent discussion in Congress focused on increasing this support to \$2.5 billion over five years (Baumgartner, 2000). Future funding will aim at supporting infrastructure development, planning and system development and filling service gaps. As part of its commitment to ongoing support for CAP, the Administration is pursuing legislative authorization to ensure that CAP becomes a core element of the health care safety net ([www.hrsa.gov/CAP](http://www.hrsa.gov/CAP)).

On the Congressional level, a “first” of its kind piece of legislation has been introduced by Senators Kennedy (D-MA) and Frist (R-TN) to amend section 310 of the Public Health Services Act. It calls on building the public health infrastructure to improve the functioning of local public health agencies. Another public health “first” was represented by the U.S. Surgeon General's Report on Mental Health released this past year. It focused on mental health as a public health issue and called for collaboration among mental health and health care providers.

A national public health collaborative partnership is represented by the Turning Point initiative, which is sponsored by the W. K. Kellogg Foundation and The Robert Wood Johnson and directed by the National Association of County and City Health Officials (NACCHO) and the University of Washington School of Public Health and Community Medicine. Turning Point focuses on strengthening the public health infrastructure so that “states, local communities and their public health agencies may respond to the challenge to protect and improve the public's health in the 21<sup>st</sup> century” ([www.naccho.org](http://www.naccho.org)). In the program's purpose statement is the acknowledgment that the effectiveness of the future public health system depends on the ability of organizations “to form strong collaborative relationships across all interested parties, both public and private.”

## CONCLUDING REMARKS

In its year 2000 report, The Institute of the Future forecasts that the future of public health in the next decade is significantly dependent on the establishment and functional operation of collaborative relationships among providers and funders, both public and private. It further points out that inadequate funding is one of the “greatest barriers to the completion of public health's missions and responsibilities...”

In New Jersey, groups like NJ Public Health CARE: Crafting a Restructured Environment are working with the state's public health leadership to identify the strengths and weaknesses in the current public health infrastructure and its financing so as to reach consensus on strategies for coordination and collaboration. The process is replete with challenges and opportunities; yet it is critical to find common ground if the vision and mission of public health is to be achieved. Through focused research and communication, the knowledge base of public policymakers can be enhanced in order to facilitate decision-making regarding public health funding and resource allocation.





## POLICY IMPLICATIONS

### **An Economic Blueprint?**

Public health experts in New Jersey agree that there is no "economic model" that characterizes public health financing. Could a five-year "economic plan" – just as *Healthy New Jersey 2010* represents a "blueprint" of our public health goals – be developed for the state? Such a plan could include contingent scenarios, anticipating shifts and trends in overall public health financing.

### **Collaboration and Coordination**

As one aspect of the devolutionary process, both national and state policymakers acknowledge the necessity for shifting towards collaboration and coordination of public health services. This shift aims to reduce duplication of services, to better target allocation of resources and to provide appropriate services to meet the specific public health needs of communities. In New Jersey's public health system – which is comprised of hundreds of local agencies – providers and elected officials have an historic "stake" in their administrative authority, and competition for funding is strong. How can the move towards collaboration and coordination be achieved while preserving the integrity of each stakeholder? What paradigm shift must be integrated so that these two goals are not perceived by stakeholders as being mutually exclusive?

### **Policymaking Tools**

Berkowitz, in her analysis of the challenges of public policymaking in the context of public health, notes that the traditional "problem identification" tools of policymakers may not be appropriate in developing public health policy because it is a field where a well-supported infrastructure must be in place to "anticipate" problems. What kind of new policymaking "tools" need to be developed through the coordinated efforts of experts in public health and public policy to meet this challenge? How will public health leadership move towards engagement in communicating and gaining the attention of policymakers during the course of their decision-making?

### **Public Health Communications**

Public health research indicates an "identity crisis" in both the public's and policymakers' perceptions of public health and its functions. What barriers exist in communicating to both groups the benefits related to supporting a well-functioning public health system? What is the media's role in meeting this challenge? In what ways and through what channels can "good information" be disseminated about the critical importance of public health in New Jersey?

### **Leadership Identity**

How does leadership find identity in the public health environment? What are its objectives? If it is to inform the public policy decision-making process, how can it be systematic and proactive, rather than idiosyncratic and reactive? In some states – e.g., Illinois, California, Michigan and Washington – there is strong leadership focused on the development of public health infrastructure. What type of collaboration needs to be facilitated in order for public health leadership — and a commitment to training and advancing a knowledge base — to flourish?

### **Limited Resources — Complexity of Services**

In an environment of limited resources, what strategies are being developed to best put the numerous goals and objectives of *Healthy New Jersey 2010* into practice? Meeting these goals requires the commitment of resources for service delivery, education, research, training and outreach for health promotion and prevention activities. In an environment of limited resources, how will implementation – especially in the area of eliminating health disparities among racial and ethnic groups – and evaluation of outcomes be ensured?

### **Data Limitations**

Data coordination and standardization are critical tools needed to facilitate evaluative research and to generate outcomes data. Most public health experts agreed that it was not possible to give a reliable "picture" of public health economics in New Jersey because of variations and differences in accounting and administrative structures of the local agencies. What level of ongoing funding support is required to promote research focusing on estimating state and local expenditures for public health?





**Information Technology**

Technological sophistication is one of the critical linkages in a contemporary public health system. Although there has been progress in “computerizing” local health agencies in New Jersey, there is still much to be accomplished in developing this infrastructure. In the technology-rich state that New Jersey is, what types of public-private partnerships can be initiated in supporting the technology needs of our state’s public health infrastructure.

**The Context of Managed Care**

Managed care continues to affect the public health system across all dimensions of financing, delivery systems and access to services. Public health advocacy organizations, including the American Public Health Association, are concerned about the effectiveness of managed care organizations in meeting the health care needs associated with prevention and with managing chronic conditions as well as with the underfunding of public health and prevention services. What strategies are being explored by policymakers and regulators to address these concerns?





## ENDNOTES

- <sup>1</sup> The genesis of this inquiry and analysis was a meeting with staff from the New Jersey Policy Forums on Health and Medical Care along with staff from New Jersey Public Health: CARE, Crafting a Restructured Environment.
- <sup>2</sup> Public health infrastructure is defined by the federal government as “the systems, competencies, relationships and resources that enable performance of the 10 essential services” (see Appendix, Figure 1, Public Health in America, “Essential Public Health Functions;” Freund and Liu, 2000).
- <sup>3</sup> The Mellman Group and Public Opinion Strategies conducted both qualitative and quantitative research in 1999 to evaluate the public’s attitude about public health.
- <sup>4</sup> See Appendix, Figure 1, Public Health In America: “Essential Public Health Services.”
- <sup>5</sup> Block grants and categorical funding mandates add to fragmentation in the public health financing system.
- <sup>6</sup> See Appendix, Table 2, “Examples of Public Health Funding Streams.”
- <sup>7</sup> Under N.J.S.A. 26:3-1, all municipalities have been required to have a local board of health since 1887.
- <sup>8</sup> See Appendix, Table 3, “New Jersey Local Health Departments, Full-Time Equivalent (FTE) Personnel, 1998.”
- <sup>9</sup> NB - Data is self-reported by the local health offices and is not verified by any outside source.
- <sup>10</sup> According to the Department of Health and Senior Services, additional support for LINCS has come from state Health Information Network Technologies (HINT) funding and the 24 LINCS agencies have contributed an estimated \$1 million annually in in-kind services.
- <sup>11</sup> Freund and Liu’s comprehensive study also provides data on core and essential public health functions performance and job title FTE’s within the local health departments. Block grants and categorical funding mandates add to fragmentation in the public health financing system.
- <sup>12</sup> Reference is made to Garrett, Laurie. Betrayal of Trust. The Collapse of Global Public Health. New York 2000.
- <sup>13</sup> For example, 1998 HCFA National Health Expenditures data, under the category “Government Public Health Activities,” represents total spending at \$36.6 billion, with \$4.2 billion coming from federal sources and \$32.4 billion (or 88 percent) coming from state and local sources. By comparison, 1998 total national health expenditures totaled over \$1.1 trillion dollars (www.hcfa.gov/stats/).
- <sup>14</sup> The eight states were selected to reflect geographic and population diversity.
- <sup>15</sup> See Eilbert, K.W., M. Barry, R. Bialek and M. Garufi, “Measuring Expenditures for Essential Public Health Services,” November 1996.
- <sup>16</sup> Researchers noted several limitations affecting the study including differences in state and local public health agencies’ organizational structures and variability in the quality of local health department data.
- <sup>17</sup> See Barry et al, “Where Do the Dollars Go? Measuring Local Public Health Expenditures.” March 1998.
- <sup>18</sup> “Statewide Public Health Expenditures: A Pilot Study in Maryland. March 2000.”
- <sup>19</sup> In 1999, the Clinton Administration proposed the Health Care Access for Uninsured Workers Program, which will be implemented as the CAP program. The Administration’s proposal was initiated in order to: “coordinate systems of care, increase the volume of services delivered and establish an accountability system to assure adequate care for the uninsured” (www.hrsa.gov/CAP).





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**APPENDIX**



**TABLE 1**

***New Jersey Local Health Department Expenditures***

**Source Amounts and Percentages of Funding**

	Local Tax	State	PHPF	Federal	All Other Sources *	Total
<b><u>1994</u></b>						
Amount	\$78,548,078	\$12,231,445	\$3,682,642	\$18,173,728	\$11,658,649	\$124,294,542
Percentage	63.20%	9.80%	3.00%	14.60%	9.40%	100.00%
<b><u>1997</u></b>						
Amount	\$118,763,052	\$17,397,372	\$3,500,070	\$20,477,745	\$24,055,657	\$184,193,896
Percentage	64.48%	9.44%	1.90%	11.12%	13.06%	100.00%
<b><u>1998</u></b>						
Amount	\$94,079,353	\$17,915,110	\$3,572,365	\$19,931,594	\$41,077,228	\$176,575,649
Percentage	53.28%	10.15%	2.02%	11.29%	23.26%	100.00%

**Activity Amounts and Percentages of Funding**

	Administration	Environmental	Communicable Diseases	Maternal & Child Health	Adult Health	Total
<b><u>1994</u></b>						
Amount	\$31,658,197	\$25,696,579	\$19,226,002	\$23,473,753	\$24,240,011	\$124,294,542
Percentage	25.50%	20.70%	15.50%	18.90%	19.50%	100.00%
<b><u>1997</u></b>						
Amount	\$59,133,389	\$32,144,036	\$17,459,506	\$34,038,151	\$41,418,814	\$184,193,896
Percentage	32.10%	17.45%	9.48%	18.48%	22.49%	100.00%
<b><u>1998</u></b>						
Amount	\$34,378,761	\$33,763,072	\$34,216,170	\$33,696,575	\$40,521,033	\$176,575,611
Percentage	19.47%	19.12%	19.38%	19.08%	22.95%	100.00%

Source: Office of Local Health, N.J. Department of Health and Senior Services.

\*Includes fees and reimbursements





**TABLE 2**  
***Examples of Public Health Funding Streams***

A 1999 Institute of Medicine report looked at the vulnerability of safety net providers at the community level. In a section focusing on the myriad of funding sources supporting a typical public health system in an urban setting, the report enumerated a patchwork of funders on federal, state, county, and local levels:

**Federal**

- Medicaid (Title IX)
- Medicare (Title XVIII)
- Federally Qualified Health Center (FQHC) payments
- Health Resources and Services Administration Bureau of Primary Health
- Title V (Maternal and Child Health Services Block Grant)
- Ryan White CARE Act
- CHIP funding (Child Health Insurance Program)
- CDC funding

**State**

- State Medicaid Programs -- Waiver and Expansion Programs
- State Charity Care programs
- State CHIP-based programs
- State public health programs
- Programs to subsidize care for special populations (e.g., infants and mothers)
- Programs to subsidize care for special needs of all populations
- WIC grants
- Immunization Programs

**County**

- County contracts for public health services
- Local public health programs

**Other**

- Foundations -- national and state
- Local contributions
- Self-pay
- Managed care contracts



**APPENDIX**



**TABLE 3**  
*New Jersey Local Health Departments*  
*Full-time Equivalent (FTE) Personnel, 1998*

Factor	Number	Total FTE		FTE / 100,000 Population	
		Median	Range	Median	Range
<b>Structure</b>					
Municipal	47	8.0	1.0 - 90.0	30.2	6.6 - 68.9
Contractual <sup>1</sup>	37	8.4	4.7 - 69.0	26.6	10.3 - 186.8
Regional	5	24.0	6.9 - 32.2	32.6	27.3 - 35.0
County	13	65.8	16.0 - 187.7	29.8	11.8 - 84.9
<i>p value for difference</i>		<i>&lt;0.001</i>		<i>0.698</i>	
<b>Population</b>					
< 25,000	29	5.2	1.0 - 13.0	33.2	10.3 - 84.9
25,000 - 49,999	39	8.8	4.7 - 65.0	26.2	11.8 - 186.8
50,000 - 99,999	20	25.8	9.1 - 79.0	31.0	15.0 - 97.4
100,000 - 249,999	8	39.8	16.0 - 79.5	31.0	6.6 - 45.9
> 250,000	6	105.5	62.0 - 187.7	30.1	15.5 - 41.9
<i>p value for trend</i>		<i>&lt;0.001</i>		<i>0.559</i>	
<b>Budget (thousands)</b>					
< \$100	4	3.5	1.0 - 5.0	26.2	10.3 - 60.0
\$100 - \$500	54	7.0	3.0 - 24.0	27.4	11.8 - 84.9
\$500 - \$1,000	17	11.8	6.0 - 27.7	31.2	15.0 - 52.7
\$1,000 - \$5,000	17	33.0	16.0 - 79.0	36.8	6.6 - 186.8
\$5,000+	10	81.1	15.5 - 187.7	32.2	15.5 - 68.9
<i>p value for trend</i>		<i>&lt;0.001</i>		<i>0.113</i>	
<b>Total</b>	<b>102</b>	<b>9.9</b>	<b>1.0 - 187.7</b>	<b>29.9</b>	<b>6.6 - 186.8</b>

<sup>1</sup> Indicates health departments covering more than one municipality.

Source: Freund and Liu. "Local Health Department Capacity and Performance in New Jersey." *Journal of Public Health Management*. 6(5) 2000.





**FIGURE 1**

***Public Health in America***

**Vision**

Healthy People in Healthy Communities

**Mission**

Promote Physical and Mental Health and  
Prevent Disease, Injury and Disability

**Public Health**

- Prevents epidemics and the spread of disease
- Protects against environmental hazards
- Prevents injuries
- Promotes and encourages healthy behaviors
- Responds to disasters and assists community in recovery

**Essential Public Health Services**

1. Monitor health status to identify community health problems
2. Diagnose and investigate health problems and health hazards in the community
3. Enforce laws and regulations that protect health and ensure safety
4. Inform, educate and empower people about health issues
5. Mobilize community partnerships to identify and solve health problems
6. (a) Link people to needed personal health services and  
(b) Assure the provision of health care when otherwise unavailable
7. Evaluate effectiveness, accessibility, and quality of personal services
8. Assure a competent public health and personal health care workforce
9. Develop policies and plans that support individual and community health efforts
10. Research for new insights and innovative solutions to health problems

Source: Public Health Functions Steering Committee Members (July 1995)





## HIGHLIGHTS

According to the U.S. Public Health Service, during the past 100 years in America, the average life span has increased by 30 years. Population-based health services have added 25 of the additional 30 years to our life spans; only 5 of those years were as a direct result of improvements in medical care. Yet, estimates suggest that less than one percent of the nation's health care expenditures support the essential public health services that have given us those extra 25 years.

When viewed on a per capita basis, Americans spend an estimated \$4,000 per capita each year on personal medical care, compared to an estimated \$44 for population-based public health services.

Public Health's "Identity Crisis" - In a 1999 survey regarding public opinion on public health, 57 percent of those surveyed could not "define" public health. When asked if the U.S. should "do more" to protect public health, 65 percent said it should do more and ranked it only below education as a policy area which should receive additional funding support.

The traditional methodology of public policymaking - problem identification, research, policy solution, implementation - may not apply to public health, a field where having the infrastructure in place to "anticipate" problems leads to a convoluted path to reaching the first step of problem identification (Berkowitz, 1999).

"At all levels of government, but particularly the local level, officials are hamstrung by limited funding... Although states have been given considerable flexibility in their use of block grants, this restrictive funding mechanism has often compromised the ability of local agencies to meet the particular needs of their communities, especially as the grants are not discretionary" (Institute of the Future, 2000).

Current obstacles to supporting public health functions and services include the following:

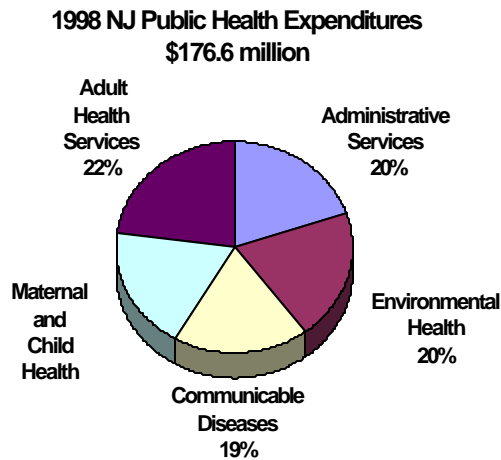
- a funding structure where core functions are inadequately funded and a disproportionate percentage of funding is targeted for direct provision of services;
- competition for funding which compromises a shift towards collaboration and cooperation;
- fragmentation of the delivery system;
- poor integration of services;
- limitations of capacity on both technical and organizational levels;
- data limitations, resulting in unreliability in showing hard outcomes for essential public health services.

A 1996 study of nine states, "Measuring Expenditures for Essential Health Services," found that:

- Population-based health services spending - \$2.7 billion (or \$36 per capita) - was only one percent of total health care expenditures (\$3,342 per capita) in the participating states;
- Predominance of personal health services in the public health system - more than two of every three dollars spent by the nine states on essential public health services (\$6.1 billion of \$8.8 billion) went for personal health services;
- Of the \$2.7 billion spent on population-based services, the largest amount (26 percent) was for enforcing laws and regulations protecting the public's health and safety; training (4 percent) and research (2 percent) showed the smallest investments;
- States were the largest funders of population-based services, providing 50 percent of the funding for these activities; federal funding accounted for 32 percent and local and other sources (fees and reimbursements) supported the remaining 18 percent of population-based health expenditures;
- Thirty-four percent of the \$7.1 billion funded by the U.S. Public Health Service on essential public health services supported research efforts, indicating the federal government's strong role as researcher in public health.



New Jersey's public health system – which is a decentralized system comprised of activities and functions at state, county, and local levels – is strongest at the local level. There are an estimated 524 boards of health and 115 local health departments. These public health agencies range in size from extremely large organizations (some 400 FTE's) to small agencies (2.5 FTE's); however, public health laws and regulations affect each of these entities in the same way.



It is estimated that in New Jersey, approximately 3 percent of all health financing comprises the public health budget; of that percentage, an estimated 2.1 percent supports the delivery of medical services, leaving less than 1 percent of the state's health dollars supporting essential public health activities.

In the years 1994, 1997 and 1998, local tax and other revenues supported the largest portion of public health services (averaging 75 percent); state and federal sources for all three years averaged approximately 23 percent.

In 1997, over \$184 million was budgeted for public health services in New Jersey. According to current DHSS estimates, New Jersey's total public health budget in 1998 was \$176.6 million (down 4 percent from 1997).

These public health expenditures are fairly evenly divided among five major categories: administrative services (including administration, nurse referrals and health education; environmental health (including food surveillance, recreational safety, etc.); communicable diseases; maternal and child health services and adult health services (including flu shots).

New Jersey's state Public Health Priority Funding has experienced funding levels of between \$3 to \$4 million for several years. Current state support for Priority Funding is \$4.165 million; distribution is by state formula to municipalities, with certain demographic criteria applied to each recipient (N.J.S.A. 26:2F).

New Jersey public health researchers Freund and Liu found that the organizational structure of New Jersey's local health departments is primarily municipal (45.2 percent) or contractual (37.4 percent). Yet county health departments (14, or 12.2 percent of public health providers) serve more (40.2 percent) of the state's population than any other group (1998).

Over half (58.8 percent) of the local health departments in New Jersey had annual budgets of less than \$500,000 and almost three-quarters of them (73.5 percent) administered their operations on annual budgets that totaled less than \$1 million.

According to New Jersey experts, the goal of obtaining a consistent and reliable picture of public health financing is compromised because of the parameters of its administrative and operational structure: each locality uses different definitions and forms of accounting structure.

NB: All expenditure data and statistics are referenced in the Issue Brief text.