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Message:

See attached changes). Only those pages with changes were faxed.

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August 20, 1993

FAX copy & changes to Ron

Ms. Christine Gebbie
AIDS Policy Office
750 17th Street, NW - Suite 1060
Washington, DC 20503

Dear Chris:

Thanks for the note. I will look you up when I'm in D.C. If there is something special I could, of course, come down for a day.

I'm actually writing on a specific matter. As you will recall your prepared a brief paper last winter "Rebuilding a Public Health Infrastructure" for a conference that I co-chaired. Larry Gostin, Nancy Dubler and I are now editing the papers for publication and with less than two weeks left wanted to give you a chance to rethink the piece that you gave us.

Given your experience in Phil Lee's office and in your current position, and with staff now available to you we thought that you might want to modify or bolster what you wrote 9 months ago. This is not an appeal to make it longer. In fact we would like you to make it tighter in part by condensing the first 5 pages or so (the paper really begins in longest on pg. 5 after the first full paragraph).

Since your things may still be in boxes or on the west coast I am sending you a copy of what you had sent us.

In any event because of production schedules we will need a final paper by **September 7th** that is an inflexible date because of printing, etc. I hope you will take the opportunity to revisit you own work.

Best wishes, will you be in San Francisco for the APHA, maybe we can have a drink?

Sincerely,

Ronald Bayer
Professor

cc: Larry Gostin
Nancy Dubler

Rebuilding a Public Health Infrastructure

Kristine M. Gebbie
American Society of Law and Medicine
New York City

A major focus of current interest in rebuilding public health infrastructure has been New York City, and to a lesser extent the other large cities which are already experiencing outbreaks of multiple-drug resistant tuberculosis (MDR-TB). In contrast, I speak from the world where MDR-TB is still a "not me" issue, and where the case numbers for all forms of tuberculosis are probably just a blip on the New York City screen. Despite the smaller numbers, the issue is just as great a challenge. The "not me" response is often not a real belief that MDR-TB is not of concern, but an honest reaction to an overwhelming workload and need to attend to the diseases and threats that are immediately evident, rather than having the time to anticipate. Concerns of how to secure an appropriate public health infrastructure permeate the public health circles of this country, and the emergence of MDR-TB has only increased the level of worry.

Infrastructure

~~While the word "infrastructure" is in increasingly common use today, it is not one we stop to define very carefully.~~ In discussions of state and local government, "infrastructure" usually refers to the capital improvements which make life in modern society possible--roads and bridges, water and sewer systems, waste water treatment systems. These systems are often built and even managed by the

public sector for the good of all. ~~To a lesser extent the definition is expanded to include all of the physical and human systems which link a community, such as police and fire departments~~. Perhaps a simple definition of any infrastructure is "what you need but often don't see". For example, works of art frequently include bridges crossing picturesque valleys or raging rivers. Considering the bridge as infrastructure, however, it isn't the visual impact that is important. What does matter is the capacity of that bridge to safely support whatever traffic will use it to cross the river below.

~~Carrying the bridge analogy a bit further:~~ Any component, such as bridge is only as strong as its weakest member, and ~~the bridge~~ must be constructed with planned uses in mind. If the middle span is weak, strong railings won't compensate. While it is not unusual for railroads to have separate bridges from auto or truck traffic, or for a pedestrian bridge to be apart from wheeled conveyances, we do not see individual bridges for each type of movement: commercial activity, commuting, recreation. With good planning a limited number of spans are organized and structured to convey all traffic (pedestrian or wheeled, private or commercial) from one bank to the other. In fact, we find it an eye-sore if there is an unnecessary proliferation of structures, and a safety hazard when a bridge is used for traffic for which it was not designed. As we learned in our response to the HIV epidemic when it emerged a decade ago, our capacity to respond was severely limited by the weak links of underfunded surveillance networks, minimal STD or substance abuse

treatment capacity, and underdeveloped community outreach in the most affected communities.

Public Health Infrastructure

Public health infrastructure can be developed just like bridges: one structure for each disease or risk or activity; or a coordinated system which serves all effectively. And since diseases know no political boundaries, it is appropriate to think of the infrastructure needs across the country, not just in any one city, county or state. ~~In doing that, a reality check is important. While it is easiest, and most common, to focus on larger cities and big health departments~~, over 70% of the local health departments in this country have less than 100 staff, and over half have less than 10 full time equivalent employees (based on data collected by the National Association of County Health Officials). ~~Whether small, and thus having a limited capacity to develop specialized knowledge in any one area of concern, or very large and specialized~~, local health ~~these~~ departments are often overwhelmed by demands for personal medical care by those without access to the existing care system.[1] ~~Most small departments cannot afford a full-time physician prepared in public health, and make use of limited hours of medical consultation from a local family practitioner or pediatrician (or in one county with which~~ I am

[1]Cahill, Kevin A. Imminent Peril: Public Health in a Declining Economy, 20th Century Fund Press, New York City, 1991.

familiar, oral surgeon).

In the years since the Institute of Medicine (IOM) Report on the Future of Public Health[2] was published, the discussion of what to do to repair the infrastructure has been overwhelmed by the national debate on health care reform. This is an important discussion which usually is focused on either the disproportionally high rate of inflation in the medical care sector of the economy, or on the inexcusably high number of individuals and families in our country who lack a mechanism of payment for personal medical care. To a lesser extent, there is attention to the non-financial barriers to care, which include geographic mal-distribution of practitioners, language or cultural barriers to communication, or divergent value judgements on what constitutes appropriate care.

If we are to have a personal care system which works well for all or almost all residents, and one that does so at a cost which is affordable, then that personal care system must be part of a larger system which includes adequately funded and well-functioning state and local health departments. For this to occur, we should probably shift our vocabulary to discuss not "health care reform" but "health reform" or "health system reform". It takes work, but it can be done: the recently published report of the Washington State Health Commission makes it clear that both personal care and population-based health services must be supported in a reformed

[2]Institute of Medicine, The Future of Public Health, National Academy Press, 1988.

system which strives for a higher level of health for all.[3] This same model is under discussion nationally.

~~What would this infrastructure look like if it were adequately supported? Perhaps rather like a well-functioning fire department, it would be for the most part invisible to the casual observer, but there to respond quickly when needed, and occupied energetically with fire prevention activities which reduce the need for emergency response, and build relationships within the community. In the same manner,~~ If enacted, we would have a well-supported public health system ~~is~~ available to respond to outbreaks of communicable diseases, or spills of toxic chemicals, ~~but is generally occupied with~~ continuously monitoring health status through vital records and reportable conditions, ~~and with~~ risk reduction and health promotion activities in a variety of settings, collaborating with care providers & others to assure and assuring quality in the overall system. Start

It is important to understand and separate the personal care activities from the public health actions. Tuberculosis presents a challenge because it overlaps into both systems. Both in large cities with large numbers of patients, and in smaller communities with only an occasional case, the lack of a universal personal care system means that the health department may be the only source of care available to the infected individual. This means not only providing anti-tuberculosis drugs, but all other primary care as well as needed hospitalization. If there were a functioning care system, the health department could limit itself to the identification of new cases, intensive casework with difficult-to-

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[3]Washington Health Care Commission. Final Report to Governor Booth Gardner and the Washington State Legislature, November 30, 1992.

treat individuals, development and enforcement of infection control guidelines, and consideration of additional primary prevention strategies, such as participation on a neighborhood housing improvement project. In the current situation, there is little or no capacity to expand tuberculosis screening into all recommended settings, let alone do a really thorough job of follow up on all of those screened. A similar story could be told of capacity to respond to HIV infection, teen pregnancy, lead poisoning or threatened drinking water sources.

Core Functions

The Institute of Medicine report cited earlier developed a rubric of terms which have become fairly common in describing the basic infrastructure role of an official health agency. These "core functions" are identified as assessment, policy development and assurance. A brief description of each will provide the framework for discussing what needs to be rebuilt across this nation.

Assessment is the process of determining what is happening in the community: gathering facts and interpreting them to provide useful information. These data include information on health status, as identified through traditional vital statistics or disease reporting systems. Assessment also encompasses information on threats to health such as that which is collected through environmental monitoring programs. Finally, a good assessment process will include attention to the community capacity to respond

to threats to health, or to maintain and promote health. This includes information on all health related resources, and community development resources. In most areas, assessment is a function shared by state and local health agencies: information may be collected or analyzed at either level, and is shared between them as it is applied to provide either a local or state-wide perspective. This local network is the foundation of the Centers for Disease Control & Prevention (CDC) national surveillance system, as well.

Policy development may be the least expensive, though occasionally the most visible of the core functions. This is the development of proposals for action, based on the information made available from assessment. Policy development may be internal to the health community, as when public health agencies and pediatric groups work to refine the schedule of childhood immunizations. It may also be national in scope, as in our ongoing efforts to clarify an appropriate response to tobacco-related diseases. At all levels, good policy development means effective communication with community leaders, political decision makers, and those directly affected by the proposed actions. A major reflection of public health policy in any jurisdiction will be the health agency's budget allocation, though policy is also expressed in statute, ordinance, executive order, organizational chart, or public education messages.

The concept of assurance as the third core function has been more difficult for many to understand and communicate. As I have considered it, it encompasses the entire range of actions needed to see that decided policy is carried out, and is carried out well. It does not mean, however, that the official health agency has sole, or even any, responsibility for the direct actions required. For example, it is public policy in all jurisdictions in this country that public water supplies be safe; I do not know of any health departments which directly manage drinking water systems. The health agency is responsible for technical assistance to and education of water system operators, for monitoring the water actually pumped to households, and for taking action should there be a failure.

The provision of personal care services, either as the community's provider of last resort, or for special populations which do not readily fit into the mainstream of service, is an assurance function assumed by many health departments. In others, there is a very strong bias against such activities, and the official agency's role is seen as that of organizer, stimulator, or even payer, of others who provide direct service. In either case, there is a risk that attention to individual ill persons will be an endless distraction from responding to the community as a whole.

These three functions do not stand in a sequence which, once completed, ends the process. Rather, they form a continuous circle, or spiral, in which assessment leads to policy development

which leads to assurance which leads to a new assessment and on again. In the present state of affairs, there are so many demands for activity on the part of health agencies, and so many unmet needs, that there is little time for thoughtful assessment of more than the obvious indicators, and policy development is often a hurried response to public outcry. From the IOM report, and the thinking of leaders in the field, a major need is to keep the three functions in balance and complementing one another over time.

Rebuilding

It's not clear whether the term should be "rebuilding" or just plain "building", but the capacity to fully perform the core public health functions is not in place in this country. In Washington State, a recent careful look at funding for public health agencies yielded the reliable estimates that less than 3% of the total health-related expenditures were directed to public health, and that this was less than 1/2 of what was needed. Further, a sizeable portion of what is now spent by the public health agencies was directed to filling the current gaps in personal health care services. There is no reason to think that the circumstances are markedly different in any of the other 49 states.

The infrastructure of official health agencies should be built with the goal of a system which can be responsive over an extended period of time to a variety of threats to health, in a variety of

changing circumstances. It would be wasteful to invest in a system which can only respond to tuberculosis in 1993 and which would need complete replacement were TB to be brought under control and some other condition emerge in its place. The system, in fact, needs to be build with the assumption of such change, based on the findings of assessment, and the decisions which emerge in the policy development process.

The assessment capacity must be an active one, based on planned surveillance of issues of concern. That means staff available to talk regularly to hospitals, physicians, other care providers. It means a system of local reporting which is pooled at the state and national levels, and which includes capacity to follow up on unusual events or suspicious circumstances. It also means active thinking about the results of surveillance--continually asking the question "what am I NOT seeing?"[4] For example, given the emergence of MDR-TB, every health agency should be critiquing current tuberculosis surveillance techniques to see if they are adequate to identify a drug-resistant infection, if it were present. Those responsible for assessment in adjoining jurisdictions should have a well-used system of comparing notes and sharing information.

Policy development should be responsive, both to emerging health information, and to the needs and concerns of the community served. We are only just fully understanding the cultural diversity of this

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[4]Institute of Medicine Emerging Infections, DC:National Academy Press, 1992.

country, and what it might take to make all of our public programs truly relevant to all. Because so many illness problems, and so many threats to health, are disproportionately felt by those in communities of color, and those using other than English as a first language, it is essential that we learn ways of building those communities into the infrastructure of public health, as advisors, as staff, and most particularly as comfortable participants in shaping direction. The public health system must be constantly alert to inclusion of those threatened with disenfranchisement, as has happened based on unpopular conditions such as substance abuse.

A further challenge to policy development is that of continuous improvement. No policy is either perfect or permanent. Many of our public health laws are outdated; written decades ago, they do not reflect current scientific understanding of diseases, or current expectations about assurance of individual civil rights while acting to protect the community. As many learned in early AIDS-related policy debates, discussions of core public health law can be difficult and painful. In some jurisdictions, public health agencies were restricted from actions which they felt were appropriate, and in others they were given unwanted authority to limit the actions of individuals. A responsive policy development function will include ongoing communications with all components of the community so that difficult policy decisions will not be debated among strangers, and the goals of the health agency will be transparent to all concerned. Laws would be updated as the social system evolves, before crises occur.

As with the more abstract discussion of assurance above, describing a rebuilt assurance function is difficult. This is because the assurance will be, in each community, a locally unique blend of care and prevention, of public and private activities. The policy debate should spell out what is expected, and who is expected to do it, so that the health agency can concentrate its efforts appropriately, either as an organizer, a provider, or a monitor of programs. In all cases, each program included in the agency should be "rich" enough that an unusual demand in one area does not necessitate shutting down all other activity. For example, while it might be reasonable to curtail most other services during a once-a-year, back-to-school immunization day, it should be possible to investigate a food-born outbreak, immunize children, conduct tuberculosis case-finding, and instruct water system operators at the same time. To return to the fire department analogy, it is only the rare and very large fire which demands all available equipment: in ordinary circumstances, even while a fire is being extinguished in one part of town, other engines are on standby elsewhere, and the school fire prevention class continues.

Beyond the direct outreach and service activities of each agency, there must be a capacity to work with and adapt quality assurance guidelines to local circumstances. That generally means staff time to attend regional or state-wide meetings to learn about the standards, and then local meetings with affected parties to consider applications and variations. Too often, people think the job is done when the standard is published in the MMWR or the

Federal Register. Blind adherence to such standards can be a force fit, wasting resources and leaving important matters untended.

If we fail to connect the assurance function with a continuing assessment, there is a further gap. For example, despite many years of assertion that all HIV infected individuals should be screened for TB, as well as the reverse, we are far from full implementation. The gap is due to the shortage of staff in both TB and HIV related programs, and to lack of planning and training time in which to develop ways to integrate these two concerns. A fully developed assurance function would have anticipated the need for staff development, revised clinic protocols, and provider education. A more active assessment function might have revealed the gap between policy and reality more fully before the enormous jump in TB cases.

The emergence of a new TB epidemic, in part resistent to many of our otherwise effective therapies, and the inter-relationship of that epidemic with the continuing expansion of HIV infection, provides a stimulus to invest in public health agencies. Policy makers are frightened by the thoughts of an old disease once again attacking the public, and continue fearful in the face of the personal and economic cost of these communicable conditions. It would be possible to create disease-specific responses, and in part we must do so--the response to any disease or threat to health must be uniquely grounded in the biology, behavior, and impact of the

causative organism. But what is really needed is a basic public health system vigorous enough to respond not only in the short term to these "popular" (or rather, unpopular) conditions, but over time to all of the many conditions which keep up from collectively living up to our potential. This infrastructure may never be as visible and glamorous as many of our high-technology curative palaces, but it is probably even more essential to keep our communities viable.