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Folder Title:
Health and Economic Impact of Core Public Health Functions 1/21/94

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

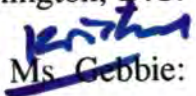
Office of the Assistant Secretary
for Health
Washington DC 20201

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FEB - 9 1994

FEB 14 1994

Kristine Gebbie, R.N., M.N.
AIDS Policy Coordinator
Executive Office of the President
750 17th Street, N.W., Suite 1060
Washington, D.C. 20500

Dear  Ms. Gebbie:

Many thanks for your participation at our planning meeting for the *Health and Economic Impact of Core Public Health Functions* project and your willingness to brave the Washington weather in the depths of January. A great deal of helpful material, interesting methodology, and sage advice was harvested from that day and will serve the report well.

We will be moving forward on a rapid time-table in order to finish an early version of this work by June and keep in front of the health care reform process. Marthe Gold and/or Steve Teutsch will be contacting you in order to solicit your input into parts of the project relevant to your areas of expertise and will keep you informed as the report progresses.

Again, I am most grateful for your support in this endeavor and look forward to a strong future for public health in this health care reform.

With best personal regards,



J. Michael McGinnis, M.D.
Deputy Assistant Secretary for Health
(Disease Prevention and Health Promotion)

cc: Dr. Marthe Gold
Dr. Steven Teutsch

AGENDA
Health and Economic Consequences of Core Public Health Functions
Project Planning Meeting

Hotel Sofitel
1914 Connecticut Avenue, NW
Washington, D.C.
January 21, 1994

10-10:20 am

Welcomes, Introductions
Context for Project
Charge to the Group
Dr. Michael McGinnis
Deputy Assistant Secretary for Health
(Disease Prevention and Health Promotion)

10:20-10:30

Project Description and Progress to Date
Dr. Marthe Gold
Office of Disease Prevention and Health Promotion

10:30-10:45

Role of the meeting Participants and Review
of the Agenda
Dr. Steven Teusch
Centers for Disease Control and Prevention (CDC)

10:45-12:00

Small Group Meetings: Developing Examples

Participants are divided into two pre-assigned groups (*see Participant List*).

Members of group A are asked to identify six to eight illnesses/ conditions or interventions where core public health functions either historically or currently have had a significant impact on the health of the U.S. population. For selected interventions, data and literature and/or logical ways of inferring the contribution of public health should be available. Mechanisms for capturing the costs of these activities to the public health sector should be identifiable.

Members of group B are asked to identify three to five emerging health issues where public health core functions will be central to protecting the health of the Nation. These may be either new health problems, or ones that are already important but likely to be of greater relative consequence in the future. It should be feasible to estimate the relative responsibility of public health for containing the problem, and the probable burden of illness if public health core functions are lacking or inadequately funded.

12:00-1:15

Working Lunch: Great Public Health Anecdotes

Participants are asked to come prepared to provide brief vignettes that tangibly demonstrate either the consequences of a successful public health initiative/undertaking, or the fallout from lack of an adequate public health infrastructure.

1:15-2:45

Small Group Meetings: Worked Examples

Members of both groups are asked to outline plausible methodologic approaches to quantifying the health and economic consequences of the core public health functions in protecting population based on a condition (group A) or issue (group B) arising from their earlier examples.

2:45-4:00

**Approaches to Describing the Value of
Public Health as a Whole**

Participants are asked to consider approaches to illustrate the value of the overall public health system (infrastructure and initiatives) quantitatively, e.g., through international or State and local comparisons. Strategies for valuing public health activities from a policy-maker perspective will be solicited from the group.

4:00

Adjourn



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Public Health Service

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for Health
Washington DC 20201

FEB 9 1994



FEB 15 1994

Kristine Gebbie, R.N., M.N.
AIDS Policy Coordinator
Executive Office of the President
750 17th Street, N.W., Suite 1060
Washington, D.C. 20500

Dear ^{Kristine} ~~Ms. Gebbie~~:

Building on the extremely useful material that came out of the January 21st meeting, Steve Teutsch and I have put together a scope of work for the "Investments" project that we believe incorporates a number of ideas that were raised on that day. We do want to thank you very much for taking the time out to help us in the development of this project.

Enclosed you will find relevant parts of a description of the scope of work that we anticipate sending out early next week to a contractor for review. We are providing it to you for your information, as well as for comments regarding the general approach to the topic. Please be aware that there will be some back and forth between the contractor and ourselves, where we will have the ability to incorporate concerns that you raise, as well as suggestions for putting different aspects of the project together. Do let us know as well if there are segments of the work that you would be available to focus more specifically on as we give greater detail to the design of the models or case-studies.

We are anticipating start-up within the next two weeks and will value your timely input. Again, many thanks for your interest and support of this work.

Sincerely,

Marthe R. Gold, M.D., M.P.H.
Assistant Director, Evaluation
Office of Disease Prevention
and Health Promotion

Enclosure

cc: Dr. Michael McGinnis
Dr. Steven Teutsch

Sorry we didn't get more of you on the 21. Your comments were extremely helpful... will be in touch.

Project Description

Purpose of Contract:

The purpose of this project is to develop models of disease and injury trends in the population (using both historical and future perspectives) that document the health and economic consequences of investment in core public health functions.

Background:

With implementation of a reformed health care delivery system, the work of the Public Health Service (PHS) and of State and local Health Departments will gradually shift from personal care services to underserved populations and toward a heightened emphasis on core public health functions. These core functions are: health status monitoring and disease surveillance; investigation and control of diseases and injuries; protection of environment, workplaces, housing, food, and water; laboratory services to support disease control and environmental protection; health education and information; community mobilization for health-related issues; targeted outreach and linkage to personal services; health services quality assurance and accountability; training and education of public health professionals; leadership, policy, planning, and administration.

While public health activities have been responsible for the control and elimination of many conditions that cause premature disability and death, the discipline of public health has often failed to receive credit for its contribution. In part, this is because gains in health status have occurred in conjunction with a number of societal and scientific advances (e.g., improvements in housing, sanitation, development of new medical technologies), making the attribution of a specific level of benefit to public health efforts difficult. Despite public health's central role in the development and communication of tools to attenuate and/or conquer illness and injury, and its leveraging role for other public and private activities vital to the success of disease control, evaluations of the overall health and economic consequences of public health-driven initiatives are lacking.

The project will identify key illnesses responsible for premature and/or avoidable morbidity and/or mortality where public health activities have had a significant impact, or where they would, with appropriate funding. Literature supporting outcomes of public health interventions for these illnesses will be reviewed in order to generate specific estimates of levels of effectiveness. Where the science base is inadequate to provide evidence specifically attributable to public health interventions, models will be developed to explore the implications of differing levels of contribution from public health activities.

Economic consequences of preventable illnesses will be assessed, using extant information, building on existing work that may be outdated, and developing new models and applying new data where necessary. Cost estimates of public health interventions will be imputed where information is available, and developed where necessary.

In general, this project will address the following questions/issues:

- How are the specific core public health functions operationalized at the State and local level?
- How do these functions interact with the medical care system, and other relevant agencies and institutions in improving the health of the public?
- What have core public health functions accomplished historically in improved health outcomes?
- Based on known public health successes in disease and injury control since the 1950s, what are aggregate estimations of morbidity/mortality averted, and savings realized to society?
- What are examples of diseases and/or injuries which have occurred because of failures in the public health system, and what have been their health and economic costs?
- What can we forecast as the short and long-term costs of diseases and injuries requiring medical/hospital care, and which might be prevented/decreased using a public health intervention?
- What are examples of priority emerging disease prevention needs for the Nation that rely for their assessment and control on the core functions which make up the public health infrastructure?
- What projections can be made regarding the costs to the Nation if these prevention needs are not met?
- What are the projected costs of achieving improvements in health status (such as the targets set by the *Healthy People 2000* objectives) through public health initiatives on priority issues?

The information produced and the models developed in this project will educate health care reform decision-makers on the contributions of core public health functions for improving the health status of the population. The final report will provide them with timely information on the above questions/issues and will document the importance of public health in a reformed health care system.

Task 2.0 Characterization of Core Public Health Functions

- Subtask 2.1** Work with project technical officers to identify person(s) with appropriate depth of expertise in public health to help frame a description of core public health functions that effectively communicates and illustrates their importance.
- Subtask 2.2** Develop an operationalized description of core functions. The contractor will work with the project technical officers to select at least four but no more than eight examples of disease or injury that dynamically illustrate the importance of the widest range of core functions. For example, the control and virtual elimination of measles draws on disease surveillance, investigation and control of disease, protection of environment (school immunization requirements), lab services, health education, targeted outreach, and leadership, at a minimum. The examples should highlight the importance of public health infrastructure at the State and local levels.
- Subtask 2.3** Develop a strategy to graphically present the above examples of core functions including accompanying graphics or photographs.
- Subtask 2.4** Prepare and submit draft examples for review and approval by the project technical officers.
- Subtask 2.5** Develop case studies of health problems where public health has been instrumental in improving health outcomes. These case studies should evidence the unique leveraging and catalyzing role of public health with other sectors (and therefore defined more broadly than State and local activities). These case studies should map to existing literature that allows discussions and/or projection of economic implications.
- The contractor, in consultation with the project technical advisors, will select relevant examples (e.g., tobacco control to reduce smoking, promotion of motor vehicle safety).
- Subtask 2.6** Develop a similar strategy to graphically present these case studies, including accompanying graphics or photographs.
- Subtask 2.7** Prepare and submit draft examples for review and approval by the project technical officers.

Task 3.0 Develop Models of Disease or Injury Trends

Subtask 3.1.1 The Historical Perspective: The contractor shall model long-term patterns of overall disease and injury averted directly or indirectly as a result of public health activities since 1950. A quantitative analysis should include the following measures: mortality, years of potential life lost (YPLL), hospitalizations, disabilities, and cost.

Subtask 3.1.2 The contractor should model the long-term patterns of disease and injury averted since 1950 for three specific conditions that illustrate the importance of the public health functions using the following criteria:

1) the magnitude of the target health problem, 2) the perceived importance of the public health impact, 3) the quality of the data demonstrating effectiveness and economic impact of public health, and 4) the relevance towards a community-based approach rather than an individual-care approach.

The set of three conditions chosen will illustrate: 1) a range of public health interventions, 2) a range of core public health functions, and 3) a range of substantive areas such as infectious disease, environmental health, chronic illness, occupational health, and perinatal/infant morbidity and mortality.

Examples to demonstrate the importance of public health may include such conditions as: smoking (e.g., the impact on lung cancer and cardiovascular disease), outbreak investigations and control (e.g., the impact on smallpox, polio measles, E.coli., tuberculosis, and toxic shock syndrome), injury prevention (e.g., the use of seat belts and child restraints), or environmental issues (e.g., fluoridation and lead in gasoline). Recommendations for selection will be made by Contractor, subject to approval by technical officers.

The contractor should estimate the morbidity and mortality averted for the conditions identified for modelling. The contractor should also estimate the economic impact averted for those conditions. The economic impact may include cost of illness estimates such as direct medical costs, direct non-medical costs, and the indirect costs of lost productivity due to morbidity or premature mortality.

Sub-Task 3.1.3 The contractor will model scenarios in which the core public health functions did and did not exist for the same time period specified above. The models will include the potential burden of illness and cost to society. Emphasis should be placed on examples of catastrophes and events averted, as well as those that were not. Examples, other than those is Sub-Task 3.1.2, should be used to illustrate the difference that public health has or could have made. The

importance of partners, such as voluntary health organizations and the medical community, should be noted as essential parts of the public health infrastructure.

- Subtask 3.2.1 The Future Perspective: The contractor should model trends of overall morbidity and mortality for the future, and demonstrate the impact public health can make. Measures included should be the same as in Sub-Task 3.1.1. The model should include the current status of the nation's health, and 5-year and 20-year projections.
- Subtask 3.2.2 The contractor must demonstrate a method for estimating preventable fractions of morbidity and mortality. Preventable conditions for which the health care system provides care and which could be decreased by effective public health action must be identified. The ten leading causes of preventable hospitalization and emergency room visits should be used.
- Subtask 3.2.3 The contractor should model the future trends, using 5 and 20 year time frames, of three emerging health problems. Conditions for modelling should be identified on the basis of the criteria listed in Subtask 3.1.2, including the ability to determine the cost of the intervention. Conditions for modelling should be selected from *Healthy People 2000* health status objectives. Examples to illustrate the importance of the future role of public health may include such conditions as: indoor air pollution (e.g, radon), and adolescent health (e.g., unintentional injury, unintended pregnancies, violence, and substance abuse).

Recommendations for selection will be made by Contractor, subject to approval by technical officers.

For each condition selected, the contractor shall estimate the costs of morbidity and mortality associated with the health event with and without public health core functions.

For each condition modelled, the contractor shall model the economic costs of achieving the reduction estimated from the preventable fraction model (at the State and local level). The economic impact should be incidence based, i.e., all downstream costs should be determined and appropriately discounted to the year the health event would have occurred. Prevalence-based, i.e. cross-sectional, impacts should also be shown. Where possible, the scale of the public health impacts should be linked to *Healthy People 2000* health status objectives. For example, if the *Healthy People 2000* goal is to reduce smoking by 10%, estimate the costs at State and local levels.

Subtask 3.2.4 The contractor should model a scenario in which the core public health functions do not exist in the future. The model will include the potential additional burden of illness and cost to society. Qualitative emphasis shall be placed on core functions that are exclusively in the domain of State and local public health authorities (e.g., surveillance, outbreak investigation, rapid response).

DELIVERY SCHEDULE

The contractor shall deliver to the technical officers the following items, within the time frame specified below: For all draft deliverables, the technical officers will provide comments to the contractor no more than one week following receipt.

<u>Item</u>	<u>Description</u>	<u>Copies</u>	<u>Delivery Date</u>
1.	Project Workplan	5	1 week
2.	Draft of Task 2.4	5	4 weeks
3.	Draft of Task 2.7	5	4 weeks
4.	Draft of models for Task 3.1	5	4 weeks
5.	Draft of models for Task 3.2	5	8 weeks
6.	Final model results for Task 3	5	12 weeks
7.	Draft of Written Report, Task 4.1	20	14 weeks
8.	Draft of Supporting Documentation, Task 4.2	20	16 weeks
9.	Interim Final Report, Task 4.1 (1 camera-ready copy) (1 electronic copy)	1000	16 weeks
10.	Final of Complete Documentation, Task 4.2	25	26 weeks



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

DEC 21 1993

Kristine Gebbie, R.N., M.N.
AIDS Policy Coordinator
Executive Office of the President
750 17th Street, N.W., Suite 1060
Washington, D.C. 20500



JAN 4 1994

Miche
Dear Ms. Gebbie:

The Public Health Service-sponsored meeting to explore the health and economic consequences of investments in public health is scheduled for January 21, 1994, 10:00 a.m. - 4:00 p.m., at the Hotel Sofitel, 1914 Connecticut Avenue N.W., in Washington, D.C.

Please call Omega Travel at (800) 486-9740 (ask for Mia) as soon as possible to arrange for your travel. If you will need a hotel room for January 20, please call Delores Flenoury (202) 205-8583 by **January 4**.

If you have any questions, please do not hesitate to call me at (202) 205-8583. I look forward to seeing you on the 21st.

Sincerely,

Marthe R. Gold, M.D., M.P.H.
Assistant Director (Evaluation)
Office of Disease Prevention
and Health Promotion

GUIDANCE FOR TRAVELERS

**Office of Disease Prevention and Health Promotion
Public Health Service
U.S. Department of Health and Human Services**

This guidance is prepared especially for people who are traveling on invitational travel orders prepared by the Office of Disease Prevention and Health Promotion (ODPHP). Securing of transportation arrangements and reimbursement for expenses will be greatly facilitated by following this guidance. If you have questions about any of these steps, please call the ODPHP secretary whose name and telephone number is provided at the end of this guidance.

1. When you are invited to a meeting convened by ODPHP, a staff person will contact you to get necessary information, including your full name, mailing address, and social security number. A travel order will be prepared and necessary information will be forwarded to the Omega travel agency, please contact Omega Airline directly to make travel arrangements.

Please note that the U.S. Government has contracts with airlines providing discounts for transportation costs between major cities. We are obligated to use these contracted airlines except in compelling circumstances that call for explicit written waiver of the contract obligation. We appreciate travelers' acceptance of this limitation on Omega's and our own flexibility in arranging airline travel.

2. A ticket will be sent to the traveler, unless time constraints require that the ticket be wired to the airport from which the traveler will depart.
3. At the meeting, ODPHP will provide travelers with a voucher form to be signed. We encourage travelers to leave the signed voucher with staff at the meeting, though they can be taken and mailed in with necessary receipts.
4. After the traveler returns from the meeting, it is necessary to send to ODPHP in the franked envelope provided for that purpose (care of the secretary whose name is provided below) the following items:

- passenger receipt of the airline ticket
- hotel/lodging receipt
- receipt for all ground transportation (taxi, shuttle, metro)/parking
- the signed voucher, if you did not leave it with staff at the meeting
- information regarding departure/arrival times and ground transportation (use attached report form, please).

Meals are reimbursed on a set schedule, varying by locality; if meals are provided as a part of the meeting, reimbursement is not provided for those meals. If ODPHP has arranged direct billing for lodging, a lodging receipt is not required and reimbursement to the traveler for lodging will not be made.

5. We request that travelers return receipts to ODPHP within one week of return from the meeting. We will prepare the travel voucher and submit it for reimbursement within two weeks of its receipt. Processing usually requires approximately 3 weeks following submission from our office.
6. If you have any difficulties, please do not hesitate to call the secretary whose name is provided below. If you have reason to believe that reimbursement has been delayed longer than 6 weeks, please be sure to call us.

We want to thank you for providing assistance to us and be willing to travel as a part of that assistance. We will do our best to make arrangements and follow-up to your travel as efficient as possible.

Secretary's Name: Delores Flenoury
Secretary's Telephone: 202/205-8583/FAX 205-9478



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

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Office of the Assistant Secretary
for Health
Washington DC 20201

DEC 3 1993

Kristine Gebbie, R.N., M.N.
AIDS Policy Coordinator
Executive Office of the President
750 17th Street, N.W., Suite 1060
Washington, D.C. 20500



DEC 6 1993

Dear ^{Ms. Gebbie} Ms. Gebbie:

While national attention in the health care reform debate has been riveted on the medical care delivery system, changes in the Nation's health care system will have significant implications for the structure and function of public health. Those of us who understand the pivotal role of public health need to articulate to State and Federal policy makers the centrality of public health for effectively improving in quality and length of life for Americans.

I am writing to you at the request of Dr. Michael McGinnis to ask you to join us in the developmental stages of a project that is of extraordinary importance to the public health community. The Public Health Service is initiating an activity that seeks to identify health and economic returns on investments in core public health functions (i.e., health status monitoring/disease surveillance, investigation and control of diseases, protection of environment, quality assurance, laboratory services, health promotion and education, community mobilization, targeted outreach and linkage to personal services, training/education/leadership for public health professionals). The success of the project will depend on a careful selection of activities that have demonstrated effectiveness in decreasing morbidity and mortality, for which it will be possible to reasonably isolate out in a model the contribution public health has made (or could make, if adequately funded) to the outcome.

A one-day meeting will be scheduled for early January in order to engage a small group of people with particular expertise and talents in areas integral to the success of this endeavor. I hope you will be able to join us here in Washington to help in developing and refining our thinking.

Page 2 - Kristine Gebbie, R.N., M.N.

We are developing an agenda and series of questions that will structure the discussion. This will be provided to you in advance of the meeting. I will be phoning you within the next several days to see if you are available to join us in shaping this effort. I look forward to speaking with you about this project.

Sincerely,



Marthe R. Gold, M.D., M.P.H.
Assistant Director, (Evaluation)
Office of Disease Prevention
and Health Promotion

Hope we have talked by the time you receive this. I would dearly
love including a particular sort of SMTC survey at this meeting which
I'd like to describe to you.



Project External Advisory Group

Lester Breslow, M.D., M.P.H.[†]
Professor of Public Health and Associate
Director
Center Health Promotion
Jonsson Comprehensive Cancer Center
University of California, Los Angeles

Kristine Gebbie, R.N., M.N.^{*}
AIDS Policy Coordinator
Executive Office of the President

Bernard Goldstein, M.D.[†]
Director
Environmental and Occupational Health
Science Institute
Robert Wood Johnson Medical School

John Graham, Ph.D.[†]
Professor of Policy and Decision Sciences
Department of Health Policy and
Management
Harvard University

John Lumpkin, M.D.[†]
Director of Public Health
Illinois Department of Public Health

Lloyd F. Novick, M.D., M.P.H.^{*}
Director, Office of Public Health
New York Department of Health

Gilbert S. Ommen, M.D.^{*}
Dean
School of Public Health and Community
Medicine
University of Washington

Michael Osterholm, Ph.D., M.P.H.[†]
State Epidemiologist and Chief
Acute Disease and Epidemiology Section
Minnesota Department of Health

Patrick Remington, M.D., M.P.H.^{*}
Chief Medical Officer
Wisconsin Division of Health

Allan Rosenfield, M.D.^{*}
Dean
School of Public Health
Columbia University

Michael Stoto, Ph.D.[†]
Director, Division of Health Promotion
and Disease Prevention
Institute of Medicine
National Academy of Sciences

Bailus Walker, Ph.D.^{*}
Dean
College of Public Health
Health Sciences Center
University of Oklahoma

Kenneth E. Warner, Ph.D.^{*}
Professor and Chair
Department of Public Health Policy and
Management
School of Public Health
University of Michigan

^{*} Group A

[†] Group B

Tim Westmarsh
?'s for hearing?
hearing on CAC prevention?

3. clear. change
L C I
K A B due to
change by

pragmatism?
vs. religious fear

Questions for meeting preparation

1. Group A: With reference to the attached list of criteria, choose two or three illnesses/conditions or interventions that demonstrate the historical or current value of the public health system, as distinct from the medical care delivery system. It should be possible based on either existing data or plausible modeling to estimate the effect of the public health contribution.
2. Group B: With reference to the attached list of core public health functions, identify two or three examples of health problems which will be of growing importance over the next decade or two where public health, rather than medical care is required to play the predominant role in containment. These may be either emerging health problems, or ones that are already important but likely to be of greater relative consequence in the future.
3. What are examples (either retrospective or prospective) where health problems approached through a public health mechanism will be less costly and/or more successful than if approached through a personal services delivery mechanism (e.g., lead abatement vs. individual screening for and treatment of high lead levels; AIDS prevention versus treatment).
4. Consider times when you have needed to succinctly argue the importance of one or more core public health functions to a funder (legislative, University, Federal grant). What have been the anecdotes and/or case studies that most powerfully demonstrate the health and/or economic consequences of investment (or failure to invest) in public health?
5. Simply summing the value of a number of important public health initiatives will be inadequate to convey the health and economic consequences of an underfunded public health system. We are looking for approaches, as well as *specific examples* that could be used to illustrate more globally the value of a public health system. Possible approaches where specific examples would be useful include: International comparisons (e.g., countries where investment in medical care is less, but public health investment is more and health effects are apparent); Examples of States which have stronger PH infrastructures and attendant better health of the public (may need to adjust for demographic risk); Examples of results from increased or decreased investments in public health systems.

CRITERIA

1. Magnitude of the target health problem.

Comment: The degree to which this health outcome has or *has the potential to have* a large impact as quantitatively measured, e.g., in terms of mortality, morbidity, economic cost, or other relevant health measure (e.g., unintended pregnancy).

2. Perceived importance of the public health impact.

Comment: The degree to which this problem addresses an important public health topic and the degree to which it will be *perceived* to be important based on its health or social impact.

3. Quality and quantifiability of the data demonstrating effectiveness and economic impact of public health interventions.

Comment: The degree to which there are data (studies) which can demonstrate the health and economic impact of public health on the condition. Are there data and are they of high quality?

4. Ability to determine the cost of intervention.

Comment: Can the cost of the public health interventions be measured?

5. The degree to which the public health intervention reflects a community-based rather than individual-care approach.

Comment: Public health interventions can replace the need for individual level services.

CORE PUBLIC HEALTH FUNCTIONS

- Health Status monitoring and disease surveillance
- Investigation and control of diseases and injuries
- Protection of environment, workplaces, housing, food, and water
- Laboratory services to support disease control and environmental protection
- Health education and information
- Community mobilization for health related services
- Targeted outreach and linkage to personal services
- Health services quality assurance and accountability
- Training and education of public health professionals
- Leadership, policy, planning, and administration



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service



Office of the Assistant Secretary
for Health
Washington DC 20201

JAN 11 1994

JAN 12 1994

Kristine Gebbie, R.N., M.N.
AIDS Policy Coordinator
Executive Office of the President
750 17th Street, N.W., Suite 1060
Washington, D.C. 20500

Dear Ms. Gebbie: *Kristine*

I am forwarding to you briefing materials for the January 21st project planning meeting here in Washington D.C. The meeting, which runs from 10 a.m. till 4 p.m. will be at the Hotel Sofitel at 1914 Connecticut Avenue (202) 797-2000. The hotel is located a few blocks north of Dupont Circle.

You will find in the enclosed folder three items that provide a context for this project. They include: *Health Care Reform and Public Health*, a paper that has been used as background for the Health Security Act; Subtitle D of the Act, Core Functions of Public Health; and a description of the project which you will be helping us shape.

We have furnished you with an annotated agenda, which, when read in concert with the meeting preparation questions (also included) should give you a sense of how we envision the day unfolding. Please note that the group has been divided into two smaller work-groups for two of the sessions. Your small group assignment is noted on the list of outside participants.

I am delighted that you will be joining us, and look forward to an interesting and fruitful meeting next week.

Sincerely,

Marthe R. Gold, M.D., M.P.H.
Assistant Director (Evaluation)
Office of Disease Prevention
and Health Promotion

Enclosures

cc: Dr. Michael McGinnis, ODPHP
Dr. Steven Teutsch, CDC

**DEPARTMENT OF
HEALTH & HUMAN SERVICES**

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Washington DC 20201

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WASH., D.C. GMF



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HHS 396

PROJECT DESCRIPTION

Project Title: *Health and Economic Consequences of Investments in Core Public Health Functions.*

Program Evaluated:

With implementation of a reformed health care delivery system, the work of the Public Health Service (PHS) and of State and local Health Departments will gradually shift from personal care services to underserved populations and toward a heightened emphasis on core public health functions. These core functions are: health status monitoring and disease surveillance; investigation and control of diseases and injuries; protection of environment, workplaces, housing, food, and water; laboratory services to support disease control and environmental protection; health education and information; community mobilization for health-related issues; targeted outreach and linkage to personal services; health services quality assurance and accountability; training and education of public health professionals; leadership, policy, planning, and administration.

While public health activities have been responsible for the control and elimination of many conditions that have resulted in premature disability and death, the discipline of public health has often failed to receive credit for its contribution. In part, this is because gains in health status have occurred in conjunction with a number of societal and institutional transitions (e.g., improvements in housing, sanitation, increases in income), leaving it difficult to attribute a specific level of benefit to public health efforts. In addition, the modest level of funding available for public health initiatives has often precluded evaluation of their effectiveness. Therefore, the ability to impute the contribution of public health to health and economic outcomes is often absent. Using selected examples of illnesses and conditions, the project outlined here will assess the impact of investments in core public health functions on both health and economic outcomes.

PHS Coordination:

This project will be advised by an internal PHS workgroup coordinated through the Office of Disease Prevention and Health Promotion. The advisory group will provide direction and technical assistance to the project assuring that relevant PHS efforts are adequately incorporated into the development and refinement of the scope of the project. The progress of this project will be presented to the Steering Committee for the Public Health Core Functions Project, co-chaired by the Assistant Secretary for Health and the Surgeon General.

Intended Users:

This project is intended to assist State and Federal policy makers by explicitly identifying and quantifying the contributions of core public health functions to the health of Americans. Planners in Health Alliances and in State, local, and Federal health agencies will be able to use models developed here to better understand results of investments in public health functions.

Approach:***Public Health Outcomes Assessment***

This project requires the development of models that permit the assessment of outcomes of public health. Epidemiologists, economists, and disease-content experts from within the PHS, the academic community, and State and local health departments will be consulted in developing these models.

The project will identify key illnesses responsible for premature and/or avoidable morbidity and/or mortality where public health activities have had a significant impact, or where they could, with appropriate funding. Literature supporting outcomes of public health interventions for these illnesses will be reviewed in order to generate specific estimates of levels of effectiveness. Where the science base is inadequate to provide evidence specifically attributable to public health interventions, models will be developed to explore the implications of differing levels of contribution from public health activities.

Economic Inputs and Outcomes

Economic consequences of selected illnesses will be assessed, using extant information, updating work that is outdated, and developing new models or data where necessary. Cost estimates of public health interventions will be imputed where information is available, and developed where necessary.

Process of Work:

Content and methodologic experts will be convened for two project planning workshops: one internal to the PHS, the other comprised of external experts. The meetings will be constructed to elicit information relevant to the design of this study. Appropriate programs, methodologies and literatures will be identified for study design. The PHS group will constitute an advisory body for this project and will review study products as they are developed.

The project will use an outside contractor to develop approximately six short papers that document outcomes attendant to core public health functions, defined individually or in combination, in managing and/or controlling specific morbid conditions. These papers will link program activity with quantifiable health outcomes. Economic requirements and returns associated with implementation of these programs will be calculated where possible. Core elements in the scope of work include:

- a. ***Assessment of the adequacy of the science base for demonstrating and isolating the outcomes of core public health functions.*** If available information is inadequately configured for the needs of the project, the contractor, using assumptions discussed with the advisory group, will oversee the development of models to assess the core public health functions under review. Development of these models will be undertaken by recognized authorities, selected in collaboration with advisors to the project.
- b. ***Assessments of the investment required in core public health functions to produce the outcomes studied.*** The contractor will develop estimates of expenditures used/required for conducting core public health functions in accomplishing the health outcomes discussed within this project. The contractor will work with expert groups within and outside the PHS to develop these estimates.
- c. ***Assessment of adequacy of cost-of-illness information for relevant illnesses.*** Where appropriate, the contractor will use existing cost-of-illness information. If necessary--based on significant changes in medical care or outcomes for illnesses and/or outdated methodology--the contractor will work to revise cost-of-illness numbers using experts in cost-of-illness studies selected in collaboration with project advisors.

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HEALTH CARE REFORM AND PUBLIC HEALTH

-- A Paper on Population-Based Core Functions --

**The Core Functions Project
U.S. Public Health Service
1993**

HEALTH CARE REFORM AND PUBLIC HEALTH

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HEALTH CARE REFORM AND PUBLIC HEALTH

EXECUTIVE SUMMARY

There are compelling scientific, health, and economic reasons for seeking a stronger public health system for the Nation. Whether assessing the historical advances against infectious diseases or the more contemporary gains against heart disease, the greatest improvements in health status have derived from public health approaches. The dramatic gain in life expectancy for Americans over the course of this century, from less than 50 years in 1900 to more than 75 years in 1990, is attributed primarily to improvements in sanitation, the control of infectious diseases through immunizations, and other public health activities. Population-based preventive programs launched in the 1970s are also largely responsible for the more recent changes in tobacco use, blood pressure control, dietary patterns (except obesity), automobile safety restraint, and injury control measures that have fostered declines of more than 50% in stroke deaths, 40% in coronary heart disease deaths, and 25% in overall death rates for children.

This paper presents the necessary role of public health and population-based programs for supporting and enhancing the effectiveness of a reformed health care insurance system in the United States. Preventive measures focused on chronic and infectious diseases and injuries provide much of the substance of these programs, but there are also core public health functions that are necessary to support and sustain efforts that address the health needs and conditions of populations, as distinct from individuals.

The population-based core public health functions described here are: health status *monitoring* and disease surveillance; investigation and *control* of diseases and injuries; *protection* of environment, workplaces, housing, food, and water; *laboratory* services to support disease control and environmental protection; health *education* and information; community *mobilization* for health-related issues; targeted *outreach* and linkage to personal services; health services *quality* assurance and accountability; *training* and education of public health professionals; and *leadership*, policy, planning, and administration. Public health has also taken on responsibilities related to the delivery of personal health services—e.g., primary care for the underserved, home visits, operation of special clinics for targeted conditions—but personal services are addressed elsewhere in health care reform and are not the focus of this paper.

Currently less than 1% of aggregate national health expenditures support population-based public health functions. In the last decade the proportion of expenditures going to public health has declined by about a quarter—an erosion in the response capability of public health at a time when the challenge of the HIV epidemic has demanded ever more resources. Estimates presented in this paper are based on figures provided by the agencies of the U.S. Public Health Service (for Federal costs) and the reporting system of the Public Health Foundation coupled with estimates provided from several State and local health departments. The current cost estimates were used as the basis for projected incremental costs for these functions supported at levels considered by public health officials as meeting "essential" and "fully effective" levels of service.

HEALTH CARE REFORM AND PUBLIC HEALTH

I. THE AGENDA

If a fundamental purpose of health care reform is to advance the health status of Americans—not merely to improve the financing of medical treatment—careful attention must be given to strengthening the population-based prevention and public health programs of the Nation. Testimony to the opportunities at hand for reducing avoidable disease, disability, and suffering among Americans is offered in *Healthy People 2000*, the Nation's prevention agenda. Better distribution and targeting of available information, technology, and resources were determined to have the potential to yield dramatic health gains over the decade of the 1990s, including: a 28% reduction in the occurrence of low birth weight and a 31% reduction in infant death rates; a 30% decrease in the rate of teenage pregnancies; a 15% reduction in death rates of children under age 15; immunization levels of 90% or better among two year-olds and the virtual elimination of measles, diphtheria, tetanus, polio, and rubella; elimination of the occurrence of blood lead levels above 25 micrograms per deciliter in children under age 5; a 30% reduction in pregnancies among teenagers; a 26% reduction in coronary heart disease deaths; an 11% decline in diabetes-related deaths; a 71% increase in the protection of Americans from exposure to air pollutants; a 48% reduction in smoking rates among adults and an equivalent decline in the initiation of smoking by adolescents; and a 12% decrease in alcohol-related vehicular crash death rates.

Achieving these targets will result in lives saved and suffering avoided and will contribute to cost containment. Reform of the medical care system *per se*, however, will not make this vision a reality. The greatest threat to the lives of children comes from injury. Reducing the health consequences of exposure to high levels of lead and air pollutants must be addressed through community-wide environmental programs. Low birth weight and other risks to newborns derive less from inadequate medical care than from social and lifestyle factors. Pregnancy and childbirth among teenagers is a primary consequence of deficiencies in support at the level of the family, school, and community. Behavioral patterns—such as high-fat diets and overweight, alcohol abuse, and smoking—are principal contributors to the leading causes of death—heart disease, cancer, stroke, and injuries. Thus, the most effective prevention will come from population-based public health initiatives, and unless increased support for these public health programs is made an integral aim of health care reform, the Nation will fall substantially short of what is possible. This paper supports inclusion of population-based public health programs at the national, State, and local levels as part of the Nation's health care reform.

II. THE LIMITATIONS OF MEDICAL INSURANCE REFORM

The importance of a population-based approach is illustrated by a report, cited in a 1982 study by the Institute of Medicine (National Academy of Sciences), which concluded that

only 10% of premature deaths among Americans could have been avoided through improvements in access to medical treatment. On the other hand, it concluded that 50% of premature deaths could have been avoided by changes in individual behaviors, such as tobacco use, poor diet, sedentary lifestyle, use of alcohol and drugs, and risk-taking that leads to injuries. Another 20% were attributable to environmental factors. Both behavioral and environmental issues, while relevant to clinical medicine, require population-wide strategies for effective intervention. The final 20% of premature mortality was linked to inherited conditions, an area of biomedical science which is just now being fully explored and translated into effective preventive interventions. A 1993 Public Health Service study found that of all deaths among Americans in 1990, nearly half were due to causes that were behavioral in nature and substantially outside the purview of the medical system.

Reform of the medical insurance system is therefore necessary but not sufficient to improve health of Americans. Historically, gains in the health of populations have derived largely from changes in the safety and adequacy of food supplies, in the provision of safe water, in sewage disposal, and in personal behavior, including reproductive behavior. The Hippocratic treatises, *Airs, Waters, and Places*, emphasize the relationship between diseases and exposure to factors related to climate, soil, water, mode of life, and nutrition. Analyses of the trends for infectious disease deaths over the last century and a half in England and Wales indicate, for example, that the most substantial decline in tuberculosis deaths occurred as a result of an improved physical environment and better nutrition, long before the 1947 introduction of streptomycin or the later use of BCG vaccination. The dramatic gain in life expectancy for Americans over the course of this century, from less than 50 years in 1900 to more than 75 years in 1990, is attributed primarily to improvements in sanitation, the control of infectious diseases through immunizations, and other public health activities. Population-based preventive programs launched in the 1970s are also largely responsible for the more recent changes in tobacco use, blood pressure control, dietary patterns (except obesity), automobile safety restraint, and injury control measures that have fostered declines of more than 50% in stroke deaths, 40% in coronary heart disease deaths, and 25% in overall death rates for children.

The social nature of some of today's problems also reveals the boundaries of the ability of insurance reform alone to solve the health challenges of those most in need. The number of female-headed families with children in poverty increased 39% since 1980, and the number of children in poverty increased by 23% between 1980 and 1991, meaning that two and one-half million more children are living in poverty today than a decade ago. Poverty is an almost universal risk factor for all dimensions of health. People with low income suffer death rates that are twice the rates for people with incomes above the poverty level, and, for all the major chronic diseases, low income is a potent risk factor. Deaths from injury—both unintentional and violent—correlate with low income. The consequences are seen in the fact that the Nation accomplished less than half of its health targets for the year 1990. Although impressive improvements were seen in several dimensions for many Americans, the failures for poor and minority Americans were notable and telling. Vital statistics for 1991 confirmed that, while the overall infant mortality rate in the United States continues to improve, the rate for African Americans is

not keeping pace and remains over twice as high as that of the white population. Similarly high rates can also be found among some American Indian tribes. In 1984, a task force of the Department of Health and Human Services documented the excess death rates for six major conditions experienced by Black and other minority populations of Americans and found that, for African Americans alone, there were 60,000 more deaths than would have occurred if their rates were the same as for the general population.

In part, these deficiencies are attributable to disparate access to clinical services because of financial or other barriers. During the 1980s, some clinical interventions were not extended sufficiently to high risk groups of Americans--interventions such as childhood immunizations, prenatal care, family planning services, control of sexually transmitted diseases (including HIV infection), and tuberculosis control. This failure of the health care system was substantially a result of insufficient support for awareness, outreach, and service delivery tailored especially for the hard-to-reach and is testimony to the futility of merely making additional treatment dollars available, without concomitant population-based strategies and programs.

III. THE ECONOMIC BURDEN OF PREVENTABLE CONDITIONS

As the costs of health care in the United States have escalated, now at nearly one trillion dollars and approaching 14% of the Gross National Product, a new cause for attention to preventive approaches can no longer be ignored. Prevention is important for humane reasons--to avoid suffering and premature death. It is also important as an alternative to costly diagnostic and treatment interventions. Costs of over \$110 billion have been attributed to alcohol and drug abuse, and \$65 billion to smoking. Estimates of the dollar levels of the health care burden by specific problems which are preventable include \$100 billion annually resulting from injuries, \$70 billion from cancer, and \$135 billion from cardiovascular diseases.

By almost any calculation, the economic burden of preventable conditions on society is considerable (Figure 1). Several analyses have been undertaken of the cost-effectiveness of various preventive interventions. Their results are illustrative.

- Prevention of only 3 percent of the incidence of coronary by-pass operations can achieve a reduction amounting to nearly \$240 million a year.
- Lead abatement of a typical pre-1950 housing unit can prevent nearly \$3,000 in treatment costs for each case of lead toxicity.
- Prevention of only two major communicable disease outbreaks per state each year, with each affecting 200 people, could achieve a savings of up to \$10 million a year.
- Prevention of one new HIV infection for every five persons identified as HIV-positive results in savings of \$15 to \$25 for every \$1 spent in counselling, testing, referral, and partner notification and counseling.

- The estimated cost of water fluoridation for an individual's lifetime is equal to or less than the cost of one dental restoration to treat a tooth with caries.
- For each dollar invested in a smoking cessation program for pregnant women, about \$6 is saved in neonatal intensive care costs and long-term care associated with low birth weight.

Preventive interventions such as those enumerated above--directed to entire population groups rather than planned one-by-one in clinical settings--have principally been initiatives of the public health sector, that is, Federal, State, and local health departments working in partnership with the communities they serve. Because health care reform seeks not only to expand services to the underserved but also to contain runaway health care costs, the public health investment in prevention becomes ever more compelling.

IV. PUBLIC HEALTH AND POPULATION-BASED PROGRAMS

A reformed health care system that comprehensively and efficiently addresses the Nation's health needs can be envisioned as a pyramid (Figure 2). At the pyramid's base are public health and population-based programs aimed at the disease prevention, health protection, and health promotion that are so vital to shaping the population's overall healthy profile. Resting on that base in ascending tiers are: primary health care services for individuals, including clinical preventive services, first contact treatment services, and ongoing care for the commonly encountered medical conditions; secondary health care services which provide specialized attention and ongoing management for less frequent conditions, including support services to meet the basic needs of people with special challenges due to chronic and long-term conditions, such as those encountered by many elderly and people with physical and mental disabilities; and, finally, tertiary health care services providing subspecialty referral care requiring highly specialized personnel and facilities for relatively rare conditions. Basic and applied research supports interventions at all levels. Each of these dimensions of health care is important to overall health improvement, but the effectiveness of services based in the lower tiers enhances the capability of higher tiers to contribute efficiently to health improvement. No tier of this overall health care system can be financed at the expense of tiers below it without undermining the viability of the entire system.

A special focus is warranted for the foundation tier of the health care pyramid. Over the last few years, four major reports from the national Academy of Sciences have called for a stronger, more responsive public health system: *The Future of Public Health*; *Injury in America*; *Emerging Infections: Microbial Threats to Health in the United States*; and *Toward a National Health Care Survey: A Data System for the 21st Century*. Common major findings of these studies include: the need to strengthen public health leadership, enhance professional competence among public health leaders and staff, revise outdated statutes and ordinances, fill gaps in data collection, improve the system's analytic capability to use the data effectively, and build ongoing links between public health and private sector health care--the population-wide responsibilities of public health.

Public health and population-based programs include the functions that are most basic to the health care system (Figure 3). These include: health status *monitoring* and disease surveillance; investigation and *control* of diseases and injuries; *protection* of environment, workplaces, housing, food, and water; *laboratory* services to support disease control and environmental protection; health *education* and information; community *mobilization* for health-related issues; targeted *outreach* and linkage to personal services; health services *quality* assurance and accountability; *training* and education of public health professionals; and *leadership*, policy, planning, and administration. Public health has also taken on responsibilities related to the delivery of personal health services (Figure 4)—e.g., primary care for the underserved, home visits, operation of special clinics for targeted conditions—but personal services are addressed elsewhere in health care reform and are not the focus of this paper.

Health Status Monitoring and Disease Surveillance

An essential element to reform of the health care system is the ability to monitor the effects of services delivered. Public health surveillance and monitoring of health conditions and outcomes of program interventions form the basic tool for the health care system as a whole. Regular collection and analysis of information on key dimensions is vital to timely awareness, decisions, and intervention related to epidemics and emerging patterns of disease and injury, prevalence of risks to health, and resource allocation. From communicable diseases such as AIDS and tuberculosis to chronic diseases such as heart disease and cancer, a well-structured surveillance system is necessary to delineate the major health problems threatening individuals and whole communities, those most at risk for these problems, geographic distribution of risks, and capacity of services to address emerging problems. Surveillance also serves as the mechanism to monitor the effectiveness of the medical care system, to assess the costs of the health care system's interventions to prevent and treat disease, and to provide information critical to the design of prevention strategies. Crucial to evaluation of health care reform will be an information collection and analytic ability to monitor progress toward defined outcomes and to provide information necessary to refine access to services and identification of what services are needed.

A critical assessment of local, State, and national surveillance and monitoring capability leaves little doubt that improvements are needed. For example, even tracking immunizations against childhood infectious diseases is poor to nonexistent in many communities, making State and local decisions to ensure universal immunization extremely difficult. Technology exists to mount adequate information systems to support comprehensive and timely surveillance and monitoring, but investments to apply new computerized information networks have not been made.

A fully effective public health system will support the following elements of this essential function:

- Accurate diagnosis of health status, identification of threats to health and assessment of health service needs at national, State, and substate (individual cities or counties, or multi-county areas of approximately 50,000 population) levels.
- Prompt identification of emerging problems through active surveillance for infectious diseases, chronic conditions, mental illness, substance dependency, and other measures of community well-being.
- Timely collection, analysis, and publication of information on access availability, utilization, costs, and outcomes of personal health care services at national, State, and local levels.
- Publication of vital statistics and health status information about specific groups such as Hispanic, Asian American, and American Indian populations in order to plan for closing gaps in health status.
- Collaboration with purchasers and providers of care to assure that benefit plans are appropriate to population needs.

Investigation and Control of Diseases and Injuries

Public health is charged with the responsibility of managing programs to limit diseases and conditions affecting whole communities, through work to investigate an emerging problem, identify and contain its source, and marshal an appropriate emergency and treatment response. The classic examples of this function relate to infectious disease containment, but increasingly challenges are presented by environmental factors and even violence. A major public responsibility is the education of private care providers on emerging threats to health such as new epidemic diseases. Following positive laboratory tests or other evidence of a problem, public health programs manage follow-up efforts to control identified diseases, including joint efforts with housing authorities to address the sources of lead poisoning, with social services to alert high risk populations to the presence of avoidable infectious diseases, and with law enforcement to focus violence prevention efforts. One function vital to a community's well-being is that of ready and expert intervener in cases of emergency. Such emergencies may be directly related to disease control, as in the case of an outbreak of gastrointestinal disease or exposure resulting from toxic spills. They may also be natural disasters, such as hurricanes or blizzards, or civil disturbances or acts of terrorism affecting large population groups, with immediate potential health effects.

A fully effective public health system will support the following elements of this essential function:

- State and local community-based prevention to achieve *Healthy People 2000* objectives (e.g., reduction in cancer, HIV/AIDS, injuries, adolescent pregnancy, substance use).

- Active infectious disease control programs in all high-risk residential settings (e.g., penitentiaries, jails, homeless shelters).
- Technical capacity to investigate disease outbreaks and patterns of chronic disease and injury and to move quickly to follow-up with necessary contact-tracing, professional and community-wide educational "alerts," mobilization of large scale immunization programs, and other effective control measures.
- Support and technical assistance to community-based organizations collaborating in prevention programs.

Protection of Environment, Workplaces, Housing, Food, and Water

Public health has a crucial health and safety enforcement function that is basic to disease and injury prevention. Enforcing regulations governing air pollution (including indoor air), water contamination, the handling and preparation of food, sewage and solid waste disposal, radiation exposure, radon exposure, noise levels and abatement, consumer protection, recreation-related safety, and worker safety. Public health's role extends to the health and safety aspects of housing codes, including smoke alarms, hot water temperature controls, and swimming pools. Public health agencies have mandates to conduct investigations, hold informational hearings, assess fines, close facilities, and take other kinds of enforcement action. In the case of interstate and international regulation and enforcement (e.g., commerce involving food, immigration), the Federal government fulfills this function.

A fully effective public health system will support the following elements of this essential function:

- Full enforcement of sanitary codes, especially in food industry.
- Full protection of the Nation's drinking water supply.
- Regular monitoring of environmental risks, and community level planning on how to control or reduce threats to health.
- Timely follow-up of hazards, preventable injuries, and exposure-related diseases identified in occupational health programs.
- Timely approval of new drug, biologic, and medical device applications.

Laboratory Services to Support Disease Control and Environmental Protection

Provision of laboratory services represents another basic tool of health care in America. A nationwide system of State-based laboratories complements the clinical laboratory services included in clinical practice and supports prompt diagnosis of diseases, whether of epidemic proportion or rare disease events. These laboratories screen newborns for

metabolic diseases; carry out toxicology assessments of blood lead levels and other environmental toxins in children and adults; diagnose sexually transmitted diseases (e.g., HIV, syphilis, and chlamydia) and tuberculosis, for which partner notification is essential to ensure disease control; test for cholera, salmonella, shigella, *E. coli*, and other infectious or food-borne diseases; monitor threats to the safety of water and food supplies; and are critical to identifying new and emerging health problems. The supportive role of this particular public health function to the higher tiers of the health care system is exemplified by such facts as these: a \$6 public health laboratory test for chlamydia infection, the most common sexually transmitted disease, can avert more than \$4,300 in costs of treating pelvic inflammatory disease. Each AIDS case costs about \$100,000 to treat, but early HIV identification with a \$10 test through a public health laboratory can trigger counseling that can help avoid subsequent cases. Each \$1 spent in metabolic disease screening of newborns results in savings of nearly \$9 in avoided treatment costs. A laboratory measurement of lead in blood specimens, not a clinical diagnosis of neurologic damage or I.Q. deficit, first identifies children suffering from the environmental disease of lead poisoning. Especially important is laboratory expertise to monitor the quality of privately provided services and to ensure compliance of those services to standards. The potential for human suffering as well as avoidable costs, caused by poor quality tests leading to false positive and false negative laboratory results, supports the public health mandate for laboratory oversight and quality control measures.

A fully effective public health system will support the following elements of this essential function:

- Comprehensive network of laboratories using modern technology to conduct rapid screening or high volume testing in support of epidemic investigations, and regular screening for environmental toxins and infectious agents.
- Expert consultation to clinical laboratories on testing methods and interpretation of results.
- Laboratory quality assurance and improvement programs in every State.

Health Education and Information

An important population-based function of public health programs is to serve as the public's health educator. The educational function of public health is defined here as distinct from one-on-one educational and counseling interventions provided in the clinical setting. In recent years, public health education has been spurred by support for large, categorical, prevention-oriented education programs on HIV/AIDS and drug abuse prevention. Education on the health effects of cigarette smoking has contributed to clear-cut reductions in its prevalence among American adults. Yet recent reversals for women and minorities indicate the need for more vigorous efforts, including broader, comprehensive approaches, focused through public schools on children and through community organizations and public media on whole communities. A workable health care system in this country requires educated consumers, knowledgeable about a wide

spectrum of health concerns, from health-related behaviors--such as diet, exercise, and substance abuse--to guidance about the wise use of appropriate clinical services. Both the economy and the effectiveness of services in the higher tiers of the health care pyramid depend on how well users of those services are informed and educated about their appropriate use as well as about their personal role in maintaining health and preventing disease and injury.

A fully effective public health system will support the following elements of this essential function:

- All schools provided staff and material support for health education programs.
- Targeted media messages in national and local media markets to counteract inappropriate images of health hazards and behavioral risks (tobacco, alcohol or drug use, violence).
- Active collaboration between personal care providers and local health departments to reinforce health education messages.
- Regular evaluation of all organized health communication programs, with subsequent action on findings.

Community Mobilization for Health-Related Issues

Public health is charged with the responsibility to be the community organizer for prevention. Closely linked to its role as health educator, public health has the task of working with consumer groups, community organizations, neighborhood associations, religious communities, school systems, business coalitions, and others to empower people to prevent disease and injury and to protect themselves against definable risks to their health. In this role, public health often has a low profile--serving as convener, staffing meetings and their follow-up, but defining success in terms of leadership and programs that devolve to nonpublic, community-based organizations. This is a vital function in the context of today's many health challenges that can be best addressed not through traditional public health approaches, but through changing the cultures of entire communities.

A fully effective public health system will support the following elements of this essential function:

- An ongoing planning capacity to define prevention opportunities that can most effectively be taken on by nonpublic, nonclinical sectors of the community.
- Community organization capacity to mobilize community groups and associations to undertake defined prevention initiatives.

- Skilled coalition-building ability to assure that community-based prevention activities are appropriately inclusive and draw upon the full range of potential human and material resources.

Targeted Outreach and Linkage to Personal Services

In addition to the outreach and enrollee education provided by health plans, the outreach and service-linkage function of public health programs brings the most hard-to-reach to the delivery point for needed clinical services. A primary audience for such outreach is low-income people, including up to 65% of infants and toddlers in some inner cities who are not appropriately immunized, sexually active adolescents in need of guidance who need to be linked to sexually transmitted disease prevention and family planning services, pregnant adolescents who need to be linked to first trimester prenatal care, unemployed adults with asymptomatic high blood pressure, homeless adults in need of substance abuse treatment, sexually active women at risk of cervical cancer or middle-aged and older women with undetected breast cancer. Service linkages include those with child day care providers and with public education for the provision of school-based and school-linked health services, services available in public housing, multidisciplinary case management efforts with social services clients, and case finding tied to employment services. People contacted through outreach and service linkage efforts and their health problems will not necessarily present themselves for inclusion in a health plan for individually provided clinical services, even if there is a system in place to generate payment.

A fully effective public health system will support the following elements of this essential function:

- Effective entry points for socially disadvantaged to a coordinated system of clinical-care at the local level.
- Specific culturally and linguistically appropriate materials and staff to assure linkage to services for each identified special population group (migrant farm workers, homeless, immigrants, American Indians, inner city or rural poor).
- For families at highest risk of complex or multiple problems, ready access to comprehensive services, such as health services co-located with social services, food programs, employment services, and other human service agencies at neighborhood sites.
- Based on disease or risk incidence data, community education and prevention programs focused on specific conditions such as HIV, tuberculosis, or substance dependency where needed.
- Technical assistance and support for establishment of worksite health promotion/disease prevention programs for all worksites, especially those employing 50 or more people.

Health Services Quality Assurance and Accountability

The public has a stake in ensuring that all health care services and all providers are of the highest quality. Thus, public health is charged with quality assurance of health care services, and assuring that providers are appropriately certified and institutions appropriately licensed. In a system of managed competition to deliver personal health care services, public health's accountability and quality assurance function extends beyond assurance of the appropriateness and effectiveness of medical and health-related services to include assurance that plans meet their obligations to provide services to all their enrolled population and that all citizens have access to their services.

A fully effective public health system will support the following elements of this essential function:

- Efficient processes for licensure of professionals and certification of facilities, with regular verification and inspection follow-up.
- Publicly available feedback from outcomes monitoring linked to service provider systems.
- Efficient and fair procedures for applying sanctions for failure to provide services or provision of poor quality services.

Training and Education of Public Health Professionals

A special emphasis is needed on the training of public health professionals from all relevant disciplines to perform the functions described here. Also of particular importance in the context of health care reform is the need to redress the balance in the relative numbers of primary and specialty health care providers. As in the case of all health professional development, the links between education and practice settings is crucial in order to ensure competency-based, service-related experiences for professionals deployed to private as well as public health

A fully effective public health system will support the following elements of this essential function:

- Adoption of the concepts of continuous quality improvement and life-long learning within all licensure and certification programs.
- Education and training for personnel to meet the professional needs for each public health function.
- A distance-based learning network using modern interactive telecommunications technologies to facilitate training for health workers.

- State and local health departments in active partnership with health professional training programs to assure community-relevant learning experiences for all students.
- Continuing education and training programs available for all levels of official health agency personnel.

Leadership, Policy, Planning, and Administration

Inherent in each of the roles delineated above is the necessity for public health to ensure competent leadership and management. The quality and effectiveness of these tasks that are basic to a well-functioning health care system greatly depend upon the quality and effectiveness of its leaders and managers, the organizational structure within which they work to carry out their charges, and the public support provided to them. As in the management of any organization, public health leaders are responsible for policy development, agenda-setting, coalition and support-building, advocacy to marshal support for their programs, and overall accountability for the resources that are given. As part of this function, public health serves not only its own internal organizational needs; it also has responsibility for building community consensus in support of policy decisions that promote health. As a basic source and disseminator of information to the overall health care system, public health agencies use data and analyses from carrying out their surveillance and monitoring function and findings from applied research and demonstration to direct improvements in clinical practice as well as population-based services. Examples range from local coalitions convened by public health departments to address violence prevention to Surgeon General's Reports at the national level establishing the health-related effects of tobacco use or the relationships between diet and health.

A fully effective public health system will support the following elements of this essential function:

- Electronic linkage of all official health agencies (national, State, and local).
- Leadership development program in place for all levels of public health system.
- Systematic community-level planning for health improvement in all health jurisdictions.
- Joint evaluation with the medical health care system to define consistent policy and improve prevention and service delivery.

In particular at the Federal level, and as part of the leadership responsibility, public health has the additional function of supporting the development of new knowledge, experimentation in new applications, demonstration, and evaluation of innovative programs. While this function has been important in the past, as new health challenges from AIDS to adolescent pregnancy to interpersonal violence became part of the public health agenda, it is especially important in the coming period of health care reform, when new patterns of health care delivery will shift the weight of responsibility for different

aspects of the health care system. New technologies are available now, and are being constantly improved, that can facilitate many of the functions of public health outlined above; but application of these technologies requires economic analyses, research, and demonstration strategies. Findings from biomedical research will continue to break onto the public stage, requiring attention to cost-effective delivery of new disease prevention and treatment interventions. In the interests both of safeguarding the public's interest in gaining the benefits of improvements and in the interests of economy of scale, maintaining the traditional public health responsibility for these research and demonstration functions is indicated.

V. SHORT-FALLS IN THE PUBLIC HEALTH INVESTMENT

Current Investment and Trends

Total national expenditures estimated in 1993 for population-based public health activities amount to approximately \$8.4 billion (Figure 5). Of this, about \$4.1 billion is from States and localities, \$1.3 billion from Federal grants and contracts to States and localities for public health programs, and \$3 billion from supplemental population-based activities of the U.S. Public Health Service. An additional, but related, \$1.2 billion from the U.S. Department of Agriculture supports the population-based component of supplemental food program activities for women, infants, and children (WIC) administered at the local level through public health agencies. The national expenditures for population-based programs (exclusive of WIC) therefore amounts to only about 0.9% of the aggregate amount for all health care in the United States in 1993.

Small as this proportion is, it is substantially smaller than it would be if the growth in expenditures over the last decade for population-based services had not lagged far behind the growth in expenditures for treatment services. Between 1981 and 1993, estimated national health expenditures--most of which were directed to payment for medical treatment--increased more than 210% (Figure 6). During the same period, funds for population-based activities by State and local health agencies grew by only about two-thirds of that rate. To compound the challenge, much of that smaller increase that has occurred has gone to address problems related to the control of HIV infection rather than to strengthening the public health infrastructure to deal with other and longstanding problems that are still with us. The result has been a relative erosion in the response capability of public health at a time when the need has never been greater.

Conclusion

For health care reform to succeed, the supporting and complementary functions of public health must be enhanced. If the amount used by State and local health agencies and the U.S. Public Health Service for public health functions had maintained their proportionate position to the treatment services they support and seek to obviate, their 1993 level would have been nearly 30% more than it actually is. Preliminary analyses by U.S. Public Health Service agencies and State and local health agencies suggest that approximately \$7

billion additional (to a total of \$15.4 billion) is needed nationally to bring these services to the level of meeting essential needs, and that to make them fully effective would take yet another \$9.6 billion--a total of about \$100 per capita.

This paper advocates additional investment, as a part of the Nation's health care reform legislation, to rebuild a strengthened public health system. Health care reform cannot meet its national cost containment targets if sufficient attention is not devoted to prevention of unnecessary disease through public health programs. Indeed, most of the health care reform principles of greatest importance to the American people--such as security, savings, quality, and responsibility--are dependent upon successful performance of the core functions of public health. The debate on reform of our health care system offers both mandate and opportunity to redress the erosion that has occurred in our public health infrastructure by establishing a secure and adequate funding base for the core functions of public health at every level. The decisions soon to be made in this regard will shape the Nation's health prospects in fundamental ways.

Figure 1. Economic Burden of Preventable Conditions

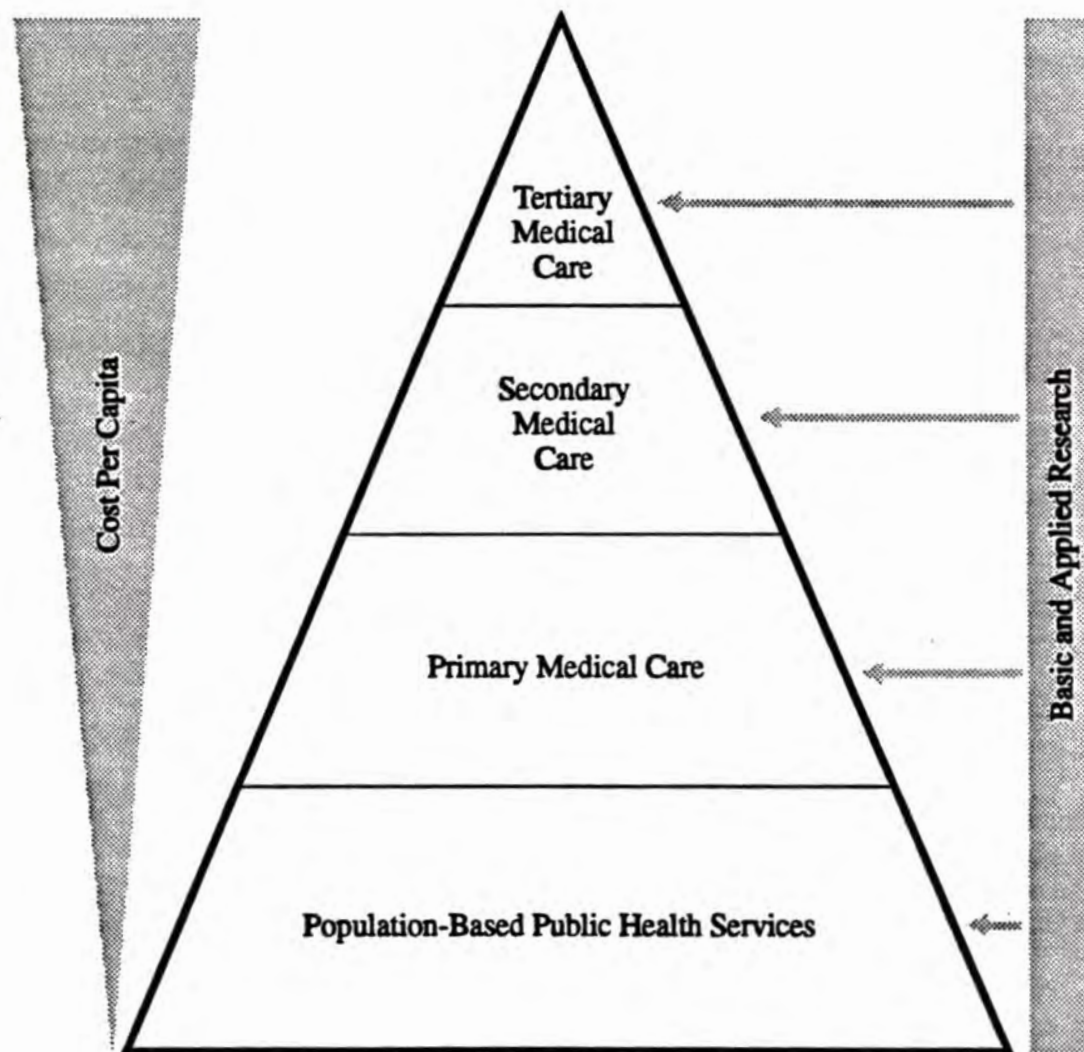
<i>Condition</i>	<i>Overall magnitude</i>	<i>Avoidable intervention ¹</i>	<i>Cost per patient ²</i>
Heart disease	7 million with coronary artery disease 490,000 deaths/yr 265,000 bypass procedures/yr 298,000 angioplasties/yr	Coronary bypass surgery	\$30,000
		Angioplasty	\$15,000
Cancer	1,130,000 new cases/yr 520,000 deaths/yr	Lung cancer treatment	\$23,000
		Cervical cancer treatment	\$15,000
Stroke	600,000 strokes/yr 145,000 deaths/yr	Hemiplegia treatment and rehabilitation	\$22,000
Injuries	2.3 million hospitalizations/yr 142,500 deaths/yr 177,000 persons with spinal cord injuries in the United States	Quadriplegia treatment and rehabilitation	\$570,000 (lifetime)
		Hip fracture treatment and rehabilitation	\$40,000
		Severe head injury treatment and rehabilitation	\$310,000 (lifetime)
HIV infection	1-1.5 million infected 118,000 AIDS cases (as of Jan 1990)	AIDS treatment	\$100,000 (lifetime)
Low birth weight baby	260,000 LBWB born/yr 23,000 deaths/yr	Neonatal intensive care for LBWB	\$10,000
Inadequate immunization	Lacking basic immunization series: 20-30%, aged 2 and younger 3%, aged 6 and older Hepatitis B	Congenital rubella syndrome treatment	\$354,000 (lifetime)
		Acute hepatitis B treatment (hospitalized)	\$6,386
Lead toxicity	200,000 children under age 6 with blood lead levels above 25 mg/dL	Medical cost of treatment	\$13,000
Dental caries	21.69 million children aged 5-17 have one or more dental caries	Caries restoration	\$38.50

¹Examples (other interventions may apply).

²Representative first-year costs, except as noted. Not indicated are non-medical costs, such as lost productivity to society.

Based on Healthy People 2000, U.S. Department of Health and Human Services, 1991.

Figure 2. Health Care Pyramid



**Figure 3. Core Public Health Functions:
Population-Wide Services**

Health status monitoring and disease surveillance

Investigation and control of diseases and injuries

Protection of environment, workplaces, housing, food, and water

Laboratory services to support disease control and environmental protection

Health education and information

Community mobilization for health-related issues

Targeted outreach and linkage to personal services

Health services quality assurance and accountability

Training and education of public health professionals

Leadership, policy, planning, and administration

**Figure 4. Core Public Health Functions:
Personal Services**

Home visits for people at risk

Primary care for unserved and underserved people

Treatment services for targeted conditions—e.g., AIDS, alcohol and other drug abuse, mental illness

Clinical preventive services—e.g., immunization, STDs, family planning, WIC

Payments for personal services delivered by others

**Figure 5. Need for Investment in Population-Based
Public Health Functions**

	<i>Expenditures (in billions)*</i>		
	<i>Current</i>	<i>Essential</i>	<i>Fully Effective</i>
Public Health Service	\$3.0	\$5.4	\$8.5
Federal Grants to State and local health departments.....	1.3	5.9	12.4
State and local health departments	4.1	4.1	4.1
Total	\$8.4	\$15.4	\$25.0
As a percent of total national health expenditures.....	0.9%	1.7%	2.7%

Note: Increments proposed to come from set aside. States and localities expected to maintain funding at inflation-adjusted \$4.1 billion level (1993 dollars).

Source: PHS agencies and CDC survey of States

*A collaborative project of the Public Health Service and State and local health department officials continues the process of refining these original estimates. In the absence of an ideal system, the numbers presented here were derived from several sources, including the record of U.S. Public Health Service appropriations, Public Health Foundation reports on State and local public health expenditures, estimates by a sample of State and local health agencies, estimates of population-based health expenditures done for Washington State Health Commission's reform proposal, and a national estimate done by the American Public Health Association. Because these are estimates and the reporting systems on which they are based do not use consistent definitions, special efforts were made to avoid double-counting Federal grant dollars as they move out through the system or double-counting State funds granted to local jurisdictions. Critical judgment of experienced health officials was used to estimate expenditures for population-based services when a reporting category clearly included personal health services as well. State and local dollars are reported as separate figures, but differences in State laws, State and local organizational relationships, and State or local funding methods constrain separate estimates. Although the final dollar amount identified may not be as precise as, for example, per enrollee per month figures for hospital services derived from a large actuarial data base, it is important to note that the estimating methods tended to converge on the dollar amounts cited here and lend confidence to the figures.

Figure 6. Comparison of Population-Based Public Health Expenditures,¹ by Source of Funds, Selected Years, 1981-1993

	<i>Expenditures (in billions)</i>				
	1981	1985	1989	1991	1993
PHS Agencies					
PHS expenditures, excluding Federal grants to health departments	\$1.4	\$1.3	\$1.9	\$2.8	\$3.0
State and Local Health Departments					
Federal grants to health departments ²	0.4	0.5	0.7	1.0 ³	1.3 ³
State funds	1.1	1.6	2.2	2.5 ³	2.5 ³
Local funds	0.6	0.7	0.9	1.3 ³	1.6 ³
Total	\$3.5	\$4.1	\$5.7	\$7.6	\$8.4
Total U.S. health expenditures	\$290.2	\$422.6	\$604.3	\$751.8	\$900.0
Population-based expenditures as a percent of total national health expenditures	1.2%	1.0%	0.9%	1.0%	0.9%

Notes: ¹ Expenditures for services to individuals have been excluded. For State and local health departments, the exclusion totals 58.6% of total expenditures.

² Excluding WIC.

³ Estimated based on preliminary reported figures.

Sources: DHHS, Assistant Secretary for Management and Budget (appropriations)
Survey of PHS agencies for public health functions
Public Health Foundation, ASTHO Reporting System for State and local expenditures.

THE CORE FUNCTIONS PROJECT

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For copies of this paper or inquiries about The Core Functions Project, write to the Office of Disease Prevention and Health Promotion, U.S. Public Health Service, 330 C Street, S.W., Room 2132, Washington, D.C. 20201 (202/205-8611)

Calendar No. 335

103D CONGRESS
1ST SESSION**S. 1757**

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

IN THE SENATE OF THE UNITED STATES**NOVEMBER 20 (legislative day, NOVEMBER 2), 1993**

Mr. MITCHELL (for himself, Mr. MOYNIHAN, Mr. KENNEDY, Mr. DASCHLE, Mr. ROCKEFELLER, Mr. RIEGLE, Mr. AKAKA, Mr. BAUCUS, Mrs. BOXER, Mr. BUMPERS, Mr. CAMPBELL, Mr. CONRAD, Mr. DODD, Mrs. FEINSTEIN, Mr. GLENN, Mr. GRAHAM, Mr. HARKIN, Mr. INOUE, Mr. JEFFORDS, Mr. LEAHY, Mr. LEVIN, Mr. MATHEWS, Ms. MIKULSKI, Ms. MOSELEY-BRAUN, Mrs. MURRAY, Mr. PELL, Mr. PEYOR, Mr. REID, Mr. SIMON, and Mr. WOFFORD) (by request) introduced the following bill; which was read the first time

NOVEMBER 22, 1993**Read the second time and placed on the calendar**

1 Subtitle D—Core Functions of Pub-
2 lic Health Programs; National
3 Initiatives Regarding Preven-
4 tive Health

5 PART 1—FUNDING

6 SEC. 2301. AUTHORIZATIONS OF APPROPRIATIONS.

7 (a) CORE FUNCTIONS OF PUBLIC HEALTH PRO-
8 GRAMS.—For the purpose of carrying out part 2, there

9 are authorized to be appropriated \$12,000,000 for fiscal
10 year 1995, \$325,000,000 for fiscal year 1996,
11 \$450,000,000 for fiscal year 1997, \$550,000,000 for fis-
12 cal year 1998, \$650,000,000 for fiscal year 1999, and
13 \$750,000,000 for fiscal year 2000.

14 (b) NATIONAL INITIATIVES REGARDING HEALTH
15 PROMOTION AND DISEASE PREVENTION.—For the pur-
16 pose of carrying out part 3, there are authorized to be
17 appropriated \$175,000,000 for fiscal year 1996, and
18 \$200,000,000 for each of the fiscal years 1997 through
19 2000.

20 (c) RELATION TO OTHER FUNDS.—The authoriza-
21 tions of appropriations established in subsections (a) and
22 (b) are in addition to any other authorizations of appro-
23 priations that are available for the purposes described in
24 such subsections.

1 PART 2—CORE FUNCTIONS OF PUBLIC HEALTH

2 PROGRAMS

3 SEC. 2311. PURPOSES.

4 Subject to the subsequent provisions of this subtitle,
5 the purposes of this part are to strengthen the capacity
6 of State and local public health agencies to carry out the
7 following functions:

8 (1) To monitor and protect the health of com-
9 munities against communicable diseases and expo-
10 sure to toxic environmental pollutants, occupational
11 hazards, harmful products, and poor quality health
12 care.

13 (2) To identify and control outbreaks of infec-
14 tious disease and patterns of chronic disease and in-
15 jury.

16 (3) To inform and educate health care consum-
17 ers and providers about their roles in preventing and
18 controlling disease and the appropriate use of medi-
19 cal services.

20 (4) To develop and test new prevention and
21 public health control interventions.

22 SEC. 2312. GRANTS TO STATES FOR CORE HEALTH FUNC-
23 TIONS.

24 (a) IN GENERAL.—The Secretary may make grants
25 to States for the purpose of carrying out one or more of
26 the functions described in subsection (b).

(b) CORE FUNCTIONS OF PUBLIC HEALTH PROGRAMS.—For purposes of subsection (a), the functions described in this subsection are, subject to subsection (c), as follows:

(1) Data collection, activities related to population health measurement and outcomes monitoring, including the regular collection and analysis of public health data, vital statistics, and personal health services data and analysis for planning and needs assessment purposes of data collected from health plans through the information system under title V of this Act.

(2) Activities to protect the environment and to assure the safety of housing, workplaces, food and water, including the following activities:

(A) Monitoring the overall public health quality and safety of communities.

(B) Assessing exposure to high lead levels and water contamination.

(C) Monitoring sewage and solid waste disposal, radiation exposure, radon exposure, and noise levels.

(D) Abatement of lead-related hazards.

(E) Assuring recreation and worker safety.

(F) Enforcing public health safety and sanitary codes.

(G) Other activities relating to promoting the public health of communities.

(3) Investigation and control of adverse health conditions, including improvements in emergency treatment preparedness, cooperative activities to reduce violence levels in communities, activities to control the outbreak of disease, exposure related conditions and other threats to the health status of individuals.

(4) Public information and education programs to reduce risks to health such as use of tobacco, alcohol and other drugs, sexual activities that increase the risk to HIV transmission and sexually transmitted diseases, poor diet, physical inactivity, and low childhood immunization levels.

(5) Accountability and quality assurance activities, including monitoring the quality of personal health services furnished by health plans and providers of medical and health services in a manner consistent with the overall quality of care monitoring activities undertaken under title V, and monitoring communities' overall access to health services.

(6) Provision of public health laboratory services to complement private clinical laboratory services and that screen for diseases and conditions such as metabolic diseases in newborns, provide toxicology assessments of blood lead levels and other environmental toxins, diagnose sexually transmitted diseases, tuberculosis and other diseases requiring partner notification, test for infectious and food-borne diseases, and monitor the safety of water and food supplies.

(7) Training and education to assure provision of care by all health professionals, with special emphasis placed on the training of public health professions including epidemiologists, biostatisticians, health educators, public health administrators, sanitarians and laboratory technicians.

(8) Leadership, policy development and administration activities, including needs assessment, the setting of public health standards, the development of community public health policies, and the development of community public health coalitions.

(c) RESTRICTIONS ON USE OF GRANT.—

(1) IN GENERAL.—A funding agreement for a grant under subsection (a) for a State is that the grant will not be expended—

(A) to provide inpatient services;

(B) to make cash payments to intended recipients of health services;

(C) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(D) to satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds; or

(E) to provide financial assistance to any entity other than a public or nonprofit private entity.

(2) LIMITATION ON ADMINISTRATIVE EXPENSES.—A funding agreement for a grant under subsection (a) is that the State involved will not expend more than 10 percent of the grant for administrative expenses with respect to the grant.

(d) MAINTENANCE OF EFFORT.—A funding agreement for a grant under subsection (a) is that the State involved will maintain expenditures of non-Federal amounts for core health functions at a level that is not less than the level of such expenditures maintained by the State for the fiscal year preceding the first fiscal year for which the State receives such a grant.

1 **SEC. 3312. SUBMISSION OF INFORMATION.**

2 The Secretary may make a grant under section 3312
3 only if the State involved submits to the Secretary the fol-
4 lowing information:

5 (1) A description of existing deficiencies in the
6 State's public health system (at the State level and
7 at the local level), using standards of sufficiency devel-
8 oped by the Secretary;

9 (2) A description of health status measures to
10 be improved within the State (at the State level and
11 at the local level) through expanded public health func-
12 tions;

13 (3) Measurable outcomes and process objectives
14 for improving health status and core health func-
15 tions for which the grant is to be expended.

16 (4) Information regarding each such function,
17 which—

18 (A) identifies the amount of State and
19 local funding expended on each such function
20 for the fiscal year preceding the fiscal year for

21 which the grant is sought; and

22 (B) provides a detailed description of how
23 additional Federal funding will improve each
24 such function by both the State and local public
25 health agencies.

1 (5) A description of the core health functions to
2 be carried out at the local level, and a specification
3 for each such function of—

4 (A) the communities in which the function
5 will be carried out; and

6 (B) the amount of the grant to be ex-
7 pended for the function in each community so
8 specified.

9 **SEC. 3314. REPORTS.**

10 A funding agreement for a grant under section 3312
11 is that the States involved will, not later than the date
12 specified by the Secretary, submit to the Secretary a re-
13 port describing—

14 (1) the purposes for which the grant was ex-
15 pended; and

16 (2) describing the extent of progress made by
17 the State in achieving measurable outcomes and
18 process objectives described in section 3313(3).

19 **SEC. 3315. APPLICATION FOR GRANT.**

20 The Secretary may make a grant under section 3312
21 only if an application for the grant is submitted to the
22 Secretary, the application contains each agreement de-
23 scribed in this part, the application contains the informa-
24 tion required in section 3314, and the application is in
25 such form, is made in such manner, and contains such

1 agreements, assurances, and information as the Secretary
2 determines to be necessary to carry out this part.

3 **SEC. 3316. GENERAL PROVISIONS.**

4 (a) **UNIFORM DATA SETS.**—The Secretary, in con-
5 sultation with the States, shall develop uniform sets of
6 data for the purpose of monitoring the core health func-
7 tions carried out with grants under section 3312.

8 (b) **DURATION OF GRANT.**—The period during which
9 payments are made to a State from a grant under section
10 3312 may not exceed 5 years. The provision of such pay-
11 ments shall be subject to annual approval by the Secretary
12 of the payments. This subsection may not be construed
13 as establishing a limitation on the number of grants under
14 such section that may be made to the State.)

15 **SEC. 3317. ALLOCATIONS FOR CERTAIN ACTIVITIES.**

16 Of the amounts made available under section 3301
17 for a fiscal year for carrying out this part, the Secretary
18 may reserve not more than 5 percent for carrying out the
19 following activities:

20 (1) Technical assistance with respect to plan-
21 ning, development, and operation of core health
22 functions carried out under section 3312, including
23 provision of biostatistical and epidemiological exper-
24 tise and provision of laboratory expertise.

1 (2) Development and operation of a national in-
2 formation network among State and local health
3 agencies.

4 (3) Program monitoring and evaluation of core
5 health functions carried out under section 3312.

6 (4) Development of a unified electronic report-
7 ing mechanism to improve the efficiency of adminis-
8 trative management requirements regarding the pro-
9 vision of Federal grants to State public health agen-
10 cies.

11 **SEC. 3318. DEFINITIONS.**

12 For purposes of this part:

13 (1) The term "funding agreement", with re-
14 spect to a grant under section 3312 to a State,
15 means that the Secretary may make the grant only
16 if the State makes the agreement involved.

17 (2) The term "core health functions", with re-
18 spect to a State, means the functions described in
19 section 3312(b).

20 **PART 3—NATIONAL INITIATIVES REGARDING**
21 **HEALTH PROMOTION AND DISEASE PREVENTION**

22 **SEC. 3331. GRANTS FOR NATIONAL PREVENTION INITIA-**
23 **TIVES.**

24 (a) **IN GENERAL.**—The Secretary may make grants
25 to entities described in subsection (b) for the purpose of

1 carrying out projects to develop and implement innovative
 2 community-based strategies to provide for health pro-
 3 motion and disease prevention activities for which there
 4 is a significant need, as identified under section 1701 of
 5 the Public Health Service Act.

6 (b) ELIGIBLE ENTITIES.—The entities referred to in
 7 subsection (a) are agencies of State or local government,
 8 private nonprofit organizations (including research institu-
 9 tions), and coalitions that link two or more of these
 10 groups.

11 (c) CERTAIN ACTIVITIES.—The Secretary shall en-
 12 sure that projects carried out under subsection (a)—
 13 (1) reflect approaches that take into account
 14 the special needs and concerns of the affected popu-
 15 lations;

16 (2) are targeted to the most needy and vulner-
 17 able population groups and geographic areas of the
 18 Nation;

19 (3) examine links between various high priority
 20 preventable health problems and the potential com-
 21 munity-based remedial actions; and

22 (4) establish or strengthen the links between
 23 the activities of agencies engaged in public health
 24 activities with those of health alliances, health care

1 providers, and other entities involved in the personal
 2 health care delivery system described in title I.

3 SEC. 3332. PRIORITIES.

4 (a) ESTABLISHMENT.—

5 (1) ANNUAL STATEMENT.—The Secretary shall
 6 for each fiscal year develop a statement of proposed
 7 priorities for grants under section 3331 for the fiscal
 8 year.

9 (2) ALLOCATIONS AMONG PRIORITIES.—With
 10 respect to the amounts available under section
 11 3301(b) for the fiscal year for carrying out this part;
 12 each statement under paragraph (1) for a fiscal year
 13 shall include a specification of the percentage of the
 14 amount to be devoted to projects addressing each of
 15 the proposed priorities established in the statement.

16 (3) PROCESS FOR ESTABLISHING PRIORITIES.—

17 Not later than January 1 of each fiscal year, the
 18 Secretary shall publish a statement under paragraph
 19 (1), in the Federal Register. A period of 60 days
 20 shall be allowed for the submission of public com-
 21 ments and suggestions concerning the proposed pri-
 22 orities. After analyzing and considering comments
 23 on the proposed priorities, the Secretary shall pub-
 24 lish in the Federal Register final priorities (and as-

1994 DARLING-OMENN NEW YEAR'S FAMILY NEWSLETTER

Renaissance Weekend in Hilton Head, South Carolina was a terrific interaction of families with multitudinous topical panels, sports, music and the special attraction of extensive participation by the Clintons. All five of us descended on Hilton Head on December 28 and departed January 2. Renaissance Weekend was initiated in 1981 by Phil & Linda Lader and friends as a constructive approach to celebrating the New Year among a handful of families (now 300+ families)--and put their Hilton Head resort to good use. Each of us served on a panel: "Interesting Things to Know About Where I Live", "Coping with Peer Pressure", "Views of Young Professionals", "Mr. Secretary...About Our Schools" (with Dick Riley), "Health Care Reform" (with Ira Magaziner and the Clintons), and "Dying Young at an Old Age" (with Betty Friedan). David played touch football with the President; I played the piano and Martha was one of the Renaissance Singers for the closing evening production. We renewed some friendships from 12-15 years ago. We come away reinvigorated for personal, professional and political goals. It was a great way to celebrate our 10th Anniversary; we were warmly congratulated by Rachel, Jason and David for making this milestone!

Rachel had a big year--graduating from the University of Colorado in May with a fine record. She packed up her car and drove directly to Atlanta for a sensational summer internship in Global Marketing/International sports Promotions at Coca Cola HQ. Unfortunately, no permanent hiring there. Now she is working in health policy consulting in Baltimore. For her spring vacation, she organized a wonderful week with Jason and Dad at Club Med in Sonora Bay, Mexico: intensive tennis in the AM, intensive scuba in the PM, plus lots of evening activities. They were pretty amazed that Dad survived all week with no radio, TV, newspaper, telephone or fax!

Jason is a senior at Middlebury College, immersed in his History thesis dealing with the origins and impact of the Flexner Report on Medical Education. He seems headed for business, too. He had an excellent summer job experience with the House Ethics Committee, chaired by Jim McDermott of Seattle; their offices have a spectacular view right down the Mall to the Washington Monument and Lincoln Memorial from the lower level of the Capitol. The previous summer he was an intern in the financial section at biotech leader Amgen and had a great time in southern California.

David plays on soccer, flag football, basketball and baseball teams (by season), things strategically and statistically about every sport, also plays tennis and swims. A visit to the Mariners' spring training in Arizona in early March was the highlight on the sports front (memories and autographs galore). School projects are increasingly sophisticated--a Colorado state paper, a science fair project on the water cycle, weekly current events oral reports, and his research report on elephants, embellished with his extraordinary observations from our safari in Zimbabwe and Botswana in September 1992. This year he went to a grandparent/grandchild ElderHostel at Harambe Oaks Ranch in Texas in June. In August, with Grandmom LuAnn, Uncle Steve and Mom, he explored the Oregon Trail on the

Sesquicentennial of that remarkable migration--which brought his great-grandmother and her family to Oregon by covered wagon in 1889. He and Jason and we also spent a memorable Northwest weekend visit with friends on Dinner Island in the San Juans--including crab pots, sea lions, fishing and paddle tennis. In December we three had a rendezvous in Philadelphia with Grammy Lee and Grandpa Len, Uncle Neil, and Omenn cousins. More Darling and Omenn cousins in California en route to Hilton Head. Now he must make a choice of Middle School (grade 6 next fall)!

Martha continues to work on a challenging array of local, state and national education initiatives of special interest to the Boeing CEO and the Commercial Airplane Group President. A particular focus is implementation of comprehensive state reform legislation enacted in April with considerable involvement by Boeing and Martha. She was a speaker for the Fortune Magazine Education Summit in September and drew compliments for Boeing from both Secretary Riley and President Clinton at Renaissance Weekend. She continues as a Reed College Trustee and chaired the President's Commission on Student Life, which issued an appropriately controversial report this spring. The World Affairs Council Board, a handful of education-related nonprofits and David's school work also keep her engaged. This year she and Gil joined Amitai Etzioni and John Gardner in DC for the launch of the Communitarian Network.

Gil is in his 11th year as Dean of the School of Public Health at the University of Washington. His long-term research programs on health promotion for older adults, chemoprevention of lung cancer in smokers and asbestos-exposed workers, and eco-genetics of predisposition to chemical hazards are flourishing. Meanwhile, he's much involved in national health, environmental, and science policy matters. Speaker Foley appointed him to the National Commission on Risk Assessment and Risk Management [which may never meet!], and he was among the "100 physicians" who came to the White House for the launch of the Clinton Health Plan the same weekend Martha was at the Education Summit. Along with his UW colleagues he is committed to assuring that the excellent State of Washington Health Plan be in the vanguard of national reform of medical and public health services. He's optimistic about the Mayor's new Task Force on Violence Prevention. Finally, he continues to serve on a variety of national and corporate boards and committees.

We are hopeful that the economy will continue to improve, that health care reform will be enacted in 1994, and that the quality of life in our communities and throughout our tumultuous world can be enhanced through individual inspiration and collective action. We wish all of you a healthy, satisfying and productive 1994.

Gil Omenn & Martha Darling & David, Jason, and Rachel Omenn
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GUIDANCE FOR TRAVELERS

**Office of Disease Prevention and Health Promotion
Public Health Service
U.S. Department of Health and Human Services**

This guidance is prepared especially for people who are traveling on invitational travel orders prepared by the Office of Disease Prevention and Health Promotion (ODPHP). Securing of transportation arrangements and reimbursement for expenses will be greatly facilitated by following this guidance. If you have questions about any of these steps, please call the ODPHP secretary whose name and telephone number is provided at the end of this guidance.

1. When you are invited to a meeting convened by ODPHP, a staff person will contact you to get necessary information, including your full name, mailing address, and social security number. A travel order will be prepared and necessary information will be forwarded to the Omega travel agency, please contact Omega Airline directly to make travel arrangements.

Please note that the U.S. Government has contracts with airlines providing discounts for transportation costs between major cities. We are obligated to use these contracted airlines except in compelling circumstances that call for explicit written waiver of the contract obligation. We appreciate travelers' acceptance of this limitation on Omega's and our own flexibility in arranging airline travel.

2. A ticket will be sent to the traveler, unless time constraints require that the ticket be wired to the airport from which the traveler will depart.
3. At the meeting, ODPHP will provide travelers with a voucher form to be signed. We encourage travelers to leave the signed voucher with staff at the meeting, though they can be taken and mailed in with necessary receipts.
4. After the traveler returns from the meeting, it is necessary to send to ODPHP in the franked envelope provided for that purpose (care of the secretary whose name is provided below) the following items:

- passenger receipt of the airline ticket
- hotel/lodging receipt
- receipt for all ground transportation (taxi, shuttle, metro)/parking
- the signed voucher, if you did not leave it with staff at the meeting
- information regarding departure/arrival times and ground transportation (use attached report form, please).

Meals are reimbursed on a set schedule, varying by locality; if meals are provided as a part of the meeting, reimbursement is not provided for those meals. If ODPHP has arranged direct billing for lodging, a lodging receipt is not required and reimbursement to the traveler for lodging will not be made.

5. We request that travelers return receipts to ODPHP within one week of return from the meeting. We will prepare the travel voucher and submit it for reimbursement within two weeks of its receipt. Processing usually requires approximately 3 weeks following submission from our office.
6. If you have any difficulties, please do not hesitate to call the secretary whose name is provided below. If you have reason to believe that reimbursement has been delayed longer than 6 weeks, please be sure to call us.

We want to thank you for providing assistance to us and be willing to travel as a part of that assistance. We will do our best to make arrangements and follow-up to your travel as efficient as possible.

Secretary's Name: Delores Flenoury
Secretary's Telephone: 202/205-8583/FAX 205-9478