Transformations In Public Health Systems

States' public health systems provide a window through which to observe the rapidly shifting relationships among states, local governments, and private agencies.

by Susan Wall

ABSTRACT: Public health systems are undergoing major changes. Historically, population-oriented services framed the responsibilities of the public health system. Yet over time, clinical services, particularly maternal and child health care, became an important component. More recently, many public health agencies have begun to refocus on traditional services, largely in response to Medicaid managed care and an associated decline in clients. This paper examines such transformations in thirteen states.

THE PUBLIC HEALTH SYSTEM in the United States—consisting of national, state, and local agencies—has a lengthy history of service to communities and vulnerable persons. Unlike medical care, which focuses on treating illnesses of individuals, public health has its roots in promoting health and preventing disease and injury at the community level, with the overriding goal of protecting the health of the public.[1]

Over time, personal health care, such as maternal and child health (MCH) services, has acquired more prominence in the service mix of public health agencies.[2] This change has come about largely in response to the perceived unavailability of primary care, especially preventive services, for the low-income population. Yet some have argued that this shift has undermined the fundamental mission of public health.[3] This criticism has led many states to return the focus of their public health agencies to population-oriented measures. Reversals in priorities also have been spurred by changes in states' Medicaid programs, including eligibility expansions for children and pregnant women and increased managed care enrollment. Both of these trends have given low-income persons greater access to private providers and, consequently, reduced the demand for local health departments' clinical services.

This paper examines the transformations occurring in public

Susan Wall is a research associate at the Urban Institute's Health Policy Center in Washington, D.C. She holds a master of health services administration degree and worked previously at the Physician Payment Review Commission.

health systems in thirteen states against the backdrop of the "new federalism." Particular attention is given to changes arising from the flexibility provided to states to implement Medicaid managed care reforms. The thirteen states, part of the Urban Institute's Assessing the New Federalism (ANF) project, are Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin.[4]

■ **Overview of public health.** The Institute of Medicine (IOM) defines the three core functions of public health as assessment, policy development, and assurance.[5] The public health system strives to prevent epidemics; protect the environment, workplace, housing, food, and water; promote healthy behavior; monitor the health status of the community; respond to disasters; ensure the quality of medical care; provide high-risk persons with needed services; and provide leadership and research on health policy.[6]

Public health functions are carried out by all levels of government, but the most visible activity occurs in the 3,000 county, city, and other municipal health departments throughout the country. Staffs range from more than a thousand in large jurisdictions to one public health nurse or sanitarian in the least populated areas. Nearly half of local health departments have jurisdiction over a population of less than 25,000; thus, many cannot support a large, specialized staff capable of carrying out the full spectrum of public health activities.[7]

Organization Of Public Health Systems

In each of the study states, the organization of public health functions at the state level and the relationship between state and local public health entities are unique. The degree of privatization of public health services also varies by state.[8]

■ **State departments of health.** The responsibilities of a state department of health generally involve policy making, priority setting, data collection and analysis, financing, and oversight of local public health activities. Some states provide services directly as well. Seven of the thirteen study states had stand-alone departments of public health as of 1997, while the other six states combined public health with their Medicaid program. The structure of a state's health department reflects a number of factors, including the importance the state places on core public health services, its desire to coordinate services between Medicaid and public health, and its efforts to streamline government functions. In recent years several states have restructured their health and human services departments in pursuit of such objectives. In the late 1980s Washington State removed public health programs from a larger department and elevated public health to cabinet status. In the early 1990s Florida

also created a distinct department of public health. In contrast, Michigan, New York, and Texas recently consolidated many of their health programs to take advantage of the efficiencies associated with overlapping services, populations, and funding sources.

■ **Local health departments.** Local departments provide public health services more often than state departments do. Most states organize their public health systems around county health departments. Although a single county is the most common jurisdiction, many serve a multicounty district. Some large cities, including Detroit, Houston, Milwaukee, Minneapolis, and New York, support their own city health department; in other areas, such as Seattle/King County, the city and county jointly operate a health department.

Massachusetts and New Jersey depart sharply from the county-based system. Historically, municipalities in these two states have established local boards of health. In Massachusetts there are 351 boards with varying expertise and resources, each charged with responsibilities centered on environmental health and communicable diseases. The state contracts with the boards as well as with private providers to deliver services. To combat fragmentation, Massachusetts formed twenty-seven community health network areas in 1993. New Jersey, as well, has numerous local health units: 578 local boards of health, one for each of its municipalities, and more than 100 local health departments, about half of which are run by municipalities. New Jersey officials recognize that such a high level of decentralization prevents development of a system that fully protects and serves the public, and the state is considering addressing the fragmentation through regionalization of certain services.

Other states have similarly attempted to coordinate county-based health services through regional or district offices. Except for California and Washington, local health departments in the study states are organized into public health regions. Most regional or district office responsibilities are limited to supervision, coordination, and technical support of local units.[9] Texas is the primary exception; its regional offices also provide services. Because Texas does not require its counties to operate a health department, numerous counties have elected not to do so. In these counties a state regional office typically runs a nurse-staffed clinic.

■ **Devolution.** The division of authority for public health among the thirteen states and their localities reveals in part the states' philosophy and political culture regarding devolution of control to local governments. The degree of public health centralization varies greatly and is changing in several states, typically toward increased decentralization. Efforts to devolve greater authority to localities were observed in California, Michigan, New York, and Washington.

In 1991–1992 California underwent "realignment," in which responsibility for indigent health care—including public health—was officially moved from the state to the county. New York recently shifted responsibility for environmental health to the local level. The state is developing penalties and incentives to ensure the success of devolution. Still other states, such as Wisconsin, have traditionally operated their public health system in a decentralized fashion.

A useful way to understand the extent of decentralization is to consider the proportion of spending on health at the local and state levels (Exhibit 1). The U.S. Census Bureau's annual Census of Governments combines public health spending with spending on mental health and substance abuse under the category of health. A rough estimate is that public health constitutes half of health spending.[10] The data exclude spending on Medicaid and state-supported hospitals.

The most highly centralized state, based on the locus of control of health spending, is Massachusetts. (The Massachusetts public health system is decentralized in that its local boards of health operate fairly independently and rely primarily on local funds; however, the typical board—with the exception of the Boston Department of Health and Hospitals—is very small and controls minimal resources relative to those controlled by the state.) At the other extreme is Wisconsin. Here the role of the state department of health is limited to technical assistance, program coordination, and

EXHIBIT 1
Locally Administered Health Spending As A Percentage Of Combined State And Local Health Spending, 1992 And 1994

State	1992	1994
Alabama	30.8%	31.8%
California	68.8	65.8
Colorado	39.9	37.2
Florida	14.9	18.4
Massachusetts	7.1	7.4
Michigan	56.6	62.8
Minnesota	52.7	56.2
Mississippi	30.0	28.2
New Jersey	34.8	34.7
New York	48.0	48.9
Texas	55.6	54.2
Washington	27.9	38.4
Wisconsin	79.1	79.1
U.S. total	46.7	46.4

SOURCE: U.S. Bureau of the Census, Census of Governments, 1992 and 1994.
NOTES: Local health spending represents expenditures administered by local government, supported by federal, state, and local revenue sources, as well as fees. State health spending represents expenditures administered by state government, supported by federal, state, and local revenue sources, as well as fees. Spending consists of direct expenditures (by either state or local government) only and does not include intergovernmental transfers.

general public health leadership.

In contrast to the local control common in the Midwest, the southern states of Alabama, Florida, and Mississippi have more highly centralized public health systems.[11] In fact, in these three states county health department staff are state employees. This arrangement is apparently unique to the South. However, in at least three relatively decentralized states—California, New York, and Texas—the state public health department directly provides certain core services (such as environmental health and public health nursing) in counties that lack the necessary local resources.

■ **Privatization.** Another organizational feature that distinguishes state public health systems from one another is the extent to which services are delivered by private providers rather than by government agencies. For example, many states and localities contract with nonprofit organizations to deliver family planning services; and contracts with private agencies for traditional public health services, such as communicable disease control and clinical laboratory services, are increasingly common.

The northeastern states appear most likely to contract with private providers. In Massachusetts, because local health units are small, the state relies considerably on private organizations to carry out public health functions. Similarly, private agencies in New Jersey have assumed responsibilities that were once the province of local health departments; for example, a for-profit firm has a contract with the Atlantic City Health Department to provide services for tuberculosis, sexually transmitted diseases (STDs), and foodborne disease.[12] It was also reported that New York's health department is contracting with private providers more often. At least one southern state, Texas, is increasing the number of its contracts with private providers. The state has introduced competitive bidding for MCH funds in select areas that have a sufficient number of private providers. Finally, in Minnesota, the Minneapolis city health department recently ended direct medical services, opting instead to contract with private providers for them.

Public health systems' decisions to outsource services arise from a variety of factors. These include the limited capacity of local governments to fulfill public health obligations, availability of private organizations with which to contract, anticipated cost savings and efficiency improvements, and downsizing of government.[13]

Funding Sources And Their Allocation

Public health accounts for a mere fraction of national health spending: approximately 1 percent ($8.4 billion) of the nation's total health spending in 1993.[14] These funds consist of federal, state, and

local revenues, as well as Medicaid payments, patient fees, and various regulatory fees. Over time, the relative importance of each of these sources has shifted somewhat. However, federal grants and state and local appropriations have consistently accounted for the bulk of public health funding.

■ **Funding for state public health agencies.** States, with the exception of Texas, reported that their public health budgets have fared well in recent years, and only a few departments expressed concerns about future funding levels. Most state public health departments have experienced annual increases in the past few years in the range of 4–8 percent. Increases were attributed to a number of factors: establishment of a tobacco tax (three states); better marketing of public health to the legislature, especially in the area of child health; and growth in federal grant awards.

Because federal grants make up a substantial portion of most states' public health budgets (50–85 percent among the case-study states), these grants are a primary determinant of the fiscal capacity of state public health agencies. A Wisconsin official noted that the fiscal position of the Bureau of Public Health appears strong into the future, assuming that federal funding continues. Federal funds also compensate for deficits in state support. In New Jersey an increase in federal funding offset decreases in state funding of services for MCH services and acquired immunodeficiency syndrome (AIDS) from 1992 to 1996. Finally, the availability of federal dollars often dictates the activities of state public health agencies. Colorado and Texas support few public health programs that do not draw federal dollars.

The Women, Infants, and Children (WIC) nutrition program and other U.S. Department of Agriculture nutrition funds account for the largest share of state health departments' budgets; the MCH block grant (Title V) is a distant second. Other federal grants include family planning (Title X) and the preventive services block grant. Many smaller federal grants contribute to a patchwork of funding. For example, the Washington State Department of Health receives about sixty-five federal grants. States in general have few complaints about the federal requirements associated with the receipt of grant monies. With the introduction of block grants (for such programs as MCH services and prevention) in the 1970s and 1980s, states have found the program guidelines and reporting standards less burdensome and restrictive. In addition, state financial matching requirements do not appear troublesome. For example, most states significantly overmatch their MCH block grant. Given current trends in government devolution, funding streams could converge in more encompassing block grants.

■ **Funding for local health departments.** Local health departments vary considerably, by state and within states, in their funding sources. The largest share of funding, 40 percent on average, comes from the state, including federal passthrough funds (Exhibit 2). (Passthrough funds are federal grants awarded to states, which in turn allocate them to localities; only a small amount of federal grant monies comes directly to local health departments.) States typically disburse funds on the basis of a formula. New York pays each local health department a base amount plus a match of 30–36 percent for services provided. Alabama is introducing a production-based methodology to reward health departments. Local health departments in Colorado receive various grants from the state as well as per capita operating subsidies. The Massachusetts department of health is unique in that it treats local health departments as vendors and requires them to compete for state funds alongside private providers. Finally, Wisconsin uses a combination of categorical grants (soon to be converted to a needs-based system) and competitive bidding to distribute funds to local health departments and private contractors.

Local revenue is another important source of funding. To place the local share in perspective, it is useful to consider the fraction of public health spending statewide that is controlled by local govern-

EXHIBIT 2
Sources Of Funds For Local Health Departments, FY 1991, 1992, Or 1993

State	Local[a]	State[b]	Federal[c]	Medicaid[d]	Medicare	Other[e]
Massachusetts	93%	1%	0%	1%	0%	6%
New Jersey	86	8	2	1	1	3
New York	27	26	3	18	14	12
Michigan	28	36	2	9	8	18
Minnesota	26	27	4	11	6	25
Wisconsin	54	11	2	9	11	12
Alabama	9	19	5	25	32	10
Florida	14	66	2	8	1	9
Texas	51	38	3	2	0	6
California	26	52	6	2	3	11
Colorado	50	27	2	5	5	11
Washington	34	25	4	8	2	27
United States	34	40	6	7	3	10

SOURCE: National Association of County and City Health Officials (NACCHO), unpublished data.
NOTES: The survey conducted by NACCHO asked local health departments to report revenues for the most recent fiscal year for which data were available. Percentages are an average of those percentages reported by each health department (that is, funding source proportions are not weighted by health department budget). Data for Mississippi are not available.
[a] Includes city, township, town, and county sources.
[b] Includes passthrough funds from federal government and excludes Medicaid.
[c] Includes federal monies that are paid directly to the local health department, excluding Medicaid.
[d] Includes federal and state shares of Medicaid.
[e] Includes private foundations, private health insurance, patient fees, regulatory fees, and other unspecified.

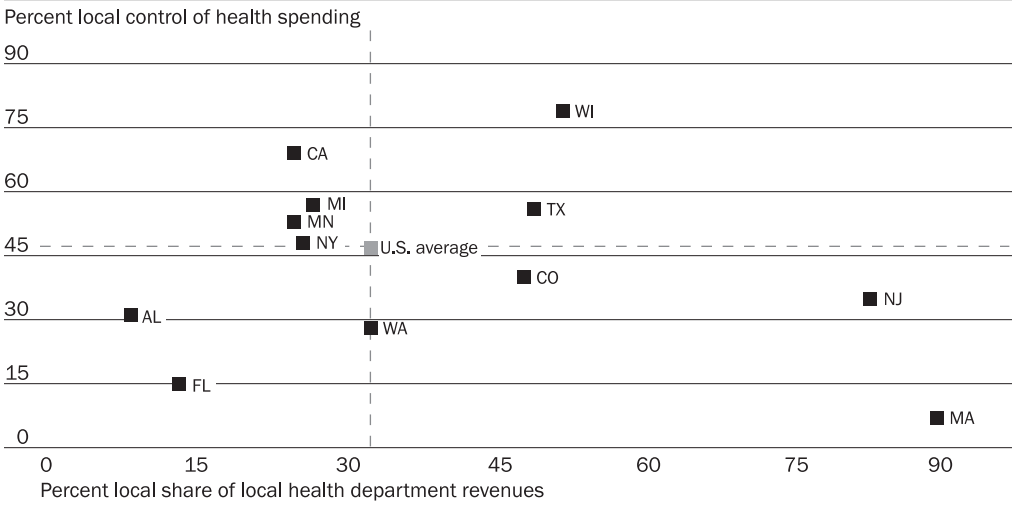
ments. Exhibit 3 displays the relationship between revenues generated at the local level (Exhibit 2) and expenditures controlled at the local level (Exhibit 1). The intersection of local revenue and expenditure shares serves as one indicator of the relative dependency of a state's public health system on its local governments.

In Massachusetts and New Jersey local boards of health receive the bulk of their funds from local sources. However, these local boards have small staffs and budgets, and most spending on health occurs at the state level. Thus, public health functions there are not entirely at the mercy of fluctuations in local support.

Local health departments in Texas and Wisconsin rely on local funds for more than half of their revenues. In fact, of the approximately 140 health departments in Texas, only half receive any state funds; the others have opted to forgo state funds and operate independently. Both states have relatively decentralized public health systems (a large percentage of locally controlled funds). The combination of above-average dependency on local revenues and decentralization suggests that the public health system in these two states is rooted in local communities and potentially vulnerable to shifting local priorities and economic fortunes.

In contrast to the above states, only 9 percent of the average local health department budget in Alabama and 14 percent in Florida are derived from local tax revenues. Both states also exhibit a high level

EXHIBIT 3
Local Public Health Expenditures And Revenues, 1992



SOURCES: National Association of City and County Health Officials, unpublished data; and U.S. Bureau of the Census, Census of Governments, 1992.
NOTES: See Exhibits 1 and 2 for description of data. Mississippi is not included because local health department data were not available. Expenditure data are from 1992; revenue data are from 1991, 1992, or 1993.

of state control over public health. (Recall that their state health departments employ county health department staff.) Thus, compared with the average state, local departments there are more closely tied to the state and seemingly have less autonomy.

The final category contains states with a below-average share of local support for health departments but a fairly high degree of local control over statewide public health funds (California, Michigan, Minnesota, and New York). From the local perspective, this configuration may be the most attractive—decentralized authority for public health without a substantial reliance on local tax support.

The percentage of local health department budgets originating from local sources reflects in part county and city taxation policies and the importance local governments attach to public health. Moreover, some local health departments have excelled at maximizing regulatory fees and public insurance revenues, which has reduced their need for local tax support.

Medicaid, in particular, has proved to be a rich source of revenue for certain local health departments. Medicaid's share of local health department budgets averaged 7 percent nationally during the early 1990s (Exhibit 2). The range for the average health department in the study states was 1–25 percent. On the low end were Massachusetts and New Jersey, most of whose local health units provide no personal health services. States with double-digit Medicaid shares were Alabama, Minnesota, and New York, where local health departments are significant providers of home health services (which likely accounts for a large fraction of their Medicaid revenues).

■ **Medicaid maximization.** Although longitudinal data are not available for all thirteen states, most reported that local health departments have grown more dependent on Medicaid revenues to support their operations. Evidence of this is available from Alabama, Florida, and Minnesota. In Alabama reimbursements (Medicaid and Medicare) accounted for 40 percent of the state department of public health (including county health departments) budget in fiscal year 1992 and increased to 48 percent in FY 1997. In Florida 14 percent of county health department revenues for children's services were from Medicaid in FY 1992 and increased to 21 percent in FY 1996. Respective figures for adult services were 16 percent and 18 percent. The growing reliance on Medicaid funds is especially pronounced in Minnesota: Medicaid increased from 9 percent of local health department budgets in 1987 to 19 percent in 1994.

Revenue trends as well as the strategies described by state officials reveal concerted efforts to maximize Medicaid funding of services, particularly MCH services. This was prompted, at least in part, by federal mandates in the late 1980s to expand coverage to children

and pregnant women, many of whom had been uninsured clients of the health department. As a result, more health departments could justify instituting formal Medicaid billing processes. Growth in federal Medicaid matching funds has released state and local monies to support other public health functions or has allowed states and localities to reduce their own public health spending.

Medicaid maximization has taken several forms. Some states now mandate that local health departments bill Medicaid for select services (New York) and screen for Medicaid eligibility (Texas). In the early 1990s California "mainstreamed" (certified as Medi-Cal providers) prenatal care agencies that had previously depended on the MCH block grant. In 1993 Wisconsin qualified its prenatal care coordination program, previously financed by MCH funds, as a Medicaid benefit. Finally, Michigan transferred its children with special health care needs program, a key MCH program, from the public health to the Medicaid division.

The Changing Role Of Public Health Systems

Medicaid's growing importance to health departments during the past decade aligns with the more fundamental change that has occurred over time in the public health system: its establishment as a provider of last resort in many communities. Although public health systems continue to work for the health of "the public," clinical services to low-income, high-risk persons have assumed increasing importance in the service mix. More recently, however, the growth of managed care in state Medicaid programs, which has reduced the number of health department clients, has prompted many states and localities to return to core public health services.

■ **Public health versus personal health services.** The range of services provided by public health agencies varies considerably across states and local jurisdictions (Exhibit 4). However, personal health services consume the largest share of the average local health department's staffing and funds.[15] The provision of immunizations and tuberculosis services is nearly universal. Well-child care; early and periodic screening, diagnosis, and treatment (EPSDT); WIC services; family planning; STD testing; and human immunodeficiency virus (HIV) testing also are relatively common. Although most of these services are provided directly to individuals, many have implications for the population at large because they are targeted at communicable diseases. Public health departments have also carved out an important role in the provision of MCH services, establishing well-child and prenatal clinics as well as programs for children with special health care needs. The delivery of comprehensive primary care by health departments is somewhat rare except in

EXHIBIT 4
Services Provided By Health Departments, 1992–1993

Service	U.S.	MA[a]	NJ[a]	NY	MI	MN	OH	WI	AL	FL	TX	CO	CA	WA
Child health														
Sick-child care	29%	6%	9%	52%	29%	35%	22%	18%	41%	93%	31%	27%	33%	20%
Well-child care	72	19	67	91	55	41	67	61	100	98	85	93	79	92
Children with special health care needs	51	6	13	93	92	88	59	57	34	41	15	89	66	83
EPSDT	67	0	20	37	100	79	58	80	100	100	75	84	79	88
WIC	67	5	27	64	84	66	53	61	100	89	67	82	64	80
School-based clinics	20	23	20	33	18	23	26	19	9	37	19	27	22	4
School health	55	29	40	32	71	60	56	79	40	88	23	61	22	60
Maternal health														
Prenatal care	54	3	17	67	47	74	47	60	83	91	62	67	58	28
Obstetrical care	23	0	3	27	11	15	22	4	37	71	33	16	32	12
Family planning	60	1	4	50	82	60	29	25	100	100	57	56	72	36
STD testing and counseling	64	3	22	67	95	23	48	39	100	100	85	44	97	76
STD treatment	59	0	22	67	82	23	38	27	91	100	77	33	90	68
HIV/AIDS testing and counseling	62	2	14	87	100	23	27	43	100	100	85	47	97	100
HIV/AIDS treatment	24	1	1	33	3	20	3	7	5	84	25	7	54	12
Immunizations	92	46	80	100	100	94	96	100	100	100	92	96	97	100
Tuberculosis services	81	28	39	98	92	71	75	89	100	100	87	73	95	92
Substance abuse	13	7	22	7	16	11	9	7	21	31	6	18	49	16
Tobacco-use control	42	22	33	75	68	57	49	59	35	47	23	45	95	42
Chronic disease														
Cancer	47	6	63	66	37	74	26	62	38	62	34	33	51	20
Cardiovascular disease	53	10	69	61	42	80	39	77	31	80	38	38	45	56
Diabetes	55	14	61	60	34	74	33	60	50	86	75	47	55	28
High blood pressure	79	34	74	80	76	83	83	95	93	79	79	82	68	64
Dental health	35	8	16	64	38	29	26	28	10	43	4	16	47	46
Home health	45	13	20	93	42	86	39	49	97	19	0	51	11	8

SOURCE: National Association of County and City Health Officials, unpublished survey data.
NOTES: EPSDT is Early and Periodic Screening, Diagnosis, and Treatment. WIC is Women, Infants, and Children (nutrition program). STD is sexually transmitted disease. HIV is human immunodeficiency virus; AIDS is acquired immunodeficiency syndrome. The survey had a response rate of 72 percent (2,079 local health departments responded). Data for Mississippi are not available.
[a] Health departments here contract out for many of the services listed, more so than most other states.

large cities, such as Birmingham, Denver, Detroit, Houston, Milwaukee, Minneapolis, and Seattle, as well as in many county health departments in California and Florida. Although most local health departments depend on public health nurses or midlevel practitioners to deliver personal health services, the staffs of larger health departments usually include one or more physicians.

Local health departments in Alabama and Florida appear most likely to deliver personal health services (Exhibit 4). In fact, public health systems in the South have traditionally considered personal health services as central to their mission because of the shortage of private providers in rural areas. Alabama's county health departments provide prenatal care to half of all pregnant women and, under the direction of the state department of health, operate the

"Public health officials are debating the role of health departments in the delivery of personal health services."

state's largest home health agency. Florida's public health system is committed to providing an even broader range of services to indigent patients. The state legislature enacted legislation in the late 1980s that directs state funds to local health departments to provide services for the uninsured. Similarly, health clinics for the poor in California are frequently administered by or under contract with the county health department. As in Alabama, most local health departments in Minnesota and New York offer home health services, which generate significant revenues. Health departments in Massachusetts and New Jersey are much less likely than those in other states are to provide clinical services directly; services there are more frequently provided under contracts with private organizations.

In almost all of the study states, public health officials are debating the role of health departments in the delivery of personal health services. Nationwide, a consensus is apparently building around refocusing public health resources on traditional population-oriented services. Several states have formalized this shift in priorities through the development or resurrection of a list of core services that local health departments are expected to fulfill. Typically, the state offers matching funds (for example, 50 percent) to the localities to encourage the provision of core services. Michigan, Minnesota, New Jersey, New York, and Washington follow this pattern.

California's approach has included divorcing the local health department from some county clinics. In some cases, this move has involved physically separating the public health nursing staff and facilities from those of the primary care clinic. In Los Angeles County the shift has perhaps been most dramatic: Among other changes, responsibility for well-child visits and immunizations has been assigned to the county clinics. Public health departments retain responsibility for testing and treatment of communicable diseases.[16] A similar split recently occurred in Denver.

■ **Declines in Medicaid clientele.** The realignment of public health priorities in many states has been initiated largely because of expansions in Medicaid managed care. As states increasingly enroll their Medicaid beneficiaries in health maintenance organizations (HMOs) or primary care case management programs—linking them with private physicians—MCH caseloads and Medicaid revenues of health departments have fallen. Other reasons for the drop in pa-

tients—both Medicaid recipients and others—are increased Medicaid payments for private physicians (Alabama and Florida) and the establishment of state-supported insurance programs (Massachusetts, Minnesota, and Washington), which have drawn many patients away from public providers to private physicians.

Data that track the decline in health departments' users are available for three southern states. Users of EPSDT services in Alabama fell by 24 percent, and maternity clients, by 15 percent from 1992 to 1996. Immunization services also have fallen sharply. In Florida health departments experienced a 19 percent drop in clients between 1991 and 1996. Finally, before the implementation of its primary care case management program in 1993, the public health system in Mississippi provided 57 percent of the state's prenatal care. By 1996, with only a portion of the state participating in the program, this figure had fallen to less than 50 percent.

Many local health departments have grown dependent on Medicaid revenues to partially cross-subsidize both care for the uninsured and population-oriented services, and they are apprehensive about the availability of funding streams to continue these services. As Medicaid patients continue to be siphoned off by private practitioners, health departments have predicted that they will be left with responsibility for the uninsured without commensurate increases in public funding.[17] Health departments argue they may be forced to dismantle their clinical services and that the uninsured may lose access to needed services. One scenario is that other revenue sources (such as MCH block grants) will cover the costs of treating the uninsured. A second, less optimistic, scenario is that the bulk of public operating revenues and grants will be required to meet core public health obligations, with little remaining for medical services for the uninsured. Alternatively, depending on the flexibility of the funds local health departments receive, services for the uninsured may remain intact while core public health services suffer.

■ **Medicaid managed care.** Local health departments have received mixed messages from the state about their role in an environment dominated by Medicaid managed care. Although many states are encouraging a return to core public health functions, they also recognize that local health departments are often important safety-net providers. In addition, many local health departments apparently do not want to relinquish their role as caregivers because of the clinical orientation of the staff and the satisfaction they gain from patient contact. Moreover, some health departments have asserted that they are better than private providers are at meeting the unique needs of low-income patients. They fear that support services and coordination of care will be shortchanged under managed care. The

"Although many public health agencies have expressed interest in contracting with HMOs, the practice is not yet widespread."

preferences of local health department staff as well as concerns about access to care may create roadblocks for states that want to effect change in their public health system. Yet the impact of Medicaid managed care—namely, dwindling demand for health departments' clinical services—may ultimately overcome any resistance on the part of local public health units and others.

Although some local health departments are concerned about Medicaid managed care, others welcome it as an opportunity for change. State and local health departments' responses to the expansion of Medicaid managed care fall into two categories: (1) assumption of a broader role involving oversight and monitoring, and (2) participation as a provider of services—clinical and "enabling"—within a managed care network.

Oversight and monitoring. Some public health agencies, especially at the state level, have begun to focus more attention on monitoring health care delivery and managed care activity. Minnesota's state health department is pushing for improved outcomes measures and data collection requirements to monitor the performance of managed care organizations. California's public health system has assumed responsibility for setting standards for the provision of public health–related services under Medi-Cal managed care. New York health departments also are considering developing systems to monitor the provision of public health–related services by managed care plans. Wisconsin's state health department is actively pursuing a somewhat broader role for its local health departments as monitors of the overall quality of care in HMOs. In still other states, including Colorado and Massachusetts, the state health department has collaborated with Medicaid to ensure that managed care contracts address quality standards, health status goals, prevention needs, and related public health concerns.

Enabling and "gap" services. In terms of service provision, some local health departments are directing more resources to enabling services such as counseling, case management, and transportation. Similarly, at least one public health system, Wisconsin's, sees itself as filling gaps left by some HMOs (for example, providing immunizations). In some states local health departments seek contracts with Medicaid managed care organizations to provide these enabling and gap services, whereas in other states public health agencies merely divert MCH block grant funds toward these activities. Massachu-

setts has turned more attention to enabling services by emphasizing support services that complement medical care in its contracts with MCH providers. In Alabama local health departments are the prime contractors for the state's Medicaid maternity case management program in half of the counties in which the program operates. In this role, many health departments provide case management and other enabling services while subcontracting with private providers to deliver clinical services. Similarly, Michigan health departments have curbed their involvement in EPSDT's clinical components and have increasingly limited their role to outreach.

Contracting with HMOs. In several states, including Florida, Minnesota, New York, and Washington, at least a few local health departments have contracted with HMOs as primary care providers or for selected services. California, Michigan, and Washington, among others, require or give preference points in the competitive bidding process to managed care plans that either cooperate with or give special consideration to health departments in creating their provider networks. California requires health plans to contract with local health departments for family planning, STD and HIV testing, immunizations, tuberculosis services, WIC, and other services, unless the plan can demonstrate its ability to provide these services. One county health department in Florida has developed its own HMO.

Although many public health agencies have expressed interest in contracting with HMOs to deliver enabling and other services, the practice is not yet widespread.[18] In fact, health departments have encountered barriers in their attempts to join Medicaid managed care networks. Reportedly, managed care plans are not always aware of the niche services offered by health departments. Moreover, health departments seeking contracts as gatekeepers may be at a disadvantage because they do not have a physician on staff, do not offer comprehensive primary care or twenty-four-hour coverage, or lack the organizational infrastructure to meet the data collection, financial, and other requirements of the plans.

Anecdotal evidence suggests that even without contracts in place, many health departments continue to provide services to Medicaid patients who bypass their assigned gatekeeper. This decision to bypass apparently is prompted by patients' preferences or habits, or by health plans' or physicians' encouragement to visit the health department for free services.

A Delicate Balance

As states and localities take steps to restructure their public health systems, they will have to balance competing demands. As early as 1988, the IOM stated that "an impossible responsibility has been

placed on America's public health agencies: to serve as stewards of the basic health needs of the entire population but at the same time avert impending disaster and provide personal health care to those rejected by the rest of the health system."[19] The thirteen states highlighted in this report clearly exhibit this tension.

The new federalism appears to be driving much of the recent effort to transform public health and refocus its mission. Specifically, increased state authority to implement mandatory managed care for Medicaid beneficiaries has led to a reduction in demand for health departments' clinical services. As a result, the traditional population-oriented goals of public health are regaining prominence. This change is reflected in some of the roles public health agencies are assuming under managed care, including oversight and monitoring. The trend away from personal services may be hastened by the block grants to states for children's health insurance programs, which could lead to more health department clients' seeking mainstream providers. Yet many local health departments will remain part of the health care safety net for the near future.

In another manifestation of the new federalism, several state departments of public health appear eager to devolve greater authority to local health departments, although some states are simultaneously pursuing coordination and consolidation of local activities through regionalization. Establishing greater local autonomy while avoiding inefficiencies and duplication of effort will create both new demands and opportunities for states and local agencies.

These changes in public health systems deserve ongoing attention. Decentralization has the potential for a more effective and creative use of resources. However, concerns exist regarding whether localities will continue to operate programs at the same level as before, once provided more leeway. As health departments grapple with declining Medicaid revenues and shifts in priorities, it will be all the more important to track the activities, funding levels, and performance of local health departments, as well as changes in uninsured persons' access to primary and preventive care.

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NOTES

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8. Unless otherwise noted, sources for the information for the sections that follow are case-study interviews conducted in the thirteen states.
9. Public Health Practice Program Office, *Profile of State and Territorial Public Health Systems: United States, 1990* (Atlanta: CDC, December 1991).
10. This estimate is based on a study of eight states' spending. See Public Health Foundation, "Measuring State Expenditures for Core Public Health Functions," *Research and Measurement in Public Health Practice*, a supplement to the *American Journal of Preventive Medicine* 11, no. 6 (1995): 58–73.
11. Alabama is the only state whose public health system is controlled by the medical society; the medical society appoints the state health officer, who serves at its pleasure rather than at that of the governor.
12. L. Whitehand et al., *Privatization and Public Health: A Study of Initiatives and Early Lessons Learned* (Washington: Public Health Foundation, 1 August 1997).
13. Ibid.
14. Center for Studying Health System Change, *Tracking Changes in the Public Health System*, Issue Brief (Washington: CSHSC, 1996).
15. A study of nine states found that 44 percent of local health department dollars were spent on personal health services, such as MCH and primary care. See K.W. Eilbert et al., *Measuring Expenditures for Essential Public Health Services* (Washington: Public Health Foundation, November 1996).
16. The reconfiguration of services occurred primarily to maximize Medicaid revenues under Los Angeles's Section 1115 waiver program.
17. From the perspective of most state-level agencies, however, there appears to be less concern about funding, as discussed earlier.
18. According to one source, local health departments served as contractors or subcontractors for Medicaid managed care programs in twenty-five states in 1996—an increase from fourteen states in 1994. The number of health departments participating in each state is unknown but appears to be small. See J. Horvath et al., *Medicaid Managed Care: A Guide for the States*, 3d ed., vol. 1, part 1 (Portland, Maine: National Academy for State Health Policy, January 1997).
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