NBPHE Review:

Health Policy and Management

January 16, 2017

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Public Health

What My Parents Think I Do
What My Friends Think I Do
What My Kids Think I Do

What Society Thinks I Do
What I Thought I’d Be Doing
What I Actually Do
Public Health

What my friends think I do
What my mother thinks I do
What society thinks I do
What the government thinks I do
What I think I do
What I really do
Disclaimer #1

Materials provided in this presentation are from a variety of sources.

Based upon the webinar format of this session, citation of original sources is not presented.
Disclaimer #2

What is on...

...the TEST
Disclaimer #3
Master’s Degree in Public Health Core Competency Development Project

Version 2.3

August 2006
# HEALTH POLICY AND MANAGEMENT

Health policy and management is a multidisciplinary field of inquiry and practice concerned with the delivery, quality and costs of health care for individuals and populations. This definition assumes both a managerial and a policy concern with the structure, process and outcomes of health services including the costs, financing, organization, outcomes and accessibility of care.

*Competencies:* Upon graduation a student with an MPH should be able to...

| 1. | Identify the main components and issues of the organization, financing and delivery of health services and public health systems in the US. |
| 2. | Describe the legal and ethical bases for public health and health services. |
| 3. | Explain methods of ensuring community health safety and preparedness. |
| 4. | Discuss the policy process for improving the health status of populations. |
| 5. | Apply the principles of program planning, development, budgeting, management and evaluation in organizational and community initiatives. |
| 6. | Apply principles of strategic planning and marketing to public health. |
| 7. | Apply quality and performance improvement concepts to address organizational performance issues. |
| 8. | Apply "systems thinking" for resolving organizational problems. |
| 9. | Communicate health policy and management issues using appropriate channels and technologies. |
| 10. | Demonstrate leadership skills for building partnerships. |
Certified in Public Health (CPH) Exam

CONTENT OUTLINE

April 2014
Health Policy and Management

1. US Health Care Delivery System
   A. Continuum of Care – Primary through Long-Term Care
   B. Not-for-profit, For-profit, Government Organizations
   C. Health Care Financing, Public and Private
   D. Federal programs – Medicare, Medicaid, Tricare, Social Security, Children’s Health Insurance
   E. Patient Protection and Affordable Care Act
      1. HIPAA
      2. Health Care Utilization, Elasticity of Demand
      3. Basic Insurance Concepts

2. Access, Cost and Quality Considerations

3. Global Health Care Systems
   A. Financing and Delivery Models

4. US Health Policy
   A. Policy-Making Process
      1. Federal
      2. State
      3. Local
   B. National Advocacy Organizations
   C. Stakeholder Participation
   D. Advocacy – Federal, State and Local Levels
   E. Social Ethics
   F. Health Economics

5. Management and Leadership
   A. Organizational Management
      1. Organizational Structure
      2. Strategic Management and Leadership
      3. Program Planning and Marketing
      4. Organizational Ethics
      5. Accountability
B. Human Resources Management
   1. Staffing Principles
   2. Recruitment, Motivation, Retention
   3. Performance Improvement

C. Financial Management
   1. Resource Allocation and Control
   2. Budgeting
READY FOR A QUIZ?
Health Care Systems

1. Receiving Certification in Public Health (CPH) from the NBPHE is an example of:

   a. Structure
   b. Environment
   c. Process
   e. Outcome
Health Care Systems

2. The smallest percentage of U.S. health care spending addresses:
   a. Nursing services
   b. Public health services
   c. Physician services
   d. Pharmaceutical services
   e. Hospital services
3. Potential Injury to research participants is best addressed in the *Belmont Report* by:

a. Respect
b. Justice
c. Litigation
d. Assessment of Benefits
e. Beneficence
4. The U.S. Constitution empowers the detention of contagious individuals entering the U.S.
   a. True
   b. False
5. Paying a monthly flat fee for all medical care needed is typical of:
   a. Fee-for-service
   b. A health maintenance organization
   c. A preferred provider organization
6. Shriner’s Hospital for Children would be classified as:
   a. Sectarian
   b. Investor owned
   c. State Government
   d. Non sectarian
   e. Federal Government
7. “By February 1, 2017 there will be a 0.2% reduction in HIV infections” is an example of:

a. Mission
b. Vision
c. Objective
d. Goal
e. Program
8. Budgeting for the recurring monthly restocking of 10,000 doses of Flu Vaccine would be a:

a. Variable cost
b. Charge
c. Fixed cost
d. General cost
We need:

• A health policy that assures adequate and sustained investment in the important determinants of health

• A strong governmental public health infrastructure

• A public health system that reflects public understanding that health is everyone’s business.
4 Components:

• Systems Thinking
• Health Policy
• Delivery Systems
• Health Management
Definition of Health

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Figure 4–2 A Strategic Web Example
Comparative Health: Cost Vs. Quality

I wish we had free medical care like in Cuba.

I wish we had good medical care like in the United States.

Image of two patients in hospital beds with thought bubbles expressing their wishes.

National Health Expenditures 2010 by Source of Payment

National Health Expenditures in the United States, by Source of Payment, 2010

Private Health Insurance: 32%
Other Private Spending: 7%
Out-of-Pocket Payments: 11%
Other Public Spending: 13%
Medicaid and CHIP\(^1\): 16%
Medicare: 20%

Total National Health Expenditures, 2010 = $2.6 Trillion

NOTES: \(^1\)Includes Children's Health Insurance Program (CHIP) and Children's Health Insurance Program expansion (Title XIX).
National Health Spending 2012 by Service
Diversity
Urban/Rural Diversity
System Resources

FIGURE 1–1 Resources required to maintain a health care delivery system
The Donabedian Model for Quality Measurement

External Environment
Patients, Societal Values, Politics, Resources, Expectations, Health Care Professionals, Scientific Discovery, and Knowledge About Patient Care

Structure → Process → Outcomes

Feedback

Structure → Feedback → Process

Process → Feedback → Structure
The Public Health System

- Community
- Health care delivery system
- Governmental Public Health Infrastructure
- Assuring the Conditions for Population Health
- Employers & Business
- Academics
- The Media

INSTITUTE OF MEDICINE
10 Essential Public Health Services
Systems Questions
Health Policy
Figure 1.3
The Intertwined Relationships Among Policy Formulation, Implementation, and Modification
SORRY OBAMA
NO
TELEPROMPTER
HERE
ONLY TEA
AND
FREEDOM OF SPEECH

THIS IS A
TAXING

KEEP
GOVERNMENT
OUT OF MY
MEDICARE!

YOU DAMN
SOCIALISTS!

REPEA
THE
PORK

RWNJ.ORG
Legal Basis
We the People
We the People of the United States,
in Order to form a more perfect Union, establish Justice,
insure domestic Tranquility, provide for the common defence,
promote the general Welfare,
and secure the Blessings of Liberty to ourselves and our
Posterity, do ordain and establish this Constitution for the
United States of America.
The federal government derives its authority for isolation and quarantine from the *Commerce Clause of the U.S. Constitution*.

- Under section 361 of the Public Health Service Act (42 U.S. Code § 264), the U.S. Secretary of Health and Human Services is authorized to take measures to prevent the entry and spread of communicable diseases from foreign countries into the United States and between states.
Statute/Law

- **Criminal Law**: conduct prohibited by government because it threatens and harms public safety and welfare
- **Civil Law**: Actions intended to protect the public health and welfare
Police Powers

• Encourage Behavior

• Coercive Action
  – Quarantine
  – Seize Property
  – Close Businesses
Administrative Regulations
**BOX 13-3 Checklist for Writing a Policy Analysis**

1. **Problem Statement**
   - Is my problem statement one sentence in the form of a question?
   - Can I identify the focus of my problem statement?
   - Can I identify several options for solving the problem?

2. **Background**
   - Does my background include all necessary factual information?
   - Have I eliminated information that is not directly relevant to the analysis?
   - Is the tone of my background appropriate?

3. **Landscape**
   - Does the landscape identify all of the key stakeholders?
   - Are the stakeholders’ views described clearly and accurately?
   - Is the structure of the landscape consistent and easy to follow?

   Is the tone of the landscape appropriate?
   - Does the reader have all the information necessary to assess the options?

4. **Options**
   - Do my options directly address the issue identified in the problem statement?
   - Do I assess the pros and cons of each option?
   - Did I apply all of the criteria to each option’s assessment?
   - Are the options sufficiently different from each other to give the client a real choice?
   - Are all of the options within the power of my client?

5. **Recommendation**
   - Is my recommendation one of the options assessed?
   - Did I recommend only one of my options?
   - Did I explain why this recommendation is the best option, despite its flaws?
Figure 7.1 A Model of the Public Policymaking Process in the United States: Policy Implementation Phase

Preferences of individuals, organizations, and interest groups, along with biological, cultural, demographic, ecological, economic, ethical, legal, psychological, social, and technological inputs

Policy Formulation Phase
- Agenda Setting
  - Problems
  - Possible Solutions
  - Political Circumstances
- Development of Legislation
- Window of Opportunity*

Policy Implementation Phase
- Bridged by Formal Enactment of Legislation
  - Rulemaking
  - Operation
- Feedback

Policy Modification Phase
- Feedback from individuals, organizations, and interest groups experiencing the consequences of policies, combined with the assessments of the performance and impact of policies by those who formulate and implement them, influence future policy formulation and implementation.

*The window of opportunity opens when there is a favorable confluence of problems, possible solutions, and political circumstances.
Healthcare Stakeholders

Providers

Payers

Employers

Patients
Ethics

Accepted standards of conduct. It includes such as the essential of life, human of language.
Allocating Resources

- Equal shares for all
- More pie for those who have gone without pie
- More power = More Pie
- Those who make the greatest contribution get the most pie
- Equal shares unless a special case
- Those with the greatest need get the most pie
A code of ethics for public health clarifies the distinctive elements of public health and the ethical principles that follow.

It makes clear to populations and communities the ideals of the public health institutions that serve them.

A code of ethics thus serves as a goal to guide public health institutions and practitioners and as a standard to which they can be held accountable.

Codes of ethics are typically relatively brief; they are not designed to provide a means of untangling convoluted ethical issues.
The Public Health Professional’s Oath

• As a public health professional, I hold sacred my duty to protect and promote the health of the public. I believe that working for the public’s health is more than a job; it is a calling to public service. Success in this calling requires integrity, clarity of purpose and, above all, the trust of the public. Whenever threats to trust in my profession arise, I will counter them with bold actions and clear statements of my professional ethical responsibilities.

• I do hereby swear and affirm to my colleagues and to the public I serve that I commit myself to the following professional obligations.

• In my work as a public health professional:

  • I will strive to understand the fundamental causes of disease and good health and work both to prevent disease and promote good health.
  • I will respect individual rights while promoting the health of the public.
  • I will work to protect and empower disenfranchised persons to ensure that basic resources and conditions for health are available to all.
  • I will seek out information and use the best available evidence to guide my work.
  • I will work with the public to ensure that my work is timely, open to review, and responsive to the public’s needs, values, and priorities.
  • I will anticipate and respect diverse values, beliefs, and cultures.
  • I will promote public health in ways that most protect and enhance both the physical and social environments.
  • I will always respect and strive to protect confidential information.
  • I will maintain and improve my own competence and effectiveness.
Belmont Report Core Principles:

**Respect for persons:** Protecting the autonomy of all people and treating them with courtesy and respect and allowing for informed consent. Researchers must be truthful and conduct no deception;

**Beneficence:** The philosophy of "Do no harm" while maximizing benefits for the research project and minimizing risks to the research subjects; and

**Justice:** ensuring reasonable, non-exploitative, and well-considered procedures are administered fairly — the fair distribution of costs and benefits to potential research participants — and equally.

Primary areas of application:
Informed consent, Assessment of risks, and Assessment of benefits
Implementing Policy
How a Bill Becomes a Law

**Figure 2-1 How a Bill Becomes a Law.**

1. Representative introduces bill in the House
2. Bill is read in the House and assigned to a committee by the Speaker
3. Bill leaves committee, is scheduled for floor consideration and debate, may be amended
4. House passes bill
5. Bill is sent to Senate
6. Senator introduces bill in the Senate
7. Bill is read in the Senate and assigned to a committee by the Majority Leader
8. Bill leaves committee, is scheduled for floor consideration and debate, may be amended
9. Senate passes bill
10. Bill is sent to House

A conference committee is created to resolve differences if both chambers do not pass an identical bill.

Identical bill is passed by both House and Senate OR one branch agrees to the other branch’s version OR bill is amended and both branches vote again and pass amended version.

Bill is presented to the President, who has four options:

- **Option 1:** President signs bill into law
- **Option 2:** During congressional session, bill becomes law after 10 days without presidential signature
- **Option 3:** When not in session, bill does not become law without presidential signature
- **Option 4:** President vetoes bill. Two-thirds vote in House and Senate can override veto.
FIGURE 2-1 How a Bill Becomes a Law.

Representative introduces bill in the House

- Bill is read in the House and assigned to a committee by the Speaker
- Bill leaves committee, is scheduled for floor consideration and debate, may be amended

- House passes bill
- Bill is sent to Senate

A conference committee is created to resolve differences if both chambers do not pass an identical bill

Senator introduces bill in the Senate

- Bill is read in the Senate and assigned to a committee by the Majority Leader
- Bill leaves committee, is scheduled for floor consideration and debate, may be amended

- Senate passes bill
- Bill is sent to House

Identical bill is passed by both House and Senate OR one branch agrees to the other branch's version OR bill is amended and both branches agree to amended bill
House passes bill

Bill is sent to Senate

A conference committee is created to resolve differences if both chambers do not pass an identical bill

Senate passes bill

Bill is sent to House

Identical bill is passed by both House and Senate OR one branch agrees to the other branch's version OR bill is amended and both branches vote again and pass amended version

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Option 4: President vetoes bill. Two-thirds vote in House and Senate can override veto
Figure 6.6. Organization of the U.S. Department of Health and Human Services

### Executive Office of the President
(Selected Offices and Agencies)

<table>
<thead>
<tr>
<th>Domestic Policy Council</th>
<th>Office of National Drug Control Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office of Management and Budget</td>
<td>Office of Science and Technology Policy</td>
</tr>
<tr>
<td>Office of National AIDS Policy</td>
<td>Council on Environmental Quality</td>
</tr>
</tbody>
</table>

### Cabinet-Level Departments

- Department of Agriculture
- Department of Commerce
- Department of Defense
- Department of Education
- Department of Energy
- Department of Health and Human Services
- Department of Housing and Urban Development
- Department of the Interior
- Department of Justice
- Department of Labor
- Department of State
- Department of Transportation
- Department of the Treasury
- Department of Veterans’ Affairs

### Independent Federal Agencies (Selected Agencies)

- Agency for International Development
- Environmental Protection Agency
- Chemical Safety and Hazards Investigation Board
- Consumer Product Safety Commission
- Federal Emergency Management Agency
- Federal Mine Safety and Health Review Commission
- Medicare Payment Advisory Commission
- National Bioethics Advisory Commission
- National Science Foundation
- National Transportation Safety Board
- Occupational Safety and Health Review Commission

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**Figure 6.5. Federal Executive Branch Agencies Contributing to Public Health Activities**

*Source: Authors’ analysis.*
A historical look at health care legislation
A historical look at health care legislation

- **1798**: The Act for the *Relief of Sick and Disabled Seamen* marks the beginning of federal involvement in health care.
- **1906**: *Pure Food and Drug Act* ensured the safety of food and cosmetics and the safety and efficacy of prescription drugs and medical devices.
- **1918**: First Federal Grants to States to Provide Public Health Services.
- **1924**: The *Veterans Act of 1924* codifies and extends federal responsibilities for health care services to veterans, who receive aid if they are injured in the line of service.
A historical look at health care legislation

- **1935**: The Social Security Act, providing pensions and other benefits to the elderly, is signed into law by President Franklin Delano Roosevelt. National health insurance is left out of the final Social Security bill because of the opposition of organized medicine and its allies.

- **1963**: The Clean Air Act established federal enforcement in interstate air pollution and assistance to state and local government in controlling air pollution.
A historical look at health care legislation

• **1965:** President Lyndon B. Johnson signs into law the landmark federal health insurance programs known as Medicare (Title XVIII) and Medicaid (Title XIX).

• **1985:** The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), signed into law by President Ronald Reagan, mandates an insurance program giving some employees the ability to continue health insurance coverage from their workplace after leaving the job. In addition, hospice care is made a permanent part of Medicare and extended to states for Medicaid.
A historical look at health care legislation

• **1996:** The Health Insurance Portability and Accountability Act improves continuity of health insurance coverage in group and individual markets for people who lose their job. The act also promotes medical savings accounts and improves access to long-term care services and coverage.

• **1997:** The State Children's Health Insurance Program is established to help provide medical care to children in low-income families that are not poor enough to qualify for Medicaid.
A historical look at health care legislation

- **2003**: President George W. Bush signs a law adding prescription drugs to Medicare Part D.
- **2010**: The Patient Protection and Affordable Care Act, also known as Obamacare. The aim of the law was to provide an expansion of health insurance coverage to more Americans through both individual health insurance exchanges.
The Doctor Will See You Now
Health Care With Trump in Charge

2017
The Year in Preview begins on
30.01.16

Proposition 61 Flies But the Idea Lives On .......... 14
Joint Venture Health Plans May Give ACOs Competition .... 25
Q&A With Marc Harrison, MD, Interncontinental's New Chief .......... 40
www.managedcaremag.com
The Patient Protection and Affordable Care Act

http://www.youtube.com/watch?v=3-Ilc5xK2_E
Hey, this is just as reliable as all the experts predicting what will happen with healthcare in 2017.
Policy Questions
Delivery Systems
Continuum of Care

Wear your BSI
Buckle-up
Eat healthier, work-out
Slow down
Shouldn’t we stop squawking and actually do something about safety?
Public Health Providers

NOTICE.
PREVENTIVES OF
CHOLERA!

Published by order of the Sanitary Committee, under the sanction of the Medical Council.

BE TEMPERATE IN EATING & DRINKING!

Avoid Raw Vegetables and Unripe Fruit!

Abstain from COLD WATER, when heated, and above all from Ardent Spirits, and if habit have rendered them indispensable, take much less than usual.
• Private Sector

• Government
Health Departments
## Key Health Facts

### Adult Health Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>U.S. Total</th>
<th>State with Highest/Worst</th>
<th>State with Lowest/Best</th>
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</thead>
<tbody>
<tr>
<td>% Uninsured, All Ages (2014)</td>
<td>11.7%</td>
<td>Texas (19.1%)</td>
<td>Massachusetts (3.3%)</td>
</tr>
<tr>
<td>AIDS Cumulative Cases Aged 13 and Older (2013 Yr End)</td>
<td>1,201,247</td>
<td>New York (203,817)</td>
<td>North Dakota (210)</td>
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<tr>
<td>Alzheimer’s Estimated Cases among Ages 65+ (2015)</td>
<td>5,426,300</td>
<td>California (590,000)</td>
<td>Alaska (6400)</td>
</tr>
<tr>
<td>% Asthma Prevalence (2013)</td>
<td>9%</td>
<td>Massachusetts (17.6%)</td>
<td>Texas (7.1%)</td>
</tr>
<tr>
<td>% Breastfeeding Exclusively at 6 Months from birth (2011)</td>
<td>18.8%</td>
<td>Mississippi (10.1%)</td>
<td>Vermont (29.6%)</td>
</tr>
<tr>
<td>Cancer Estimated New Cases (2015)</td>
<td>1,658,370</td>
<td>California (172,090)</td>
<td>D.C. (2,800)</td>
</tr>
<tr>
<td>Chlamydia Rates per 100,000 Population (2013)</td>
<td>456.1</td>
<td>D.C. (818.8)</td>
<td>West Virginia (254.5)</td>
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<tr>
<td>% Diabetes (2014)</td>
<td>N/A</td>
<td>West Virginia (14.1%)</td>
<td>Utah (7.1%)</td>
</tr>
<tr>
<td>Drug Overdose Deaths, Aggregate Crude Rates, Ages 12-25, All Intents (2011-2013)</td>
<td>7.3%</td>
<td>West Virginia (12.1%)</td>
<td>North Dakota (2.2%)</td>
</tr>
<tr>
<td>Drug Overdose Deaths, Aggregate Rates, All Ages, All Intents (2011-2013)</td>
<td>13.4%</td>
<td>West Virginia (33.5%)</td>
<td>North Dakota (2.6%)</td>
</tr>
<tr>
<td>Fruits per Day, % who met federal recommendations (2013)</td>
<td>13.1%</td>
<td>Tennessee (7.5%)</td>
<td>California (17.7%)</td>
</tr>
<tr>
<td>Human West Nile Virus Cases (as of 01/12/16)</td>
<td>2,060</td>
<td>California (730)</td>
<td>Maine &amp; Oregon (73)</td>
</tr>
<tr>
<td>% Hypertension (2013)</td>
<td>N/A</td>
<td>West Virginia (41.0%)</td>
<td>Utah (24.2%)</td>
</tr>
<tr>
<td>% Obesity (2013)</td>
<td>N/A</td>
<td>Arkansas (35.9%)</td>
<td>Colorado (21.3%)</td>
</tr>
<tr>
<td>% Physical Inactivity (2013)</td>
<td>N/A</td>
<td>Mississippi (31.6%)</td>
<td>Colorado (16.4%)</td>
</tr>
</tbody>
</table>
Top 10 Achievements in Public Health
Top 10 Achievements in Public Health

1. Vaccination
2. Motor-vehicle safety
3. Safer workplaces
4. Control of infectious diseases
5. Decline in deaths from coronary heart disease and stroke
6. Safer and healthier foods
7. Healthier mothers and babies
8. Family planning
9. Fluoridation of drinking water
10. Recognition of tobacco use as a health hazard
Panic In the Streets (1950)
Local Public Health Departments
Flint, Michigan
Public Health Expenditures As a Percentage of Health Expenditures

- Public Health Expenditures: 1%
- Total Health Expenditures: 99%

The Core Function Project: U.S. Public Health Service, 1993
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
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<tr>
<td>West Virginia</td>
<td>$408,520,377</td>
<td>$220.8</td>
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<tr>
<td>Hawaii</td>
<td>$224,753,616</td>
<td>$158.3</td>
<td>2</td>
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<td>District of Columbia</td>
<td>$91,997,000</td>
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<tr>
<td>Alaska</td>
<td>$93,214,800</td>
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<tr>
<td>North Dakota</td>
<td>$72,323,700</td>
<td>$97.8</td>
<td>5</td>
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<td>New York</td>
<td>$1,874,587,954</td>
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<td>Idaho</td>
<td>$154,803,600</td>
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<td>Alabama</td>
<td>$287,264,301</td>
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<tr>
<td>Wyoming</td>
<td>$33,068,221</td>
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<td>Rhode Island</td>
<td>$56,145,349</td>
<td>$53.2</td>
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<tr>
<td>Massachusetts</td>
<td>$335,705,756</td>
<td>$49.8</td>
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<tr>
<td>Arkansas</td>
<td>$145,412,143</td>
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<td>13</td>
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<tr>
<td>Colorado</td>
<td>$260,902,121</td>
<td>$48.7</td>
<td>14</td>
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<tr>
<td>New Mexico</td>
<td>$99,350,600</td>
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<tr>
<td>Tennessee</td>
<td>$298,726,100</td>
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<tr>
<td>Vermont</td>
<td>$28,181,164</td>
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<td>Delaware</td>
<td>$41,472,100</td>
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<td>Nebraska</td>
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<tr>
<td>Maryland</td>
<td>$237,627,036</td>
<td>$39.8</td>
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<td>$152,538,640</td>
<td>$39.3</td>
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<td>$120,929,906</td>
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<tr>
<td>Washington</td>
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<td>South Dakota</td>
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<td><strong>MEDIAN $33.50</strong></td>
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<tr>
<td>Kentucky</td>
<td>$148,038,883</td>
<td>$33.5</td>
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<tr>
<td>Utah</td>
<td>$93,046,700</td>
<td>$31.6</td>
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<tr>
<td>Connecticut</td>
<td>$111,447,778</td>
<td>$31.0</td>
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<tr>
<td>Mississippi</td>
<td>$36,065,124</td>
<td>$12.0</td>
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<tr>
<td>Arizona</td>
<td>$60,517,200</td>
<td>$9.0</td>
<td>49</td>
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<tr>
<td>Missouri</td>
<td>$35,679,606</td>
<td>$5.9</td>
<td>50</td>
</tr>
<tr>
<td>Nevada</td>
<td>$11,523,491</td>
<td>$4.1</td>
<td>51</td>
</tr>
</tbody>
</table>

Source: TFAH analysis. For a detailed methodology, see Investing in America’s Health at www.healthyamericans.org
HOW ARE LOCAL HEALTH DEPARTMENTS FUNDED?*

Local health departments (LHDs), on average, receive 25 percent of their funding from local sources—including city/township revenue and county revenue. Another 20 percent of local health department funding comes from direct state funds. Federal funds that “pass through” states en route to localities account for another 17 percent of the typical local health department revenues.

Not Specified 2%
Other 7%
Fees 11%
Medicare 5%
Medicaid 10%
Federal Direct 2%
Local 25%
State Direct 20%
Federal Pass-Through 17%

Source: National Association of County and City Health Officials, 2009
* Among LHDs reporting detailed revenue data.
Private Sector
Personal Health
Preventive/Health Promotion
Primary Care

TWO Great Walk-In Clinics
NO APPOINTMENT NECESSARY

Morrison Street Walk-In Clinic
6543 Morrison St.
Niagara Walk-In Walmart
7481 Oakwood Dr.
PRIVATE (NONGOVERNMENT) OWNERSHIP

Voluntary (Not for profit)

Sectarian

Roman Catholic, Salvation Army, Lutheran, Methodist, Baptist, Presbyterian, Latter Day Saints, Jewish, etc.

Nonsectarian

Community

Industrial (railroad, lumber, union) Kaiser-Permanente Plan Shriners Hospitals

Investor-owned (For profit)

Individual owner Partnership Corporation

Single hospital (Investor-owned hospitals)

GOVERNMENT OWNERSHIP

Department of Defense

Army Navy Air Force

Federal

Department of Veterans Affairs

Department of Health and Human Services

Indian Health Service Other

Department of Justice—Prisons

State

Long-term psychiatric, chronic, and other University academic medical (health) centers

Local

Hospital district or authority County City-county City

Figure 2.4. Hospital ownership.
Elder Care/Long Term Care

• Home Health
• Senior Living Communities

Nursing Homes
Retirement Communities
Payment for Care
Fee-For-Service
Managed Care
Overall Health Care Ranking

Low

U.K.

SWITZERLAND

SWEDEN

AUSTRALIA

GERMANY

THE NETHERLANDS

NEW ZEALAND

NORWAY

FRANCE

CANADA

U.S.

High

U.S.

### EXHIBIT ES-1. OVERALL RANKING

#### COUNTRY RANKINGS
- **Top 2**
- **Middle**
- **Bottom 2**

#### OVERALL RANKING (2013)

<table>
<thead>
<tr>
<th></th>
<th>AUS</th>
<th>CAN</th>
<th>FRA</th>
<th>GER</th>
<th>NETH</th>
<th>NZ</th>
<th>NOR</th>
<th>SWE</th>
<th>SWIZ</th>
<th>UK</th>
<th>US</th>
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<tr>
<td>Quality Care</td>
<td>4</td>
<td>10</td>
<td>9</td>
<td>5</td>
<td>5</td>
<td>7</td>
<td>7</td>
<td>3</td>
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<tr>
<td>Effective Care</td>
<td>4</td>
<td>7</td>
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<td>6</td>
<td>5</td>
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<td>Safe Care</td>
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<td>10</td>
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<td>6</td>
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<td>11</td>
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<tr>
<td>Coordinated Care</td>
<td>4</td>
<td>8</td>
<td>9</td>
<td>10</td>
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<td>2</td>
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<td>1</td>
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<tr>
<td>Patient-Centered Care</td>
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<td>8</td>
<td>10</td>
<td>7</td>
<td>3</td>
<td>6</td>
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<td>Access</td>
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<tr>
<td>Cost-Related Problem</td>
<td>9</td>
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<td>4</td>
<td>8</td>
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<td>3</td>
<td>1</td>
<td>7</td>
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<td>11</td>
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<tr>
<td>Timeliness of Care</td>
<td>6</td>
<td>11</td>
<td>10</td>
<td>4</td>
<td>2</td>
<td>7</td>
<td>8</td>
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<td>Efficiency</td>
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<td>10</td>
<td>8</td>
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<td>7</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>6</td>
<td>1</td>
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<td>Equity</td>
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<td>7</td>
<td>4</td>
<td>8</td>
<td>10</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>11</td>
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<tr>
<td>Healthy Lives</td>
<td>4</td>
<td>8</td>
<td>1</td>
<td>7</td>
<td>5</td>
<td>9</td>
<td>6</td>
<td>2</td>
<td>3</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Health Expenditures/Capita, 2011**</td>
<td>$3,800</td>
<td>$4,522</td>
<td>$4,118</td>
<td>$4,495</td>
<td>$5,099</td>
<td>$3,182</td>
<td>$5,669</td>
<td>$3,925</td>
<td>$5,643</td>
<td>$3,405</td>
<td>$8,508</td>
</tr>
</tbody>
</table>

**Notes:**
- * Includes ties.
- ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.

**Source:** Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund National Scorecard 2011; World Health Organization; and Organization for Economic Cooperation and Development, OECD Health Data, 2013 (Paris: OECD, Nov. 2013).
A characterization of 60 countries based on a survey of more than 16,000 people from four regions.

The U.S.'s health care system ranks 15th “by perception”.

The Danish people are more than happy to pay high taxes in exchange for quality public health care and other social benefits. (Denmark is the happiest country in the world.)

People in Canada, which ranks No. 3 on this list, are coming to the U.S. in greater numbers to pursue better health care than what they receive back at home.
Countries With the Most Well-Developed Public Health Care Systems 2016 (US News)

United Kingdom
United Kingdom's Best Health Care System Rank: 4
Best Countries Overall Rank: 3
NEXT: Canada

France
France's Best Health Care System Rank: 8
Best Countries Overall Rank: 8
NEXT: Australia

Germany
Germany's Best Health Care System Rank: 5
Best Countries Overall Rank: 1
NEXT: United Kingdom

Austria
Austria's Best Health Care System Rank: 9
Best Countries Overall Rank: 12
NEXT: France

Netherlands
Netherlands' Best Health Care System Rank: 6
Best Countries Overall Rank: 9
NEXT: Germany

New Zealand
New Zealand's Best Health Care System Rank: 10
Best Countries Overall Rank: 11
NEXT: Austria

Australia
Australia's Best Health Care System Rank: 7
Best Countries Overall Rank: 6
NEXT: Netherlands
Preparedness
What is Disaster Risk Reduction?

- the conceptual framework of elements considered with the possibilities to minimize vulnerabilities and disaster risks throughout a society, to avoid (prevention) or to limit (mitigation and preparedness) the adverse impacts of hazards, within the broad context of sustainable development.
Americans Need a Disaster Reality Check

55%
More than half of all Americans fear they will experience a natural or manmade disaster.

86%
Believe a 72 hour emergency kit recommended by FEMA or the Red Cross would improve their chances of surviving a disaster.

72%
Have made no effort to put together such a kit.

BASIC EMERGENCY SUPPLY KIT

*One gallon of water per person per day

#1 excuse given by Americans for not owning an emergency kit is that they expect first responders to come to their aid. This is an unrealistic belief in the wake of a major disaster.

The Chapman University Survey of American Fears 2015
Delivery Systems Questions
Health Management
Leadership

A *leadership* is a process of enableness to motivate a group of people to organize a group of people to achieve a common goal through intentional influence.
The management functions are interrelated like the pieces of a puzzle.
Figure 4.10. Organization chart of a freestanding home health agency.
Line and Staff

- Director of Public Health
- Executive Assistant to the Director
- Medical Director
  - Associate Director for Patient Care
  - Associate Director for Environmental Services
Figure 15.2. Four Models of Organization
Figure 15.3. Mixed Organizational Structure
Figure 15.4. Matrix Organization
Human Resources

Recruiting. Screening. Hiring.
PEOPLE MANAGEMENT

- Attract
- Educate
- Train
- Motivate
- Empower
- Reward
I. Individual Characteristics

1. Interests
2. Attitudes
   * toward self
   * toward job
   * toward aspects of the work situation
3. Needs
   * security
   * social
   * achievement

II. Job Characteristics (Examples)

1. Types of intrinsic rewards
2. Degree of autonomy
3. Amount of direct performance feedback
4. Degree of variety in tasks

III. Work Environment Characteristics

1. Immediate work environment
   * peers
   * supervisor(s)
2. Organizational actions
   * reward practice
   * systemwide rewards
   * individual rewards
   * organizational climate

Note: These lists are not intended to be exhaustive but are meant to indicate some of the more important variables influencing the employee motivation.

<table>
<thead>
<tr>
<th>Theory X</th>
<th>Classical</th>
<th>Theory Y</th>
<th>Behavioral</th>
</tr>
</thead>
</table>

**McGregor’s Theory of Human Motivation**
Theory Z / Contingency Theory
Situational Management
Strategic Planning
Components of a Plan

Means

Mission
Strategies
Tactics

Ends

Vision
Goals
Objectives
Figure 15.1. Strategic Planning Model

### Morbidity and Mortality

**MICHT-1**  
Reduce the rate of fetal and infant deaths

<table>
<thead>
<tr>
<th>Objective</th>
<th>Description</th>
<th>View Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>MICHT-1.1</td>
<td>Reduce the rate of fetal deaths at 20 or more weeks of gestation</td>
<td></td>
</tr>
<tr>
<td>MICHT-1.2</td>
<td>Reduce the rate of fetal and infant deaths during perinatal period (28 weeks of gestation to 7 days after birth)</td>
<td></td>
</tr>
<tr>
<td>MICHT-1.3</td>
<td>Reduce the rate of all infant deaths (within 1 year)</td>
<td></td>
</tr>
<tr>
<td>MICHT-1.4</td>
<td>Reduce the rate of neonatal deaths (within the first 28 days of life)</td>
<td></td>
</tr>
<tr>
<td>MICHT-1.5</td>
<td>Reduce the rate of postneonatal deaths (between 28 days and 1 year)</td>
<td></td>
</tr>
<tr>
<td>MICHT-1.6</td>
<td>Reduce the rate of infant deaths related to birth defects (all birth defects)</td>
<td></td>
</tr>
</tbody>
</table>
Healthy People in Healthy Communities
A Systematic Approach to Health Improvement

Goals

Objectives

Determinants of Health
  Policies and Interventions
  Physical Environment
  Behavior
  Individual Biology
  Social Environment

Access to Quality Health Care

Health Status

What are Consumers’ Needs, Wants, and Demands?

Needs - state of felt deprivation including physical, social, and individual needs i.e. hunger

Wants - form that a human need takes as shaped by culture and individual personality i.e. bread

Demands - human wants backed by buying power i.e. money
<table>
<thead>
<tr>
<th>10 Essential Public Health Services</th>
<th>Product</th>
<th>Price</th>
<th>Place</th>
<th>Promotion</th>
<th>People</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Monitor Health Status</td>
<td></td>
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<tr>
<td>2. Diagnose &amp; Investigate</td>
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<tr>
<td>3. Inform, Educate, &amp; Empower</td>
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<td>4. Mobilize Community Partnerships</td>
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<tr>
<td>5. Develop Policies &amp; Plan</td>
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<tr>
<td>6. Enforce Laws &amp; Regulations</td>
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<td>7. Link people to needed Services</td>
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<td>8. Assure a competent workforce</td>
<td></td>
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<tr>
<td>9. Evaluate Effectiveness, Accessibility &amp; Quality</td>
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<td></td>
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<tr>
<td>10. Research for new insights</td>
<td></td>
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</tbody>
</table>

Marketing
The 5 P’s
(4 P’s)
Financial Management

- Financial information that can be used to improve decision making.
- The management of the sources and uses of resources within an organization.

F: Financing
- P: Payment
- D: Demand
- I: Insurance

S: Supply
- Basic services
- Special programs
- Research and technology
- Physicians
- Allied health professionals

E: Health care expenditures
Q: Utilization

E = P \times Q
Cost vs. Charges

The resources require to provide the good or service

What the consumer is asked to pay, this includes surplus revenue or profit
Fixed Cost Vs. Variable Cost
The Capital Budget

• Capital Budgets plans for the acquisition of high-value, long-term (>1 year) assets.
The Operating Budget

- **Revenue** is a forecast of resource inflows into the organization.

- **Expenses** represent the resources that an organization uses up carrying on its activities.

- A **surplus or profit** is the excess of revenues over expenses.

- A **deficit or loss** is an excess of expenses over revenues.
For Profit
Investor Owned

Not for Profit
(Not “Non Profit”)
Health Informatics
Figure 17.1. The Professional Public Health Workforce: Major Work Settings

PROTECTING YOUR HEALTH

1 IN 3 MISSING

America will be short more than a quarter million public health workers by 2020 – that’s one-third of the workforce needed to keep the world we live in healthy.

Source: Association of Schools of Public Health
Education/Training
Health173+ Public Health Careers

- Advocacy Director $38,000 - $71,000
- Assistant Environmental Scientist $50,000 - $92,000
- Assistant Inspector General $34,000 - $64,000
- Assistant Professor Epidemiology $69,000 - $130,000
- Assistant Public Health Professor $36,000 - $66,000
- Associate Biostatistics $55,000 - $102,000
- Associate Epidemiologist $55,000 - $102,000
- Behavioral Health Administrator $45,000 - $84,000
- Behavioral Scientist $55,000 - $102,000
- Biosecurity Specialist $18,000 - $33,000
- Biostatistician $55,000 - $102,000
- Bioterrorism Researcher $35,000 - $84,000
- Chief Medical Officer $65,000 - $121,000
- Child Health Specialist $34,000 - $63,000
- Childbirth Health Educator $48,000 - $90,000
- Chronic Disease Health Educator $58,000 - $107,000
- Chronic Disease Management Coordinator $42,000 - $79,000
- Chronic Disease Medical Epidemiologist $55,000 - $101,000
- Clinical Epidemiologist $48,000 - $89,000
- Clinical Infectious Disease Specialist $78,000 - $147,000
- Clinical Research Director $53,000 - $99,000
- Communicable Disease Analyst $38,000 - $71,000
- Communications Director $43,000 - $81,000
- Community Activist $19,000 - $35,000
- Community Counselor $25,000 - $48,000
- Community Health Educator $42,000 - $78,000
- Community Health Nursing Consultant $51,000 - $94,000
- Community Health Worker $33,000 - $62,000
- Community Outreach Specialist $28,000 - $52,000
- Corporate Medical Director $60,000 - $112,000
- Correctional Medicine Physician $101,000 - $200,000
- Deputy Director $47,000 - $87,000
- Director of Applied Research $45,000 - $82,000
- Director of Emergency Medical Services $46,000 - $85,000
- Disaster Preparedness Coordinator $38,000 - $71,000
- Disaster Preparedness Researcher $36,000 - $68,000
- Disease Ecologist $30,000 - $55,000
- Emergency Preparedness Specialist $37,000 - $68,000
- Environmental Health Supervisor $32,000 - $60,000
- Environmental Engineer $54,000 - $101,000
- Environmental Health Director $46,000 - $86,000
- Environmental Health Engineer $53,000 - $99,000
- Environmental Health Executive $51,000 - $94,000
- Environmental Health Nurse $43,000 - $78,000
- Environmental Health Safety Engineer $52,000 - $98,000
- Environmental Health Technician $28,000 - $52,000
- Environmental Specialist $33,000 - $62,000
- Epidemiologists $36,000 - $66,000
- Epidemiology Investigator $42,000 - $84,000
- Federal Agency Director $44,000 - $84,000
- Food Inspector $28,000 - $52,000
- Food Scientist $48,000 - $91,000
- Food Service Sanitarian $34,000 - $63,000
- Forensic Pathologist $33,000 - $62,000
- Genetic Engineer $50,000 - $95,000
- Geographer $44,000 - $81,000
- Hazardous Waste Inspector $37,000 - $72,000
- Health Administrator $42,000 - $79,000
- Health and Wellness Manager $46,000 - $84,000
- Health Commissioner $40,000 - $74,000
- Health Communications Specialist $33,000 - $62,000
- Health Education Health Promotion $39,000 - $72,000
- Health Educators $27,000 - $53,000
- Health Facilities Surveyor $39,000 - $74,000
- Health Legislative Assistant $33,000 - $61,000
- Health Physicist $56,000 - $104,000
- Health Science Kinesiology $38,000 - $70,000
- Health Scientist $43,000 - $80,000
- Health Supervisor $32,000 - $60,000
- Health Unit Coordinator $34,000 - $64,000
- Home Visit Nurse $45,000 - $84,000
- Homeless Services Educator $35,000 - $65,000
- Hospital Administrator $45,000 - $84,000
- Hydrologist $45,000 - $83,000
- Industrial Hygienist $49,000 - $91,000
- Infection Preventionist $55,000 - $110,000
- Infectious Disease Public Health Advisor $51,000 - $95,000
- Informatics Specialist $52,000 - $95,000
- Injury Prevention Specialist $39,000 - $74,000
Recruitment/Retention
Quality

performance improvement
Take the Exam!  
Get Certified in Public Health (CPH)!

Why Should I Get Certified?

Because it is good for the profession and it is good for you!

Certification in public health is an idea whose time has come. Setting standards is an essential step toward elevating the status of public health professionals. The National Board of Public Health Examiners (NBPHE), an independent board of public health professionals, educators and experts, has created the first general test developed specifically on the core competencies taught to all public health graduates of CEPH-accredited schools and programs. Get certified to advance the practice of public health, improve your skills and knowledge and advance your career. Certification in public health is voluntary, but an idea whose time has come!
Estimated 44,000 to 98,000 deaths annually from adverse events &
Over 1 million injuries
Accreditation Overview

Accreditation using the PHAB standards and measures can help a health department achieve performance excellence.
Continuous Quality Management
Baldrige Health Care Criteria Framework:

Organizational Profile:
Environment, Relationships, and Challenges

1 Leadership
2 Strategic Planning
3 Focus on Patients, Other Customers, and Markets
4 Measurement, Analysis, and Knowledge Management
5 Staff Focus
6 Process Management
7 Organizational Performance Results
Six Sigma

- Process must not produce more than 3.4 defects per million opportunities.
Quality Requires an Ongoing Commitment
Management Questions
Wrapping Up
HEALTH POLICY AND MANAGEMENT

Health policy and management is a multidisciplinary field of inquiry and practice concerned with the delivery, quality and costs of health care for individuals and populations. This definition assumes both a managerial and a policy concern with the structure, process and outcomes of health services including the costs, financing, organization, outcomes and accessibility of care.

**Competencies:** Upon graduation a student with an MPH should be able to...

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Identify the main components and issues of the organization, financing and delivery of health services and public health systems in the US.</td>
</tr>
<tr>
<td>2</td>
<td>Describe the legal and ethical bases for public health and health services.</td>
</tr>
<tr>
<td>3</td>
<td>Explain methods of ensuring community health safety and preparedness.</td>
</tr>
<tr>
<td>4</td>
<td>Discuss the policy process for improving the health status of populations.</td>
</tr>
<tr>
<td>5</td>
<td>Apply the principles of program planning, development, budgeting, management and evaluation in organizational and community initiatives.</td>
</tr>
<tr>
<td>6</td>
<td>Apply principles of strategic planning and marketing to public health.</td>
</tr>
<tr>
<td>7</td>
<td>Apply quality and performance improvement concepts to address organizational performance issues.</td>
</tr>
<tr>
<td>8</td>
<td>Apply &quot;systems thinking&quot; for resolving organizational problems.</td>
</tr>
<tr>
<td>9</td>
<td>Communicate health policy and management issues using appropriate channels and technologies.</td>
</tr>
<tr>
<td>10</td>
<td>Demonstrate leadership skills for building partnerships.</td>
</tr>
</tbody>
</table>
Health Policy and Management

1. US Health Care Delivery System
   A. Continuum of Care – Primary through Long-Term Care
   B. Not-for-profit, For-profit, Government Organizations
   C. Health Care Financing, Public and Private
   D. Federal programs – Medicare, Medicaid, Tricare, Social Security, Children’s Health Insurance
   E. Patient Protection and Affordable Care Act
      1. HIPAA
      F. Health Care Utilization, Elasticity of Demand
      G. Basic Insurance Concepts
2. Access, Cost and Quality Considerations
3. Global Health Care Systems
   A. Financing and Delivery Models
4. US Health Policy
   A. Policy-Making Process
      1. Federal
      2. State
      3. Local
   B. National Advocacy Organizations
   C. Stakeholder Participation
   D. Advocacy – Federal, State and Local Levels
   E. Social Ethics
   F. Health Economics
5. Management and Leadership
   A. Organizational Management
      1. Organizational Structure
      2. Strategic Management and Leadership
      3. Program Planning and Marketing
      4. Organizational Ethics
      5. Accountability
B. Human Resources Management
   1. Staffing Principles
   2. Recruitment, Motivation, Retention
   3. Performance Improvement
C. Financial Management
   1. Resource Allocation and Control
   2. Budgeting
1. Being awarded Certification in Public Health (CPH) from the NBPHE as a result of successfully passing its examination is an example of:

   a. Structure
   b. Environment
   c. Process
   e. Outcome
Health Care Systems

1. Receiving Certification in Public Health (CPH) from the NBPHE is an example of:
   a. Structure
   b. Environment
   c. Process
   e. Outcome
2. The smallest percentage of U.S. health care spending addresses:
   
a. Nursing services
b. Public health services
c. Physician services
d. Pharmaceutical services
e. Hospital services
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   a. Nursing services
   b. **Public health services**
   c. Physician services
   d. Pharmaceutical services
   e. Hospital services
3. Potential Injury to research participants is best addressed in the *Belmont Report* by:

a. Respect  
b. Justice  
c. Litigation  
d. Assessment of Benefits  
e. Beneficence
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a. Respect  
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POLICY

4. The U.S. Constitution empowers the detention of contagious individuals entering the U.S.
   a. True
   b. False
4. The U.S. Constitution empowers the detention of contagious individuals entering the U.S.

a. True

b. False
5. Paying a monthly fee for all medical care needed is typical of:

   a. Fee-for-service
   b. A health maintenance organization
   c. A preferred provider organization
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a. Fee-for-service

b. A health maintenance organization

c. A preferred provider organization
DELIVERY SYSTEMS

6. Shriner’s Hospital for Children would be classified as:
   a. Sectarian
   b. Investor owned
   c. State Government
   d. Non sectarian
   e. Federal Government
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a. Sectarian
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7. “By February 1, 2017 there will be a 0.2% reduction in HIV infections” is an example of:

a. Mission
b. Vision
c. Objective
d. Goal
e. Program
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a. Mission  
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e. Program
8. Budgeting for the recurring monthly restocking of 10,000 doses of Flu Vaccine would be a:

a. Variable cost
b. Charge
c. Fixed cost
d. General cost
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Essentials Of Management And Leadership In Public Health
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Thank You