COMMITTEE FINDINGS

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JOINT SELECT COMMITTEE ON PUBLIC HEALTH FINANCING: FINDINGS

1. What is the role of Washington's public health system?

- **Investments in public health have improved well-being, saved lives, and saved money through its focus on disease prevention and health promotion.**

  Promoting healthy, prevention-based behaviors and providing a safe environment have been at the core of public health's work. In addition to increasing the quality and number of healthy years of the population, these measures have been demonstrated to be cost-effective strategies that save money that would otherwise be spent later on health care services.

- **By their nature, public health services are provided on a continual basis in order to detect and prevent injury and illness.**

  Although they may not be visible to the public, many of the activities of the public health system are in a constant state of activation in order to monitor and safeguard community health conditions.

- **Public health services in Washington are provided through a decentralized system involving 35 different local health jurisdictions that receive local, state and federal support.**

  Public health is one of state and local government's earliest functions in Washington. Counties have traditionally provided much of services and have been governed by local health boards.

- **The benefit of establishing priorities at the local level has resulted in differences in basic core services.**

  Washington's public health system has traditionally allowed local governments to establish priorities for public health activities in accordance with their views of their constituents' needs. While such a system promotes local control, the types of public health services that are offered across the various jurisdictions statewide vary in their availability and quality.

- **Through the Public Health Improvement Plan, the public health system in Washington has developed process measures for local health departments and the state department of health. This work has been recognized as a national model and provides a solid foundation for the public health system to begin defining indicators to measure its quality and effectiveness.**

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The process measures describe basic functions that health departments are expected to perform, regardless of size or specific services provided. By design, the standards do not describe the incidence of individual diseases or health conditions. In future work, the PHIP standards assessment process will provide data on service quality and begin to link specific disease indicators with performance assessment.

- **As the needs of Washington's residents have changed over time, the responsibilities of the public health system have also changed.**

  Emphasis in earlier parts of the twentieth century focused on the control and treatment of communicable diseases such as tuberculosis. Later, additional functions were added as traditional functions appeared to yield some successes.

2. What are the emerging developments in public health?

- **Increased efficiency in transportation has required that local public health officials be aware of health risks from all parts of the world.**

  Washington's geographic location and economy have made it a hub for international activity which brings people and goods into the state every day. This activity has increased the potential risk that its citizens could be exposed to public health hazards once considered foreign. The recent SARS outbreak in China that migrated to Toronto is an example of such a threat.

- **Recent disasters, both local and global, have raised concerns about including public health systems as a component of emergency preparedness efforts.**

  Emergency preparedness planning may benefit from several capabilities of the public health system, including its ability to identify diseases; coordinate the responses of health care personnel and facilities; and distribute medicines and medical equipment.

- **Certain conditions thought to have been controlled have reemerged.**

  The reappearance of tuberculosis and other diseases after they were believed to have been contained has in recent years added to the demands on public health.

- **The public health system has coordinated links to health care for those with unmet needs.**

  The lack of access to certain health care services has meant in a number of places that public health resources have been spent coordinating care services for individuals with unmet needs.

- **Public health approaches have been applied to reduce the prevalence and the health effects of certain chronic conditions that have been increasing in the population.**

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Public health may be used to change unhealthy behaviors, as evidenced by tobacco cessation efforts, using prevention-based strategies to deter the onset of the conditions caused by these behaviors.

- **Home visits from public health nurses have helped to promote healthy practices and habits in families.**

  Some evidence suggests that home visits from public health nurses to at-risk, first-time mothers can produce social and health benefits for both the mothers and their children.

- **Fees are an appropriate basis for certain environmental health activities, but are not applicable for certain other activities. While retaining the current fee-based structure as much as possible, other environmental health areas lack funding and need another sort of funding structure.**

  While fees are used to cover the cost to conduct environmental health activities directly related to the human activity being conducted, they are not a practicable means to fund all threats that the environment poses to public health. These threats come from the natural environment, such as West Nile Virus, the human "built" environment, such as mold or lead in schools, or a combination of the two, such as failures in on-site sewage systems.

- **The public health system must use the work of the Public Health Improvement Plan to move forward with the identification of performance and health indicators that can provide comparative analysis and measurement of agency performance and the ability of public health interventions to improve health outcomes.**

  As a result of the PHIP assessment findings to date, significant investments are being made to improve evaluation strategies for public health programs that address specific health problems. Service quality and health indicator data will be available for every county, and the underlying causes of health problems will be described. Service quality and health indicator data must be developed in such a way that fair and objective comparisons of different local health jurisdictions can be made. Public health programs should be designed to use evidence that an intervention works, and to calculate the costs and benefits of these efforts.

3. What are the public health funding structure and trends?

- **State and local governments spent about $590 million on public health services in Fiscal Year 2004.**

  About half of this spending was by the state Department of Health (DoH) on statewide activities, and the other half occurred locally, by the 35 local health jurisdictions (LHJs).

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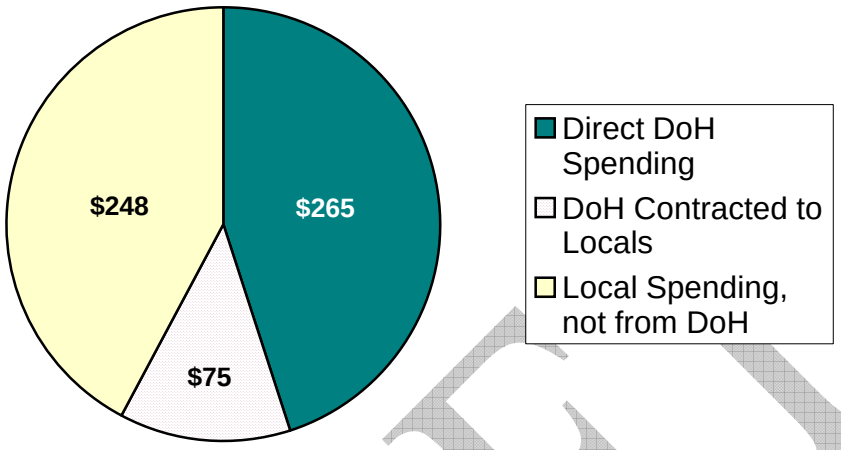
FY 2004 Public Health Spending

Dollars in Millions



- **State and local governments use five principal strategies to prevent disease and promote health.**

  At the state level, almost two-thirds of spending is in the broad category of health promotion. This reflects inclusion in that category of federal funding for the Women, Infant, and Children (WIC) nutrition program, childhood immunizations, and a variety of disease-specific federal categorical grants. Local health department spending is directed more equally across the full range of public health strategies.

	State Health Department*	Local Health Departments*	Statewide Total
Stopping Communicable Disease (includes maintaining emergency response capacity)	**$1**	**$67**	**$68**
Promoting Healthy Lives (includes chronic disease prevention, and support to high-risk families and pregnant women)	**$172**	**$85**	**$257**
Assuring Safe Food, Water, & Air	**$22**	**$56**	**$78**
Using Health Information to Guide Decisions	**$12**	**$25**	**$37**
Helping People Access Medical & Dental Care	**$25**	**$65**	**$90**
Administration	**$32**	**$25**	**$57**
TOTAL	**$265**	**$323**	**$589**

** $75 million of federal and state funds contracted by the state DoH are shown as a local health department expenditure. Totals do not include $23 million of fee-supported DoH health professional and facility regulatory activities.*

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- **Public health expenditures comprise 3.2 percent of state government's total estimated health care spending for the 2005-07 biennium.**

  Of the estimated $6.9 billion of state funds Washington state government is budgeted to spend on health care in fiscal years 2006 and 2007, $223.7 million is budgeted for expenditure on public health.

- **Public Health in Washington is financed by a complex, and often confusing, variety of sources.**

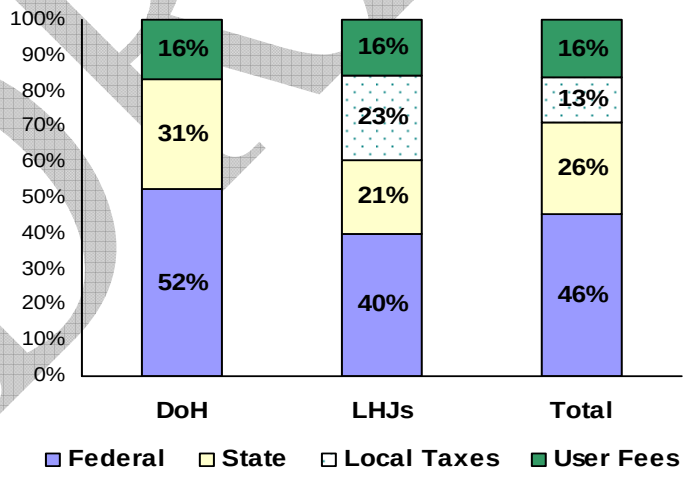
  These include:

  → federal grants – some ongoing, and some for short-term demonstration purposes only – for specific functions such as WIC, childhood immunizations, AIDS treatment and prevention, emergency preparedness, water quality, family planning, and a range of disease-specific conditions;

  → annual state appropriations from General Fund-State (GF-S) and Health Services Account taxes, and from the state's tobacco lawsuit settlement;

  → appropriations from local tax sources by county governments and, in some cases and to a more limited extent, cities; and

  → fees charged for state and local regulatory activities in areas such as food handler permits, restaurant inspections, septic system inspections, and issuance of birth and death certificates.



- **There is little dedicated state or local revenue for public health.**

  In 1993, the Legislature dedicated 2.95% of the Motor Vehicle Excise Tax (MVET) to local public health, but this was repealed in 2000 following passage of Initiative 695. At one time, county governments were obligated to spend 21.5 cents per $1,000 of local

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assessed valuation on tuberculosis control and public health, but this statutory restriction on use of local property tax revenues was repealed in 1977. Currently, a small portion of cigarette taxes and tobacco settlement funds are dedicated to tobacco prevention and control programs.

- **State and local public health officials and experts report that the need for additional funding is particularly critical at the local health jurisdiction level.**

  For the past five years, these officials and experts have been engaged in an intensive and comprehensive effort to define the services that need to be delivered by a fully functional local health department, and to quantify what it should cost to deliver those services. Based upon a rigorous review and refinement of that work conducted at the Joint Select Committee's request, these officials and experts concluded that total local-level spending would need to almost double from the 2004 level in order to assure fully adequate level of public health services for Washington state residents:

Estimated Spending Needed
To Assure a Functional Local Public Health System
(Dollars in Millions)

	LHJ Spending In FY 04*	Estimated Spending Needed	Unment Funding "Gap"	% Increase Needed to Fill Gap
Stopping Communicable Disease (includes maintaining emergency response capacity)	**$73**	**$153**	**$80**	**110%**
Promoting Healthy Lives (includes chronic disease prevention, and support to high-risk families and pregnant women)	**$92**	**$188**	**$96**	**104%**
Assuring Safe Food, Water, & Air	**$61**	**$134**	**$73**	**120%**
Using Health Information to Guide Decisions	**$27**	**$64**	**$37**	**135%**
Helping People Access Medical & Dental Care	**$70**	**$99**	**$29**	**41%**
TOTAL	**$323**	**$638**	**$315**	**97%**

** Administration and support costs, at approximately 8% of total, are allocated across direct service functions proportional to the cost of those functions.*

- **Spending on Washington's public health system increased by 18% during 1998 – 2004, after controlling for inflation and population growth.**

  State department-level spending increased by 20% per resident. Local department-level spending increased by 16% per resident though, as discussed later, this statewide average masks significant variation among individual local health departments, with some seeing an increase in total spending, and others not. During this same period, total personal

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health care expenditures in Washington increased by 38% per resident, after controlling for inflation.

However, the prospects for similar increases in the near future are uncertain.

- **Over 70% of the 1998-2004 spending growth was due to increased federal funding. Washington's public health system has become increasingly reliant upon federal financial support.**

  → federal funding for public health is discretionary and has been reduced in many areas.

  → federal grants almost always carry "categorical" restrictions which require that they be used only for specific purposes such as WIC, bio-terrorism, AIDS, or demonstration projects. As a result, these federal funds often can't be used for activities state and local health officials judge to be of equal or greater importance to assuring the public's health.

- **Approximately 13% of the 1998-2004 growth in public health spending per resident was due to fee increases, which increased 15% faster than inflation during this period at both the state and local levels.**

  The capacity to address gaps in current public health services through additional fee increases is limited, since:

  → The benefit of certain kinds of public health activities accrue to the public at large and over long periods of time, and cannot be linked directly to any one fee payment. These include activities such as working with infected people and their contacts to stop the spread of communicable disease; educating the public to prevent accidents and the development of chronic diseases; testing air, water, soil, and dead animals for the presence of health hazards; and analyzing data to identify community health risks, disease patterns, and effective intervention strategies.

  → Increasing fees in existing fee programs to too high a level – for example, for septic system permits, or for immunizations –may discourage compliance, resulting in greater health risks for the general public. In addition, fees that are out of proportion to the benefits received invite judicial scrutiny – the courts have interpreted such financing mechanisms to be taxes, irrespective of the nomenclature.

  → Shifting staff from fee-supported activities to respond to public health emergencies such as disease outbreaks results in reduced revenues at the very time additional resources are needed most.

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- **The remaining 17% of the increase in state and local public health spending between 1998 and 2004 was due to two ongoing, but static, infusions of new state funds:**

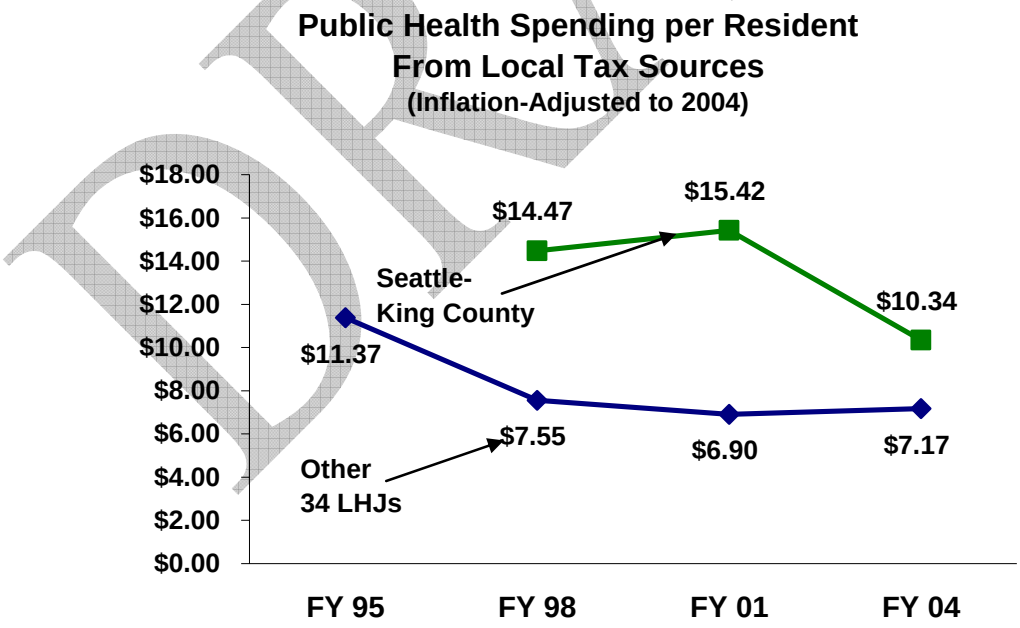
  → $24 million to "backfill" approximately 90% of what local health departments received from the MVET prior to its 1999 repeal. This appropriation has not been increased for inflation since 2003.

  → $26 million per year for tobacco-use prevention and cessation activities. Approximately half of this expenditure has been funded from $100 million that was set-aside for that purpose from the first payments the state received under the national tobacco lawsuit settlement. That set-aside will be depleted by 2009. The balance is a portion of the cigarette tax increase levied in 2001 by Initiative 773.

  After controlling for these two ongoing, but static, infusions and inflation, state funding per resident actually decreased by about 25% between 1998 and 2004.

- **On a statewide basis, local tax spending on public health decreased by about 15% between 1998 and 2004, after controlling for population growth and inflation.**

  However, as shown below and on the next page, there is considerable local variation. Local tax support for public health in Seattle-King County decreased by about 30% during this period. It decreased by only about 5% in the other 34 local health jurisdictions, but averaged about 30% less per resident than in King County.



- **These decreases in county tax support seem likely to continue, if:**

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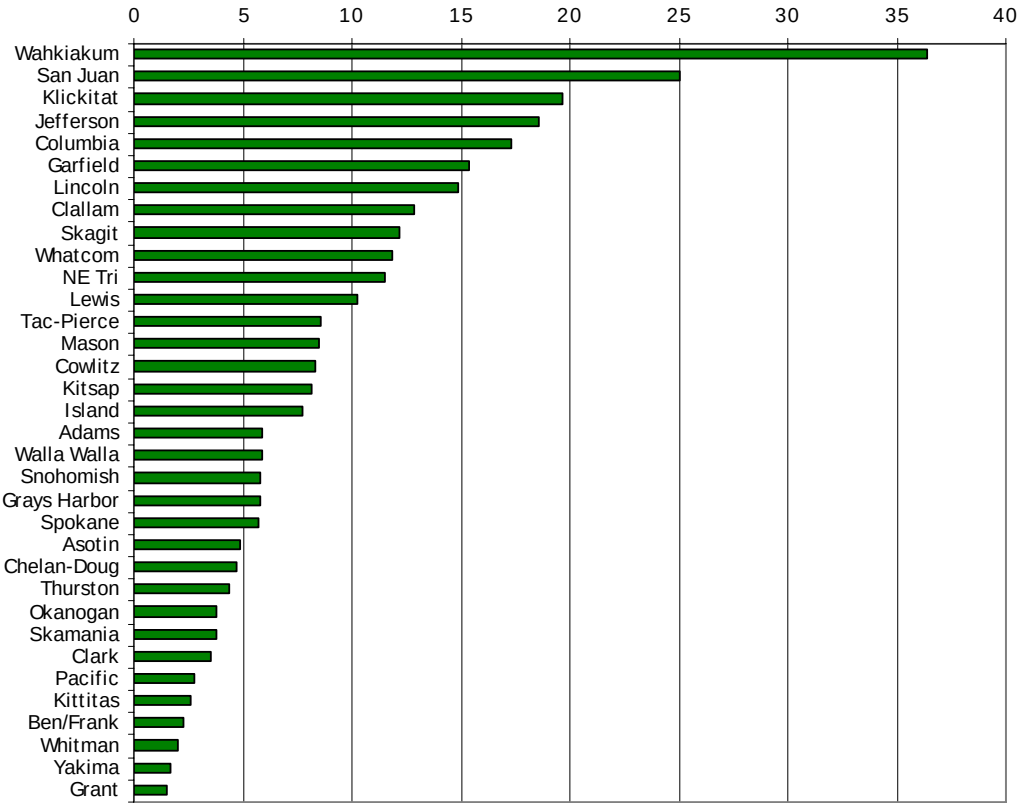
→ There are continued increases in criminal just costs, which have grown from an average of 62% of county general fund revenues in 1998, to an average of 66% in 2004.

→ Initiative 747 is upheld. I-747 has limited growth in property tax revenues to 1% per year since 2001, unless a higher level is approved by referendum.

Figure 7: Total Per Capita Local Government Contributions by LHJ in 2005 Dollars, 2004
(Total does not include permit/fee revenue or fund balance)



Note: This chart does not include data for Seattle-King County Public Health. The chart on page 9 contains per resident spending data for Seattle-King County Public Health that may be used for comparison on this chart.

- **These differing levels of local tax support result from a combination of factors, including:**

→ differences in local property, sales, and real estate excise tax bases;

→ differing local spending commitments, particularly for criminal justice, which is the largest area of expenditure for most counties. For example, in 2004, San Juan County spent 37% of its general fund revenues on law and criminal justice

services; Wahkiakum spent 53%, and Whatcom County 54%. By contrast, law and criminal justice services comprised 61% of King County's general fund revenues; 66% of Pierce County's; and 67% of Grant's.

→ differing levels of demand on the local public health system, particularly in areas with large concentrations of low-income and immigrant populations.

- **These differences in local taxing capacity, local spending capacity, and perceived local needs limit the extent to which local-options taxes can be relied upon to assure availability of a basic level of local public health services statewide.**

4. What are the priorities of the public health community for additional investment in public health today?

- **The public health community has undertaken a thoughtful and deliberative process to establish its priorities for potential additional investment in the public health system.**

  Public health experts from around the state were convened in special workshops to develop priorities for additional investment in the public health system and to estimate the staffing support needed. Priorities were grouped into three levels of investment. In selecting priorities and estimating costs, the community focused on needs believed to exist statewide and utilized other criteria to guide their decision-making. The recommendations allow for an even distribution of new resources to serve all communities.

- **The public health community's priorities for additional investment in the public health system reflect both existing and emerging needs of the system.**

  The public health community believes the greatest unmet needs to be workers and information tools that would help to stop the spread of communicable disease, reduce the growing impact of chronic disease, and help support at-risk families and teens to avoid problems. In addition, the community believes that protecting food, water and air are basic responsibilities that cannot be neglected, and that helping people get the critical health services they need will help them lead healthier lives.

- **The priorities of the public health community for additional investment in the public health system, as documented in "Creating a Stronger Public Health System" presented to committee members at the May 25, 2006 meeting, is a reasonable template that the committee may rely upon in considering and formulating its own recommendations for future investment in the system.**

  The public health community's priorities document sets out issues, needs, and proposed actions that have been thoughtfully considered. The expertise and input from the community in its prioritization process means that the product is of significant import and value.

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COMMITTEE CONCLUSIONS

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JOINT SELECT COMMITTEE ON PUBLIC HEALTH FINANCING: CONCLUSIONS

1. Delivery, governance, and funding of local public health services must continue to be a joint responsibility addressed in close and cooperative partnership between state and local government. Neither level of government has the resources, funding, knowledge, or expertise to accomplish the work alone.

2. Events in the 21st century have changed the face of public health. These include the 9/11 attacks, bioterrorism, rapidly and newly emerging communicable diseases like SARS, multiple-antibiotic resistant tuberculosis, avian flu, and more. Threats are often more global, jeopardizing the health of tens of thousands of citizens in a short time frame.

3. Other non-communicable, population-based illnesses and conditions related to personal health behaviors, such as childhood and adult obesity and diabetes, are emerging challenges. If not addressed through prevention and health promotion efforts, including changes in the built environment, these conditions may shorten the lives of future generations while incurring unsustainable increases in healthcare costs.

4. There is a need for additional investment in local public health services, particularly in the areas of:

    a. communicable disease prevention and response;

    b. preparedness for and response to the public health emergencies that might emerge from pandemic disease, earthquake, flood, or terrorism;

    c. prevention and supportive management of chronic diseases and disabilities;

    d. promotion of healthy development in young children and mothers; and

    e. collection and analysis of data to identify local health trends, and to evaluate program effectiveness.

    Strengthening communicable disease prevention and response infrastructure has been clearly and strongly identified by all stakeholders as the highest and most urgent priority statewide.

5. The Joint Select Committee on Public Health Finance required a statewide assessment of current state and local public health functions, as well as deficiencies and gaps, and a prioritization of the relative importance of those gaps. In response, The Statewide Priorities for Action was developed by the Washington State Association of Local Public Health Officials, with assistance from the Washington State Department of Health and the Washington State Board of Health, representing a thoughtful, deliberative, and promising blueprint for effectively distributing additional resources in order to create a stronger public health system.

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While acknowledging the reality that local needs vary from jurisdiction to jurisdiction, the Committee recognizes the Priorities for Action as a consensus statement that describes needed activities to address statewide gaps in the existing services that public health provides, prioritizes those activities, and quantifies the costs of the activities. This is not an endorsement of the specific findings.

6. Differences in local tax bases, statutory limitations on local revenue growth, and the large and growing demand that law enforcement and criminal justice costs place on county resources, coupled with choices that local governments make in prioritizing and assigning available funds, have resulted in a differential in the level of public health services delivered from one jurisdiction to another, and in the extent of per capita public health funding expended in each jurisdiction. The funding for local public health not only varies from one jurisdiction to another, but in some cases is insufficient to ensure delivery of essential services. Discretionary funding at the local level has stagnated or been reduced over time.

7. Some services (or "core functions") are so essential to the state's public health without regard to jurisdictional boundaries that the state should help to ensure that a certain basic level of competence and capacity in these functions be present consistently throughout the state. This is an appropriate role for the state given the expanded and changed need for public health. Enhanced state funding should be used along with maintenance local funding to help achieve the needed capacity and competence in core functional areas.

8. In addition, representatives of local governments also recognize the importance and need for improved public health services in the current environment. Local jurisdictions must play a role in providing some of the additional funding resources and deciding how they are spent to avoid recurrence or exacerbation of current disparities in funding and service availability across jurisdictions. The historic erosion of funding support from cities and counties should be addressed.

9. The lack of a stable source of funding provided specifically for public health services has eroded the ability of local health jurisdictions to maintain a reliable statewide system that protects the public's health.

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COMMITTEE RECOMMENDATIONS

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JOINT SELECT COMMITTEE ON PUBLIC HEALTH FINANCING: RECOMMENDATIONS

Delivery of public health services should focus on core, priority services and maximize efficiency:

1. Certain core public health functions should be consistently available in all parts of the state. These core public health functions include stopping communicable disease, promoting health, investing in healthy families, protecting against environmental health risks, and helping people access care. Enhanced state funding shall be provided to those core functions that have a statewide impact.

2. Any additional state assistance should be conditioned on the requirement that each local health jurisdiction receiving funds should meet an acceptable level of performance with respect to core functions, focusing first on existing functions provided at less than a basic level and then on the prioritization of gaps identified by local public health stakeholders in "Statewide Priorities for Action"[1].

3. Multi-jurisdictional or regional efforts should be undertaken whenever appropriate and possible to deliver services more efficiently. Mutual aid networks should be established to address significant public health emergencies.

4. Performance measurement tools to assess the quality of delivery of public health services and more transparent indicators that provide a clearer picture of the status of the health of the public should be developed to allow policymakers and the public to more easily evaluate the effectiveness of public health system performance and the impact of any additional investment of state funds. These tools and indicators should build upon the progress already made through the "Standards for Public Health in Washington State" since 1994.

State funding for public health activities:

5. The state should maintain its current investment in public health funding and provide additional investments through a stable and dedicated funding source or sources. There must be a report back to the Legislature demonstrating how expenditures have been used to meet core functions.

[1] "Statewide Priorities for Action" document is available from the Washington State Association of Local Public Health Officials (WSALPHO), the Department of Health (DOH), or the Legislature.

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6. The additional investment should seek to mitigate disparities in local jurisdictional core function capacity and competence and per capita funding and to strengthen the current system.

7. The state should provide additional funding in the amount of approximately $50 million annually during the ’07-’09 biennium, as an initial investment. This funding should come from tobacco tax revenues that currently deposited to the General Fund.

8. A dedicated account for public health revenues should be established.

9. The committee adopts the Recommended Distributional Formula.

Local funding for public health activities

10. Local governments should play a role in financing the additional investment in public health services.

11. To qualify for the additional state funding, local governments should be required to maintain at least their current level of funding for public health.

12. Further discussion of the establishment of local option tax authority is needed to identify the merits of authorizing any such funding, as well its purpose and character.

Long-Term, Overall Funding

13. These funding recommendations are the first step in what must be continuing state and local efforts to fund the public health system at a level that provides the capacity to effectively deliver the five core functions.

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JOINT SELECT COMMITTEE ON PUBLIC HEALTH FINANCING: RECOMMENDED DISTRIBUTIONAL FORMULA

The Committee recommends that, in legislation developed to provide additional state funding for local public health, the legislature consider a four-part distributional formula based on the following concepts in this order of priority.

- For a first portion of the funding, distribute finds based on a sales tax equalization approach (i.e., provide funds to jurisdictions with below-average taxing capacity to raise revenues to a set percentage of the statewide average per capita local general sales tax collections), but require that funds be utilized for core public health functions.
  - *Rationale:* To mitigate public health deficiencies that result from disparities in tax bases.

- For a second portion of the funding, distribute on a per capita basis and possibly based on other factors reflective of local demand for services (e.g. prevalence of illness or condition, or rate of illness or condition; factors/formula to be worked out later with local public health input).
  - *Rationale:* To provide equity in funding based on disparities in burden of need for core functions, as measured by population and potential other factors.

- For a third portion of funding, provide a financial incentive for local jurisdictions to increase local investments in core public health function.
  - *Rationale:* To enhance the public health system as provided in "Statewide Priorities", and to ensure a state/local funding partnership in the financing for the funded priorities.

- For a fourth portion of funding, distribute funds to jurisdictions that develop creative and/or more cost effective ways in delivering public health services on an inter- or multi-jurisdictional basis.
  - *Rationale:* To promote innovative thinking and improvements in the delivery of services, and foster interjurisdictional approaches.

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