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JOINT SELECT COMMITTEE ON PUBLIC HEALTH FINANCING: DRAFT FINDINGS

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

- **Investments in public health improves well-being, saves lives, and saves money through its focus on disease prevention and health promotion, yet spending on public health is considerably less than spending on medical care.**

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

- **Although its work often takes place out of public view, the public health system is continuously activated, providing Washington residents with "round the clock" protection against injury and illness.**

  The public health system is constantly working, protecting against communicable disease and environmental health hazards, preventing chronic disease, providing access to essential health services, and preparing for emergencies. These activities are seldom witnessed by the public and are often taken for granted, leaving many unaware of their value, and the costs and effort associated with them.

- **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 come at the expense of uniformity in the statewide public health system.**

  The decentralized nature of Washington's public health system has allowed local governments to establish priorities that are responsive to the populations that they serve, but has also led to a lack of uniformity in the types of public health services offered and the level of performance that each local health jurisdiction is

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capable of providing them. As a result, it is not possible to identify a minimum set of public health services that every citizen in Washington can depend on.

- **Through the Public Health Improvement Plan, the public health system in Washington has developed process measures to determine the performance of local health jurisdictions relative to each other.**

  In its twelve years of existence, the PHIP has begun a process of establishing uniform standards that local health jurisdictions must strive to meet in performing the duties associated with certain public health activities. These standards are the first step to developing uniform expectations for citizens across Washington to hold public health accountable in its work.

- **Despite changing needs over the course of the state's history, the importance of public health has remained strong.**

  Emphasis in earlier parts of the twentieth century focused on the control and treatment of communicable diseases like tuberculosis, etc. 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 requires that local public health officials always be vigilant of threats from all parts of the world.**

  Washington's geographic location and its strong commercial position have made it a hub for international activity which brings people and goods into the state every day. This activity also makes Washington vulnerable to threats that may have once been considered foreign. The recent SARS outbreak in China that migrated to Toronto is an example of such a threat.

- **The increasing awareness of the potential occurrence of large-scale crises has reinforced the role of public health as an essential component of statewide emergency preparedness.**

  One of the critical determinants of an effective response to an emergency – natural, biological, or human-made – in Washington will be the strength of the public health system, including its ability to identify diseases; coordinate the responses of personnel and facilities, and distribute medicines and medical equipment. The threats posed by a pandemic flu, large-scale earthquake or tsunami, or terrorist event require that the public health community be able to respond in a timely, coordinated manner with the appropriate resources.

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- **There is a tendency to become complacent about diseases and conditions believed to have been controlled, only to find their recurrence once public health efforts have been relaxed.**

  The reappearance of tuberculosis and other diseases after they are believed to have been contained demonstrates the need for policy makers to maintain support for a vigorous public health system characterized by continued vigilance.

- **As access to certain health care services decreases, there is increasing pressure on the public health system to provide for these unmet needs.**

  The lack of access to certain health care services, including mental health services and chemical dependency services, strains the resources of public health officials as people turn to public health as a last option for assistance. Public health resources are spent coordinating care services for these individuals.

- **There is an opportunity for public health measures to be applied to the challenge of reducing the prevalence and the health effects of certain chronic conditions that have been increasing in the population.**

  The success of Washington's tobacco cessation efforts demonstrate that public health approaches to certain chronic conditions can prevent their development and lessen the severity of the illnesses. Public health's ability to change unhealthy behaviors offers an opportunity to apply prevention-based strategies to deter the onset of the conditions caused by these behaviors. One example is a diet and exercise campaign against obesity that would prevent the heart disease and diabetes associated with that behavior-related condition.

- **Public health, through programs such as nurse home visits, promotes healthy practices and habits that translate into healthy families.**

  There is a proven track record that shows that visits by public health nurses to at-risk first-time mothers tend to create supportive environments for the children, self-sufficiency for the parents, and reduced use of future public assistance.

- **There are emerging threats posed by environmental hazards that the current structure of public health cannot adequately protect against due to the fee-based structure of funding environmental health.**

  While fees cover the cost to conduct environmental health activities directly related to the human activity being conducted, they do not account for 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,

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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 in Washington is moving toward a system of performance measures to promote accountability for the delivery of quality services.**

  The Public Health Improvement Plan process has resulted in statewide process measures that local health jurisdictions use to evaluate the effectiveness of the services that they provide. As standardized data become available, Washington's public health system will be able to move toward performance measures that evaluate the actual outcomes that public health is achieving.

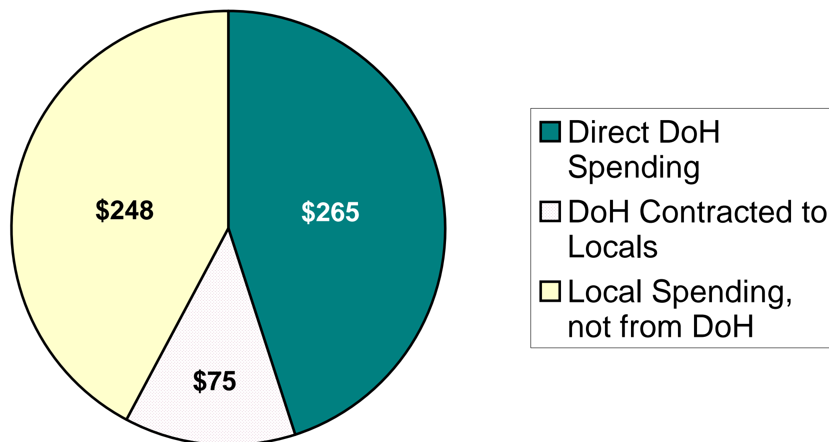
3. What is the public health funding structure and trends?

- **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).

FY 2004 Public Health Spending

Dollars in Millions



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- **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.*

- **Public Health spending is a very small share of total health care spending, and has grown much more slowly.**

  The federal Department of Health and Human Services estimates that a total of $32.25 billion was expended on personal health care in Washington in 2004. That is over 50 times the amount expended that year by Washington's state and local public health departments. Total personal health care expenditures in Washington grew by $6.5 billion – 30% -- between 2001 and 2004, according to federal estimates. State and local public health expenditures grew by $79 million – 15% -- during the same period, primarily because of the availability of new funding from the state tobacco lawsuit settlement, and federal bio-terrorism grants.

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

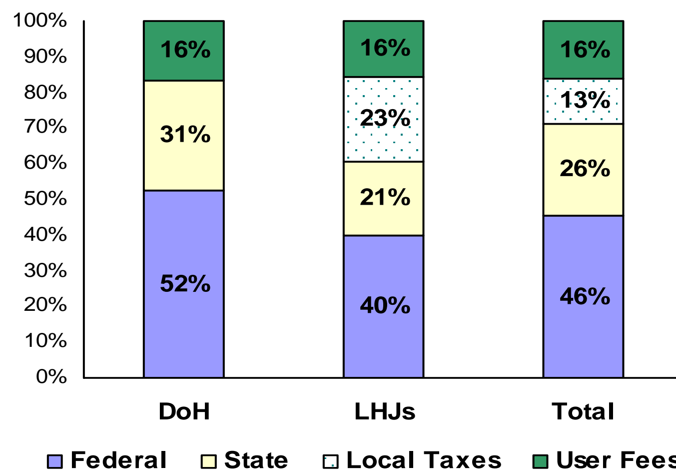
  These include:

  → 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 source 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 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.

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- **Washington's 1993 health care reform legislation recognized the critical role Public Health could play in preventing illness and reducing medical cost inflation, and held out the possibility of future state funding increases, after development of statewide public health standards and the completion of local needs assessments. However, significant state funding increases never occurred, for a variety of reasons.**

  These included passage of Initiative 601, which limited future increases in state spending; the determination that the hospital business and occupations tax that was expected to finance a significant portion of health reform activities could not be applied to hospitals' revenues from Medicare and Medicaid; and the repeal of the Motor Vehicles Excise Tax, as discussed above.

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

  For the past five years, these 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 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:

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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.

However, future similar increases seem unlikely.

- **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 is discretionary, and seems likely to be reduced as national leaders increase their efforts to reduce the federal deficit without making significant cuts in entitlement or defense spending.

  → 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

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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:

  → It is often not feasible, not fair, or not beneficial from the perspective of the community as a whole to charge any particular beneficiary for important pubic health services. 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 to too high a level – for example, for septic system permits, or for immunizations – can 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.

- **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

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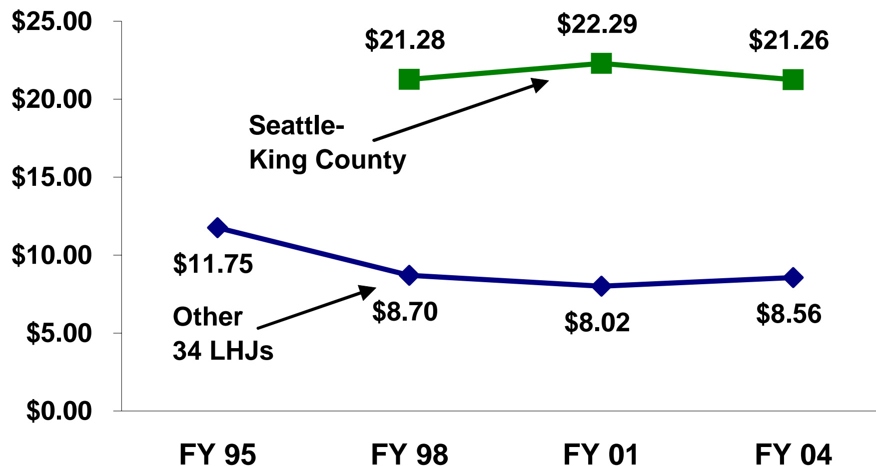
be depleted by 2009. The balance is a portion of the cigarette tax increase levied in 2001 by Initiative 773.

After controlling for these two one-time 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 slightly 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 remained stable at about $21 per resident throughout this period. In the 34 other local health jurisdictions, it averaged less than half that much per resident, and decreased by about 27% after controlling for inflation.

Public Health Spending per Resident
From Local Tax Sources
(Inflation-Adjusted to 2004)



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

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

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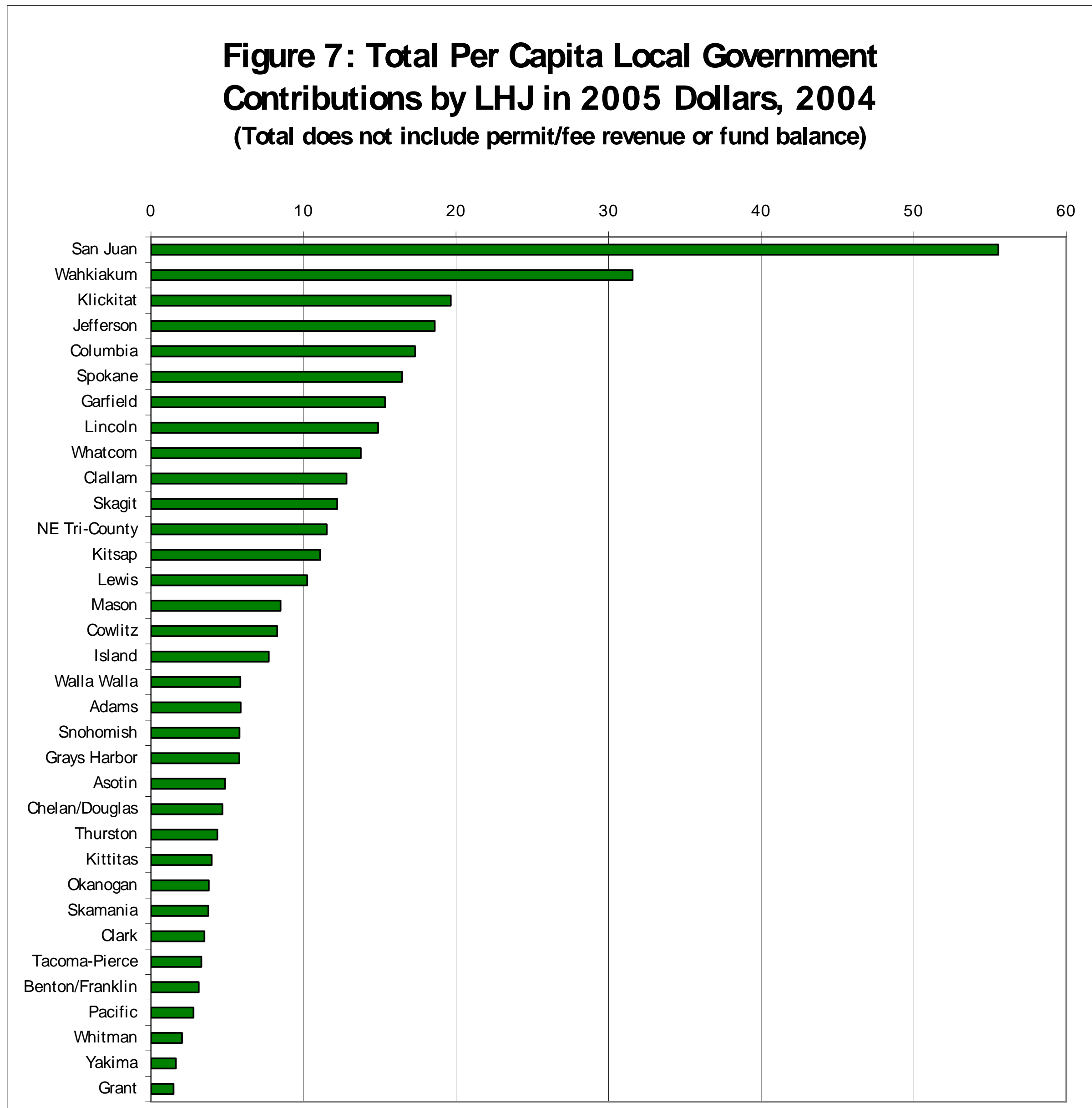

- **These differing levels of local tax support result from a combination of factors, including:**

  → 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

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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.

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- **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, sets an appropriate starting point from which the committee may establish 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.