

## What Directions for Public Health under the Affordable Care Act?

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### Introduction

Change is in the air for public health. A central driver has been the passage and implementation of federal health reform, which prompts this issue brief. The Patient Protection and Affordable Care Act of 2010 (the ACA)<sup>1</sup> creates both opportunities and challenges for the future of public health. The ACA's central thrust was expanded health coverage, which itself greatly affects what public health needs to do, can do, and should do.

The ACA also raises the profile of public health generally and addresses specific public health issues—adding new funding, creating new entities to help set priorities, and encouraging innovation, especially for population health including chronic conditions.

Even as reform was boosting public health, however, fiscal pressures were beginning to erode budgetary support for traditional public health programs. This erosion occurred first at the state level, where revenues dropped sharply during the great recession.<sup>2</sup> More currently, pressures to reduce the federal deficit are affecting federal budgeting as well.

Drawing upon a literature scan and key informant interviews, this brief argues that the ACA throws into sharp relief the opportunity—and the need—that public health has to set priorities among its many worthy goals, refocus its agenda, and shore up not only funding but also alliances as support for the future. We begin with the ACA, focus heavily upon priority setting and funding issues for public health, and conclude with a discussion of key issues going forward.

### The ACA is a signal accomplishment for public health

The ACA's emphases on prevention and population health illustrate how far public health has advanced as federal policy. Recognition of this advance is an important starting point for considering what remains to be done. Compare the unsuccessful early-1990s push for health reform. At that time, as one informant explained, public health advocates were jubilant when they won a simple mention of public health in the Clinton proposal.

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**The Affordable Care Act builds prevention into coverage expansion and reform, and creates new mechanisms and new funding for many public health activities. Much work remains, however, to assure that health reform becomes a wellspring of appreciation for public health's value and not the high water mark for public health advocacy.**

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In 2010, in sharp contrast, public health was deeply imbedded into the ACA. Indeed, President Barack Obama had made prevention and public health a cornerstone of his approach to health policy early in his candidacy, well before the final reform bills took shape.<sup>3</sup> Senator John

McCain's candidacy was also supportive, but in a less central way.<sup>4</sup> Such high-level attention is a testament to improved advocacy for and understanding of public health in the run-up to reform.<sup>5</sup>

Many people and organizations have advanced public health by describing its nature and importance for improving the population health, the respective roles of different levels of government, and the need to modernize operations.<sup>6</sup> Many advocates have promoted specific aspects of public health. Others have advocated for more support in general, along with more accountability and other changes.<sup>7</sup> These efforts all played their part in building a culture for change. The ACA, however, actually set change in motion and set the stage for further evolution.<sup>8</sup>

## A thumbnail of the ACA and public health

Others have already capably explained the ACA's complexities,<sup>9</sup> including the reform's "huge" number of provisions related to "prevention and wellness."<sup>10</sup> Only a brief overview is provided here.

### Insurance expansion

How to enroll more people in both public and private coverage occupies most of the law—and most of its funding. Medicaid expansions address all low-income Americans. New insurance purchasing exchanges and some subsidies help middle-income people and small businesses obtain coverage. People with higher incomes and larger businesses are strongly encouraged to protect themselves. Insurers are no longer allowed to exclude those with preexisting health conditions or set annual or lifetime ceilings that stop paying for the most expensive conditions.

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**"It is a poor government that does not realize that the prolonged life, health, and happiness of its people are its greatest asset." — Charles H. Mayo<sup>12</sup>**

Government addresses health in multiple ways. How to categorize them is itself a challenge; this brief uses the following approach. *Clinical services* mainly address problems or risks after they arise, are mainly provided by private caregivers, and are funded largely by public and private insurance coverage, along with patient payments.

*Public health* mainly addresses problems before they arise, often by focusing on an entire population rather than on one person at a time. The focus of intervention shifts over time as threats to health change. Public health is almost wholly provided and funded by government.

*Prevention* can be addressed clinically, as an adjunct to dealing with more acute problems, for example, through individual screening and counseling. Public health takes prevention as a centerpiece, seeking to help protect entire populations, classically through efforts like better sanitation and broad inoculation against communicable disease (and sometimes tracking contacts of people infected), as well as education in health. Moving beyond the classic services is a central focus of the ACA and of this brief.

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In addition, Medicare and new private insurance policies are also required to cover proven clinical preventive services at no cost to patients, and state Medicaid programs are encouraged to do so by a higher federal matching percentage. The U.S. Preventive Services Task Force is to determine whether services' effectiveness is proven.<sup>11</sup>

Unlike prior coverage expansions, moreover, the law addresses concerns about the adequacy of health care services delivery and the supply of needed professionals.<sup>13</sup> For example, community- and school-based health clinics get new support. New monies are allotted for workforce education, including of public health professionals. Primary care and community-based care get more attention than before.<sup>14</sup> A new national workforce commission is directed to sort through programs, set priorities, and consider innovative ways to meet health workforce needs.<sup>15</sup>

These coverage provisions indirectly help public health. They likely raise public awareness of the value of clinical prevention and wellness and provide concrete rewards to practitioners who emphasize health promotion. Broader coverage also means that when public health screening finds a problem, an affected individual can obtain appropriate clinical therapy for acute or chronic conditions.

Improved coverage also reduces the burden on public health programs to provide needed services themselves. Many traditional programs within state and local public health departments provide services to the needy or fund private entities to do so, filling gaps in available coverage or emphasizing other services seen as underprovided.<sup>16</sup>

The ACA reduces the need for public health programs to fund such public clinics, screening programs, and the like. They can either be reduced in scope, leaving better insured people to obtain privately provided services, or they can continue to serve their constituencies but reduce their claim on scarce program dollars by instead claiming reimbursements from private and public insurance.<sup>17</sup>

### Public health

Many ACA provisions also directly benefit public health. Arguably the two most important are the new policy development mechanism of the National Prevention Council and a sizeable new Prevention Fund (box).<sup>18</sup> Together, these provisions offer the possibility of rationalizing a host of current policies and programs, improving the evidence base for designing interventions, and supporting both infrastructure and effective

initiatives. The Council is to develop a national strategy that promotes health across all agencies.<sup>19</sup> Importantly, it reflects the emerging goal of creating "health in all policies"<sup>20</sup> by including all agencies that substantially influence health. Public health expertise

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#### SEC. 4002. PREVENTION AND PUBLIC HEALTH FUND

(b) FUNDING.—There are hereby authorized to be appropriated, and appropriated, to the Fund, out of any monies in the Treasury not otherwise appropriated—

- (1) for fiscal year 2010, \$500,000,000;
- (2) for fiscal year 2011, \$750,000,000;
- (3) for fiscal year 2012, \$1,000,000,000;
- (4) for fiscal year 2013, \$1,250,000,000;
- (5) for fiscal year 2014, \$1,500,000,000; and
- (6) for fiscal year 2015, and each fiscal year thereafter, \$2,000,000,000.

—The Affordable Care Act

is assured through an advisory panel supporting the Council that is housed within the Department of Health and Human Services (HHS).

The Prevention Fund was meant to create an “expanded and sustained national investment”<sup>21</sup> in place of the shifting and uncertain funding of annual appropriations at all levels of government.<sup>22</sup> It also provides discretionary support that, theoretically at least, might be managed to improve the overall effectiveness of public health activities, quite unlike the separate silos of traditional categorical or line-item funding.

HHS has split the first two years’ \$1.25 billion among competing objectives. The central mission of advancing the effectiveness of community-based prevention has been the largest single category of funding. Numerous “community transformation” grants have been competitively awarded to demonstrate the effectiveness of different approaches—mainly initiatives to improve diet, physical activity, and energy balance that may reduce the incidence and progression of chronic conditions like diabetes and heart disease.<sup>23</sup> Support from the Fund has also gone to clinical prevention and public health infrastructure and workforce, as well as to research and tracking.<sup>24</sup>

Key questions for public health in the near future are how to protect the Fund and whether to use its monies to “backfill shortfalls in core public health programs”<sup>25</sup> or instead to focus new funding on so-called Winnable Battles<sup>26</sup> against known hazards and transforming the way that public health departments do business. The national strategic agenda due in spring 2011 may help shape how allocations are undertaken in the future.

Beyond these two key innovations, the ACA funds or proposes many other programs or interventions whose variety makes them difficult to summarize. Provisions include new CDC grants to states to promote healthy aging, nutritional labeling in chain restaurants, research on the provision of public health services, capacity-building grants for public health agencies and their laboratories, and grants to give small businesses access to wellness programs, among others.

### Expanding coverage and expanding public health

From one perspective, the “ACA is about insurance coverage and costs—not about population health.”<sup>27</sup> Yet an orientation toward population health is a theme that runs through many aspects of the ACA. Among public health programs, for example, the ACA emphasizes community-based prevention, building on the start made the previous year by the ARRA stimulus legislation,<sup>28</sup> but moving from the ARRA’s time-limited support to long-term funding through the Fund.

A population orientation pervades even the coverage provisions. Payment for clinical preventive services, for

example, encourages caregivers to focus their attention on caring for large blocks of patients, rather than one sick patient at a time. As another example, states are encouraged to think systematically about how better to serve Medicare-Medicaid dual eligibles as a class, rather than thinking about individual service benefits and payment rates.

Providers of clinical care are also encouraged to take responsibility for entire populations through medical homes and new accountable care organizations. Finally, the law’s coverage expansion focuses upon all Americans, nationwide, no longer on the selected subgroups previously covered—the aged or the categorically eligible poor people supported to different extents by traditional state Medicaid programs.

## Vulnerabilities and challenges

### History of funding

Historically, population-oriented public health programs have often lost out relative to other priorities. Support for coverage and clinical health spending gets enormously more funding to begin with, which is to be expected, and grows faster over time because it is an entitlement.

Although the ACA has given historically high attention to prevention and public health, recent legislative history also shows the field’s vulnerabilities, especially in funding.

In 2009, as the landmark ARRA stimulus bill advanced from committee consideration toward final passage, the dollars it allotted to public health declined in order to win votes.<sup>29</sup> ARRA’s final level of \$1 billion remained large for prevention and public health, but was still less than the additional funding given to community health centers—and both were dwarfed by the fiscal relief for states through Medicaid and other programs.

In 2009–2010, as the ACA was taking shape, the House bill also gave progressively less money to public health as the bill moved forward. Even so, it was more generous than the Senate bill, which was enacted as the ACA. (The Senate bill became law without any compromise with the House bill, for electoral reasons unrelated to public health.)

Unlike the entitlement funding for clinical care, federal funds for public health programs are annually appropriated, which subjects public health funding to yearly budget battles. Some key ACA provisions were protected by multi-year appropriations, notably including the Fund. A number of others were simply authorized, which means that despite the ACA they have to go through a new appropriations process each year to win any funding at all.

Since the ACA's enactment, the Fund has been implemented as designed, with some new funding directed to population health. The Fund allocations made, however, have also included substantial funds for clinical providers. The scheduled increase for 2011 also proceeded as intended. Since ACA enactment, however, the CDC's budgets have lost out relative to the NIH, even more so compared with Medicare and Medicaid.<sup>30</sup>

Most recently, public health has been caught up in partisan efforts to defund the ACA. Bills under consideration in the House would abolish the Fund altogether or make it wholly discretionary within each year's budget.<sup>31</sup> This is not to say that such effort will succeed or that President Obama will not carry through his stated intent to veto any such change.<sup>32</sup> It merely observes that public health is seen as a relatively easy target for cuts and for some legislators to demonstrate their opposition to growth in the public sector as against private enterprise.

Meanwhile, at the state level, a historically large drop in states' own-source revenues has forced substantial cuts to public health budgets. New federal revenues helped states, not only temporary ARRA stimulus funding channeled through Medicaid and other grant programs,<sup>33</sup> but also one-time H1N1 funding.<sup>34</sup> Nonetheless, many public health staff were lost in states and localities.<sup>35</sup> More cuts are occurring: the ARRA stimulus support ended in June 2011, and the economy has been slow to fully recover.<sup>36</sup> Most recently, states' revenues rebounded somewhat in the last quarter of fiscal year 2011, but public health lost out to Medicaid in the budgetary competition for state dollars. Almost all the additional funds were used to cover higher Medicaid enrollment from the recession and unemployment.<sup>37</sup>

The problem of adequate and steady funding for population health activities has cropped up repeatedly. Despite the ACA, this issue of funding poses a major challenge going forward.

### **Intrinsic challenges of promoting population health**

Public health practitioners and advocates appear politically challenged to convince budgeters of its value. (That budget scoring of a provision's impact uses a short time horizon is also a challenge for promoting long-term investments in public health.) Private providers of clinical services and even community health centers are able to garner more political support. What might explain this discrepancy?

One persuasive argument is that public health is routinely unfunded for four reasons.<sup>38</sup> Its programs generally create future benefits rather than helping someone immediately. They also typically benefit the public at large rather than identified individuals.<sup>39</sup>

In addition, better health is fueled by many factors other than public health. All three of these characteristics make even the clear successes of interventions like sanitation and inoculation nearly invisible to the public eye. Finally, public health initiatives often require change and thus inevitably meet with resistance.

Beyond this, it is increasingly recognized that today's largest threats to health arise from the contribution of Americans' lifestyles to chronic conditions—a problem largely outside the reach of clinical care.<sup>40</sup> Epidemiology documents the problem, but solutions require asking people for especially difficult changes—to forego the perceived benefits of easy living and to resist their instinct for hearty eating.<sup>41</sup> It also requires confronting industries that cater to those inclinations. In contrast, there was no personal downside to giving up dirty water, nor any lobby that promoted typhus.

Finally, public health is a fragmented field. The categorical nature of federal funding streams is both a symptom and a cause of fragmentation; underlying contributors are changes in risks to health and in understanding of how they may be ameliorated.<sup>42</sup> Fragmentation makes it hard to explain public health needs to the public and to its representatives who control the purse strings. It also greatly complicates managers' attempts to make reasonable tradeoffs across worthy activities that all compete for limited resources, as considered next.

## **Challenges and opportunities**

### **Priorities**

Public health practitioners and promoters are good at making long lists of their activities and goals. Each item often seems distinct from others. Unfortunately, each is also often seen as a priority, or a worthy goal, with groupings of them deemed "essential."<sup>43</sup> Moving from such lists of priorities to actual prioritization seems likely to improve the effectiveness of public health's interventions and promote accountability for performance. Better accountability is a key strategy, if not a prerequisite, to increasing and stabilizing funding flows.<sup>44</sup>

Increasingly, public health thought leaders are developing a theme that unifies those lengthy fragmented listings: All of public health has the single overarching goal of increasing the overall health of the population. Each public health intervention, from contact tracing to tobacco cessation, contributes in its own way. Indeed, clinical care and many other, non-health public programs also affect health, which is the message of Health in All Policies. Seeing all interventions as interrelated efforts greatly enhances the potential reach, and value, of overall public intervention.

Such a perspective should, theoretically, allow decision-makers to match each risk with initiatives in the program area most suited to effectuate change. Decision-makers should also be able to decide which risks and accompanying interventions deserve the most attention. In short, addressing a common goal through multiple areas at once should allow moving from separate listings of priorities to actually prioritizing activities. A key link, however, is a common metric by which to measure progress toward the common goal.

Unfortunately, this line of thought also exposes the weakness of existing tools for measuring actual impacts on health. In practice, many different performance metrics are in use, varying across programs. It is the work of a generation, not of an issue brief, to create reliable measures of this sort. The ACA will help. It contains numerous provisions meant to develop better information and standards for assessing effectiveness in clinical and population health. It already applies an effectiveness standard for coverage of clinical prevention services, as noted above.

The ACA also continues federal efforts to promote health information technology (HIT) and data sharing. ARRA provided a huge boost of infrastructural assistance for HIT start-up; and payment incentives also motivate use of HIT in ongoing clinical care.<sup>45</sup> Better data is key to consistent measurement of impacts.

In the meantime, a practical issue is that public health practitioners have strong roots in epidemiology and may resent use of less statistically rigorous measures to measure program effectiveness and their own performance.<sup>47</sup> One response to this concern is to remember that first lieutenants, captains of industry, and legislative appropriators all make very consequential decisions based on imperfect measures and intuition.

Decision-makers can and do make reasonable judgments in a rough and ready way. How many people are affected by an intervention? How severe is the risk they face or other benefit they might achieve? What is the plausible range of impacts, perhaps based on the naturally occurring variation in outcomes or some evidence of program impact?

What is the common-sense plausibility of the logic by which the intervention addresses its target? How many other factors complicate a judgment of causal relationship? Do others appear to maintain similar

approaches over time or drop them? Such an approach, which mixes quantitative evidence and qualitative judgment, underlay the New York City health department's top 10 targets for improvement and the ensuing focus on Winnable Battles.<sup>48</sup> It might also be helpful to compare findings on approaches used in other fields.<sup>49</sup>

It does not take a controlled trial to decide that a highway department should pay for roadside guardrails by chasms and on curves, but not on straightaways next to cornfields. What it does take is a willingness to establish a hierarchy of priorities, agreeing on what works even without rock-solid scientific evidence.

It is common to refer to public health spending as an investment. Much like education, public health does not serve current consumption needs but is expected to bear fruit in the future, in often unpredictable ways. Thinking like investors, public health managers can seek to improve their portfolio of interventions. They may not be able to reliably compute a precise dollar

return on investment for all activities, but they can make reasonable judgments about orders of magnitude, which programs are the highest performers and which the lowest, and then move resources from the bottom to the top. Such organized prioritization seems likely to improve their ability to justify their budgetary needs.

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**It is hardest of all to value the foundational activities of public health.**

These do not themselves directly attempt to influence health but do enable departments or programs to design and implement such interventions. This is one meaning of "infrastructure." Key capabilities of this sort include data gathering and analysis, planning and maintenance of standby capacities for emergencies, and decision analysis and program management. They cannot be attributed to any one active intervention. Here, a major hope for improvement and steady funding lies in the movement to accredit health departments in the fashion of hospitals and other key actors in health.<sup>46</sup>

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It can thus be argued that skill in decision analysis and management are important capabilities for public health, alongside medicine and epidemiology. Going forward, it is very important to improve the evidence base and over time to begin benchmarking public health activities against other interventions, from airline safety to clinical care.<sup>50</sup>

**Partnerships**

Partnering with others is increasingly recognized as a good mode of operations for public health departments.<sup>51</sup> In an era of fiscal constraint, a clear benefit is monetary, what can be called burden-sharing, dollar-stretching, or leveraging limited resources. Where missions of public entities are complementary or overlapping, it is consistent with the cost containment goals of the ACA to avoid wasteful duplication of effort or, worse, sending confusing or inconsistent signals to the public or a targeted sector.

Partnering goes beyond simple contracting out for specialized services or ones that can be accomplished more efficiently by others, such as vaccine warehousing or delivery. It means working across agencies and sectors to develop strategies and to implement activities or initiatives. Potential partners include sister agencies, commercial enterprises, private providers of health care, and nonprofit service or community organizations. Some problems, such as natural disasters, are too big, and others, such as epidemics, too complex to be addressed in isolation.

Partnering can tap the natural synergy of capabilities. For example, large chain retailers have strong logistical capabilities and the ability to track and

manage supply chains and deliveries, which is crucial in disasters. Schools and supermarkets are logical partners for nutrition initiatives, while in efforts to make neighborhoods safe and walkable, it makes sense to work with police and zoning officials.

Public health and clinical medical services can also work more effectively together, for example, with public health screeners referring patients more seamlessly to private caregivers, while caregivers look to public health or social services providers to address behavioral issues or environmental problems not amenable to the medical model of service provision.

The increased emphasis on and support for electronic health records and use of data under ACA and, before it, ARRA, offers additional opportunities for partnerships. Public health can use aggregated clinical data to identify emerging problems in a geographic area or subpopulation and feed this information back to clinicians.<sup>53</sup> Educational institutions and individual researchers are always hungry for data to meet needs of teaching, thesis development, or generation of publications. Community groups could partner in public education and reduction of disparities.

Beyond the enhanced capabilities, working with others often adds value for one's own work. Public health personnel may learn much about management and making tradeoffs, while the private participants may come to better appreciate the importance of public health and the dedication of its practitioners. Private partners can also bring advantages in flexibility and nimbleness of approach not available to a public agency constrained to operate through regulations and public sector employment rules.

All partners may improve their ability to communicate what they are doing and why, which is important for achieving public cooperation. Relying more openly on private input and participation also makes clear that public health is about protecting the public's health, not about protecting public jobs. Finally, partnering may also

develop new allies in the budget process, who can enhance credibility with appropriators.

### Promotion

Public health has a good story to tell about how much it has done for health<sup>54</sup> and why it needs adequate and reliable funding, but its practitioners often seem challenged to sell their product to outside budgeters.<sup>55</sup> Improved evidence and more support from partners have already been noted as helpful

here. Another apparent challenge is public health's discomfort with salesmanship. Many practitioners seem to see the value of public health activities to be self-evident and

perhaps also to think that selfless dedication to the public good shows the righteousness of funding. Some are simply uncomfortable justifying issues of life and health in monetary terms.

Simply learning how to talk more like an economist or business person about financing, resource constraint, and tradeoffs among objectives is one approach to improvement.<sup>56</sup> Working to develop a business-model-like value proposition to promote their work might also be useful. Adding value, which is what any purchaser seeks, is the key, not necessarily only cost containment. The value proposition can be supported by a mix of quantitative and qualitative evidence, including success stories, perhaps citing specific individuals.<sup>57</sup> The ACA encourages such evidence building.

There are many feasible models for giving operational health agencies more reliable funding. Enhanced federal funding, like the Prevention Fund, is justified because public health issues cross state boundaries, even national ones, and federal spending can be countercyclical. Federal standards for accreditation of public health might be made a condition of federal grant funding, perhaps even for aspects of Medicaid. A small percentage of Medicaid or Medicare funding might be earmarked for public health, building in growth over time.

State funding might be more secure if appropriated from a trust fund rather than a state's general fund, where budgetary competition is most intense. Assessments on affected industries are a familiar way of funding related state activities, for example, in insurance or for professional boards.<sup>58</sup>

There is thus no shortage of ways to solidify funding. But to adopt any of them depends on winning over legislators at some level of government. How to build support through the value proposition and advocacy is a much larger issue than what fundraising mechanism implements the support.

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"You public health people make it so easy to say no to you."

— a state senator<sup>52</sup>

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## Concluding discussion

When asked to name a small number of top priorities for public health going forward, thoughtful key informants typically gave one of two kinds of response. Some answered by listing leading population-health problems. These included, in various orders, obesity and inactivity; alcohol and substance abuse; mental health, especially depression; violence; and tobacco use. Others focused on the need to improve how health departments operate: How can they develop new tools for today's lifestyle-related problems, from developing "nudges" and making it easier to do the right thing to stronger interventions such as taxation or regulation; build new partnerships; assess performance; and build support to fund effective activities? This brief has mainly discussed the latter set of topics, often termed the "new public health."<sup>59</sup>

The thesis here is that the ACA raises interrelated issues of large importance for the future of public health—its defining paradigm, its funding, its evidence base, its interrelations with others, and its ability to communicate. Public health has no rigidly fixed subject matter but rather is defined by its capabilities to respond to shifting threats to population health over time—which the ACA encourages to be addressed systematically. Public health departments need the reliable funding stream at least begun by the ACA to do so. Public health's evidence base was classically developed

through in-house statistics and epidemiology, but increasingly information technology and research capabilities allow it to benefit from input from health services and from other agencies, as is promoted by the ACA. Good evidence of many kinds is needed to set productive priorities and to earn budgetary support, as well as to help convince an often skeptical public to act prudently.

The ACA also promotes Health in all Policies, which over time should encourage use of common metrics of effectiveness across programs affecting health. Ultimately, expectations for such effectiveness could spread to clinical health services delivery as well, with major benefits for promoting value in an enormous sector of the economy. Such metrics will be slow in coming. In the meantime, public health can leverage its limited resources by strengthening bonds with others in both public and private sectors.

Better ability to communicate—to learn, to teach, and to express its value proposition—will be a key ingredient for successful data collection, fundraising, and implementation of initiatives. The ACA creates a big opportunity to transform the federal role in public health and better document its accomplishments. Much work remains to assure that health reform becomes a wellspring of appreciation for public health's value, rather than the high water mark for public health advocacy.

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## Notes

1. The Patient Protection and Affordable Care Act, Public Law 111-148, 124 Stat. 119-1025, March 23, 2010, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, 124 Stat. 1029-1083, March 30, 2010, both accessible online from <http://www.gpo.gov>.
2. National Association of State Budget Officers 2010.
3. One of "three central tenets" of then Senator Obama's proposal as a candidate was "a public health infrastructure that works with our medical system to prevent disease and improve health" (Obama 2008 at 1538).
4. Senator McCain recognized the importance of "finding ways to keep the American people healthier," but this was not one of the "four pillars" of his approach (McCain 2008 at 1539).
5. Henry and Russo 2009.
6. For example, Institute of Medicine 1988, 2002; Association of Schools of Public Health 2011.
7. Trust for America's Health 2008.
8. Other factors than the ACA influence the current evolution of public health. These include the shifting nature of threats to the public's health; fiscal pressures on non-entitlement budgets; public attitudes about public governance; and the strengths and weaknesses exposed by 9-11, Katrina, and H1N1. This brief addresses ACA-related change because the law gives public health new ways to address key issues.
9. For example, Koh & Sibelius 2010; Henry J. Kaiser Family Foundation 2011; GWU & RWJF 2011.
10. The words are those of Senator Harkin (2009, at S13661). Among the discussions of public health provisions are Hall et al. 2010, Preston and Alexander 2010, American Public Health Association 2010, and Trust for America's Health 2011a & 2011b.
11. The Task Force recommends that clinicians provide preventive services whose evidence of effectiveness is good, earning a grade of A or B. Also to be covered are immunizations recommended by CDC's Advisory Committee on Immunization Practices. The Health Resources and Services Administration also play a role.
12. Mayo 1919, at 412.
13. Title V of the ACA addresses the "Health Care Workforce."
14. For example, the commission is to make attracting and retaining professionals into primary care a high-priority area, and more training slots are to be allocated to primary care and in-community training.
15. Sec. 5101 calls for a national health care workforce commission. Support for job training and the health care workforce flows through many programs and at least three cabinet departments—Education, Health, and Labor.
16. Essential public service no. 7 is to "link people to needed personal health services and assure the provision of health care when otherwise unavailable" (Institute of Medicine 2002, CDC 2010b). Salinsky (2010) discusses public health's service provision; and estimated budgetary savings within such

- programs under the ACA are discussed by Dorn and Buettgens (2010) and Bovbjerg, Ormond, and Chen (2011).
17. Agencies and other providers of services may often need to change their operations to adopt business practices that support such billing.
  18. These two provisions start the ACA's Title IV on Prevention of Chronic Disease and Improving Public Health. Sect. 3001 creates the National Prevention, Health Promotion and Public Health Council, and sect.4002 establishes the Prevention and Public Health Fund.
  19. Section 4002 of the ACA lists a dozen cabinet officers or other high level administrators who shall form the Council.
  20. Kickbush et al. 2008, Collins and Koplan 2009.
  21. Harkin 2009, at S13661.
  22. Even the extra federal funds for H1N1 and under ARRA, welcome though they were for state and local actors, were one-time boosts, not a reliable funding stream.
  23. The Community Preventive Services Task Force is directed to consider which population-based preventive services are effective and make recommendations for their implementation. It plays no formal role in agency planning or decisions on how to allocate the Fund.
  24. HHS 2010, 2011; Appleby 2010.
  25. Gould 2011.
  26. Winnable Battles are "public health priorities with large-scale impact on health and with known, effective strategies to address them" (CDC 2011). The term gained wide usage with the appointment of Thomas R. Frieden as CDC Director (Bakshi 2010).
  27. Jacobson and Somers 2011.
  28. The American Recovery and Reinvestment Tax Act of 2009 was passed as Public Law 111-5 on February 17, 2009. Its implementation and funding amounts are tracked on <http://www.recovery.gov>. Much ARRA funding went to shore up state Medicaid and vaccination programs, but the single largest health item was a new \$450 for community-based prevention.
  29. The allotment declined from early figures of \$3 billion in the House and \$5.8 billion in the Senate to \$1 billion in the final enactment (National Association of County and City Health Officials 2009a, 2009b).
  30. D. Brown (2011) and Johnson (2011) discuss developments through the President's budget of February 2011. In April 2011, a compromise Continuing Resolution cut more than \$700 million, or over 10 percent, from the CDC's discretionary budget. See AHL 2011, Zigmond 2011.
  31. *New York Times* 2011.
  32. Office of Management and Budget 2011.
  33. ARRA provided about \$250 billion under Medicaid, partly as a temporary increase in the federal matching rate, partly as an increase in DSH funding (for disproportionate share hospitals). See HHS Jan. 2001.
  34. See HHS 2009; H1N1 grants totaled some \$350 million for 2009.
  35. See Association of State and Territorial Health Officials 2011, National Association of County and City Health Officials 2011, Galewitz 2011.
  36. As of early August 2011, fears are growing of a "double dip" recession; job growth is being outpaced by increases in the employment age population. Economist 2011.
  37. Rueben 2011.
  38. Hemenway 2010.
  39. The tendency of individual impacts to draw more policy attention than merely "statistical" lives has long been recognized (for example, Cook and Vaupel 1976).
  40. Frieden, Bassett, Thorpe, and Farley 2008.
  41. Brownell, Kersh, Ludwig, Post, Puhl, Schwartz, and Willett 2010; Severson 2010.
  42. Fragmentation partly may also arise from piecemeal growth in understanding of prevailing health risks. Public health has taken on various salient threats in turn, starting with poor sanitation, various communicable diseases, and other environmental hazards, but now also extending to prevention of lifestyle-related chronic conditions. Each success helps to shift attention, but the traditional threats are not eliminated, merely held in check, requiring some level of continuing operations.
  43. See for example, The 10 Essential Public Health Services, BOX 3-1, in Institute of Medicine 2002.
  44. Trust for America's Health 2008.
  45. Blumenthal 2009.
  46. Public Health Accreditation Board 2011.
  47. Many state officials have expressed dissatisfaction with Trust for America's Health's attempts to quantify performance on preparedness, for example.
  48. Wortsman 2005, Frieden et al. 2008.
  49. Cost effectiveness studies routinely benchmark results against achievements by other interventions, notably the annual Medicare cost of annual treatment for end stage renal disease (Cohen, Neumann, and Weinstein 2008); many clinical interventions cost much more than that per life year. The ACA has a number of provisions related to determining the effectiveness of services and programs, notably in Title VI, Subtitle D on "Patient-Centered Outcomes Research." However, its section 1182 also limits the practical use of cost effectiveness analysis.
  50. A similar effort occurs for clinical prevention services compared with therapeutic interventions, and results have policy relevance.
  51. Zahner 2005; Casey, Prentice, Williamson, Boyle, Hsu, and Beery 2007; Johnson 2009.
  52. Libbey 2009, at p.4.
  53. Changes in how insurance pays for services may well be needed to fully implement this approach in many clinical settings. The ACA encourages development of clinical management entities including medical homes and accountable care organizations. Such entities are meant to emphasize achieving good outcomes over delivering numerous services, and this mindset makes them good natural partners for public health activities.
  54. McGinnis, Williams-Russo, and Knickman 2002.
  55. The ACA itself shows successful promotion but continuing challenges, as discussed in the prior section.
  56. Schlaff, Ormond, and Waidmann 2011.
  57. Lavizzo-Mourey 2010.
  58. Every state imposes premium taxes on health insurers (Graham 2010). Fully 46 states plus the District of Columbia use provider assessments to help pay for their Medicaid programs (National Conference of State Legislatures 2011).
  59. Lavizzo-Mourey 2008, 2010; Libbey 2009; Washington State Department of Health 2010a & 2010b.

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