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This policy statement is supported by the Medical Care Section and the CHPPD Section. It aims to respond to the following topics identified as policy gaps by the Action Board and JPC:

- Health reform and the changing role of the public health system
- Public health workforce issues
- Financing options for increasing public health funding

We look forward to collaborating with other APHA members and Sections and interest groups who may wish to comment on these issues.

C6-1 Public Health's Critical Role in Health Reform in the United States

I. Problem Statement

"I take care of an uninsured patient population. Not only am I seeing increased numbers of patients, due to the economic crisis, but patients that have previously had stable medical problems are becoming increasingly less stable related to stress from lack of work and less ability to eat healthfully because of cost. I anticipate an increased incidence of domestic violence, and women feeling more 'trapped'- and an associated decrease in the availability of programs for assistance... this is all part of things 'mushrooming.'" - Amy Fendrich, M.D. member, APHA Medical Care Section. Personal communication, February 17, 2009.

The U.S. remains alone among developed nations in failing to provide coverage for health care to all residents. The crisis threatens to become more painful as the economy slows. APHA members are joining with national leaders who are proposing to reform the health system.

An estimated 45-47 million Americans have no health care coverage (1, 2) and one-third of Americans under age 65 went without insurance at some point during the past two years (3). There is growing evidence that many of those who have some type of public or private coverage face serious barriers to care, restrictions to allowable benefits, or prohibitive costs (4, 5).

A December 2008 Gallup poll revealed 21% of Americans have difficulty paying for their health care needs. The rate was higher for African Americans and Latinos (30%) (6). A national poll conducted in March 2009 found that 67% of respondents believe too many patients are not getting the medical tests and treatments they need. For those with low incomes, 43% had skipped dental care and 41% had postponed medical care in the past year due to high costs (7).

Health care expenditures are increasing at a faster rate than the economy. Americans do not use more pharmaceuticals, doctor visits or hospital days than people in other countries – in fact we in the U.S. use fewer. As a result of our fragmented investor-driven system, the U.S. pays higher prices per unit of service, compared with other countries, and also experiences more intensive use of new technologies. The New America Foundation (8) has estimated that the US economy lost \$207 billion in 2007 because of poor health and shorter lifespan of the uninsured—an amount stated to be the sum total expense of the public cost of providing health care coverage to all Americans (9). Without a reform, the trajectory of current health care spending for individuals and families is projected to increase from \$326 billion in 2009 to between \$478 and \$548 billion by 2019—while the ranks of uninsured Americans is estimated to reach 57 to 65.7 million Americans (10).

In short, the health system is broken because it is not available to everyone, and there is no system for controlling costs. While costs continue to increase, there is no concomitant increase in access to health services or improvement in health outcomes.

Private health insurance plans cover about half the people in the U.S. who are insured and private funds account for less than half of health expenditures (11). Most privately insured people obtain insurance based on their employment and contribute to the cost of coverage. Premium costs alone have risen 57% for employers and 79% for employees between 1996 to 2006 (12). There is no requirement that employers offer health benefits. Private insurance plans vary widely, and increasingly fail to cover basic needs: they may not be affordable, may not cover dependents, and may exclude people with certain health conditions or coverage for certain benefits. Employees with job-based insurance can lose coverage if they change jobs, or if employers change the terms of coverage or discontinue it. The cost of unpaid, uncompensated health care delivered to those unable to pay is 37% of total health care expenditures—an estimated \$42.7

billion in 2008. This cost is shifted into higher premiums for covered individuals amounting to an annual hidden tax of \$368 per person or \$1,017 per family (13).

The system is discriminatory. African Americans and other racial and ethnic minority populations in the US are more likely to be living in poverty or receiving Medicaid than their White counterparts and Hispanics are the most likely to be uninsured. (14). Three-quarters of the adult Medicaid population are women (15).

Public Input

Interest in health reform has been both broad and intense over the past year. A national poll conducted in March 2009 found nearly half (48%) were “somewhat worried” or “very worried” about the adequacy of their current health care coverage. (16). Myriad groups and citizens organizations have developed position papers supporting health care reform from a variety of perspectives, often prepared by or on behalf of individuals with who are already failed by the current system (17-24).

The Center for Policy Analysis' *Criteria to Evaluate Health Care Reform* (25) encompasses a broad view of health reform, incorporating the concerns of national public health and women's groups and emphasizing public health and social justice. It calls for universal, affordable coverage, with fair and stable financing, that controls costs; an accountable delivery system that offers quality, appropriate, accessible and equitable care; eliminating social and economic disparities that undermine health; and a strong public health system.

The Obama Administration has placed a high priority on health care reform, establishing an Office of Health Care Reform, holding a series of town hall meetings, and hosting a White House Forum on Health Reform in March 2009 with key policy and industry stakeholders. A report from the Forum indicates that interest is high, but there remained a lack of consensus about financing strategies and the role of a public plan (26).

People from all walks of life were asked to participate in health care reform house parties during December 2008 and report their findings back to the just-forming Obama Administration. Over 30,000 participant surveys were summarized revealing cost (55%) and lack of emphasis on prevention (20%) as top concerns (27). While cost issues remain tantamount, the public's awareness of the importance of prevention offers a tremendous opportunity to envision and create a health system that addresses health needs of communities and vulnerable populations.

The Critical Role of Public Health

Effective public health activities are essential to the health and well-being of our society. The mission of public health is to fulfill society's interest in assuring conditions in which people can be healthy (28, 29). Governmental public health agencies serve as the foundation for population health through provision of three core functions. These functions include routine assessment of the population's health, development of comprehensive public health policy using science and leadership, and assurance that basic safety-net personal health services are provided to those who cannot afford them (28, 29). Government public health agencies (30):

- ④ Monitor health status to identify community health problems
- ④ Diagnose and investigate health problems and hazards in the community
- ④ Inform, educate, empower people about health issues
- ④ Mobilize community partnerships to identify and solve health problems
- ④ Develop policies and plans that support individual and community health efforts
- ④ Enforce laws and regulations that protect health and ensure safety
- ④ Link people to needed personal health services and assure the provision of health care when otherwise unavailable
- ④ Assure a competent public health and personal health care workforce
- ④ Evaluate effectiveness, accessibility, and quality of personal and population-based health services
- ④ Research for new insights for innovative solutions to health problems

Government public health agencies cannot function alone to improve population health. A public health system is required, which is comprised of all sectors of society. As such, there is a need to support a broader public health system as an integral part of reforming the nation's health. Our government public health agencies are chronically underfunded, with an estimated shortfall of \$20 billion per year. The U.S spends an average of \$120 per person on public health, less than the average per capita expenditure of other Organization for Economic Cooperation and Development countries (31).

Covering the uninsured and modernizing America's health care system are urgent priorities, but they are not enough. The Prevention Institute estimates that only 15% of premature deaths are directly attributed to shortfalls in medical care (32). This nation is facing an epidemic of chronic diseases such as obesity, diabetes, heart disease, asthma and HIV/AIDS— all of which can be delayed in onset if not prevented entirely (33, 34). More than half —162 million Americans—have a chronic condition (33) and children are increasingly being affected (32). About 13% of working-age people with chronic conditions were uninsured in 2007; 28% of those—over 20 million people—had problems paying medical bills (35).

The Institute of Medicine (IOM) (36) provides an important bridge to understanding the relationship between health care coverage of individuals and serious risks to communities where coverage rates are low. Data show that rates of preventable diseases and conditions are greater in uninsured and underinsured groups. For example, uninsured patients are significantly more likely to present with advanced stage cancer compared to those with private insurance (37) and children without insurance are more

likely to miss routine preventive care (38). Even more striking, IOM findings point to communities in Los Angeles with up to 45% uninsured and an average of 28% uninsured in the state of Texas. Evidence suggests that the health care infrastructure is more robust in areas where more people are insured. Conversely, an underinsured community has worse access to basic and specialty care, impacting broader community health.

II. Key Public Health Issues in Health Reform

🌐 Social Determinants of Health

APHA policies support the government's obligation to address social, economic and political determinants of health. Key elements include clean and safe food, water and air; safety from violence, security in income, nutrition, shelter, and community; unfettered access to clinical preventive services, immunizations and screenings; and disease surveillance. These environmental, economic, and social justice issues all play vital roles in the health of our communities nationwide (39-43).

Among the determinants of health, racial and ethnic health disparities highlight that minority populations suffer disproportionately in basic health indicators. For example,

African Americans and Latinos have higher rates of infant mortality, diabetes-related mortality, and AIDS (14) and have an increased risk of advanced stage cancer—irrespective of health insurance status—compared with their white counterparts. (37). People with disabilities or chronic conditions can be denied services because of coverage caps or denied coverage altogether due to preexisting conditions. Physical and attitudinal barriers at medical offices also reduce access to routine preventive care for disabled women (44, 45). Our nation needs to ensure that assessments and interventions in a reformed health system address and reverse the health status disparities still found in racial/ethnic minority communities and among people with special needs. Health impact assessments can call attention to neighborhood conditions and broader social and economic policies that directly affect health at the population level (46). The concept is similar to environmental assessments, mandatory for federally-funded projects, and is adopted in 15 states (47). For example, residents, city planners, and health departments can call for healthy built environments. These require quality housing, access to public transit, schools and parks; safe routes for pedestrians and bicyclists; meaningful and productive employment; unpolluted air, soil, and water; and, cooperation, trust, and civic participation. The *Healthy Development Measurement Tool*, developed by a program at the San Francisco Department of Public Health, connects public health to urban development planning to achieve a higher quality social and physical environment that advances health (48). With an evidence base and appropriate measurement tools, health impact can be assessed in a broad spectrum of local, state and federal policies to improve their effect on public health.

🌐 Health IT

Inefficiencies are inherent in a patchwork system with many layers of administration and redundancies, in part because health care providers and service agencies cannot easily share or exchange information. As a result, calls for upgrading health care information technology have become more popular (49-51). The IOM's *Quality Chasm* report (52) called for new organizational models capable of investing in health information technology (IT); managing new clinical knowledge and skills; designing care processes based on best practices; assembling and deploying multidisciplinary teams; coordinating care; and measuring and improving performance.

The Obama Administration has proposed investments to modernize health IT. The HITECH Act of 2009 will allow qualified physicians to purchase electronic medical record systems for specified purposes including electronic data exchange and other “meaningful” uses to increase coordination and efficiency. If fully adopted, the eventual ability to aggregate population health data available from electronic health systems is predicted to be a powerful tool for improving and transforming medicine (49).

The development of databases, registries, and tracking systems facilitate monitoring of diseases, risk factors, and other factors needed to assess, plan for, and predict interventions and outcomes. IT tools such as immunization registries and cancer registries support disease prevention and surveillance efforts. Other technological devices like home testing for cholesterol and glucose levels, and online services supporting weight loss and smoking cessation provide valuable low cost tools to help Americans manage their own health (53, 54).

Telemedicine also can help reduce barriers for geographically isolated, frail or disabled consumers, or individuals with specific language or translation needs. Investing in telemedicine would increase efficiency and reduce barriers by bringing health services to individuals in their homes and communities (55). Privacy issues have been a commonly-raised concern, although a recent report concludes that enhanced privacy and security measures built into health IT can bolster public trust and confidence (56). Realizing the projected benefits of health IT in improving care and reducing costs is dependent on proper alignment of the financing and organization of the health care system (57).

Health Care Accountability and Oversight

A Rand study of 12 U.S. cities found that, on average, people only receive 50% to 60% of recommended care; quality was found lacking on a number of measures (58). Health planning and regulatory oversight have been essential tools in controlling market-driven inefficiencies in health care delivery (59). Unlike other industries, where competition and market forces promote price controls and efficiency, price controls in the health care industry are weak, and often misdirected. Competition in health care has resulted in overcapacity, rather than greater efficiency (i.e. capacity that matches consumer needs) and lower costs for consumers. Community health planning and regulation have been shown to improve performance by supporting planning, supplementing resources, addressing overcapacity, and promoting standards.

A hallmark of community health planning is to involve a broad range of stakeholders in identifying, assessing, prioritizing, and designing interventions so they are accountable to the community that needs and uses them. In Rochester, New York, a long-standing history of community-based planning helped limit the expansion of hospital capacity, and control the diffusion of expensive medical technology to effectively control health care expenditures (60). Massachusetts researchers are involving the public in quality of care and consumer engagement efforts with positive outcomes for community involvement (61). Aligning Forces for Quality is working with targeted communities and national organizations to increase consumer engagement in understanding risks, treatment options and quality of care issues (62). Such examples can serve as models for many communities across the U.S. The Obama Administration has embraced *Core Principles for Public Engagement* (63) that welcome public participation, inclusive planning, outreach to diverse communities, transparency and other relevant principles.

Improving the Population's Health/Strengthening the Public Health Infrastructure

The federal, state, and local governments play critical roles across the full range of disease prevention and health promotion activities. First, working together, governments at all levels should lead the effort to develop a national and regional strategy for public health and align funding mechanisms to support its implementation.

Second, the field of public health would benefit from greater research to optimize organization of the 3,000 health departments in this nation, collaborative arrangements between levels of government and its private partners, performance

and accountability indicators, integrated and interoperable communication networks, and disaster preparedness and response. Third, the government must invest in workforce recruitment as well as modernizing our physical structures, particularly our public health laboratories. Addressing critical shortages in school nurses, public health clinic personnel, and home care/personal assistants also strengthen our ability to keep our population healthier and avoid worsening undiagnosed or untreated conditions. Recruitment among ethnic minorities and in populations representing growing immigrant communities is needed to ensure culturally and linguistically appropriate care.

III. Financing Comprehensive Reform

Most other industrialized countries employ some degree of government involvement to assure universal coverage and to control costs. All have better coverage and spend less than the U.S. (64, 65) They have health outcomes that are at least as good as the U.S., and in some cases better (66-70). Current U.S. reform proposals vary in methods of financing and coverage, and the degree of change they seek to make to the existing patchwork system.

The fragmented, investor-driven financing and organization of the U.S. system is unable to control costs. This system routinely defeats the ability to realize savings from improvements in health status and in the quality of care. Potential savings are diverted to charging higher prices for products and services, high administrative expenses and profits. In order to achieve public health goals, the reformed financing system must address this central problem

APHA has expressed support for the single payer financing system for decades, including through the 14 Points and in a 1995 policy statement. Under this system, a single payer—the government—pays directly for all health care. Eligibility is guaranteed automatically as a condition of the program. This system is widely accepted by the Lewin Group (71) and other analysts (1, 72) to be capable of achieving the two important attributes of successful and sustainable health care systems: universal coverage and cost control.

A single payer system would leverage the federal government's economic power to negotiate affordable prices with health care providers and the pharmaceutical industry. The system eliminates the participation of the thousands of private health insurance plans, and therefore sharply reduces administration costs, estimated at 31% of health care expenditures, many times higher than Medicare or other national systems (69, 73). The Institute for Health and Socio-Economic Policy asserts that implementing a single payer system would create over 2.6 million new jobs—more than the number of jobs lost during 2008—and create an economic fiscal stimulus of \$317 billion (74). The authors concluded that cost savings would exceed the new costs of providing universal coverage

for all. Conversely, evidence from the mixed public-private reformed system enacted in Massachusetts indicate that while coverage has increased, expenditures continue to climb, leading to predictions that an inherently inefficient system may be unsustainable (75, 76).

Single payer proposals have been portrayed as too sharp a departure from present arrangements (77-80) and a public-private “hybrid” approach has received considerable attention in Congress (64). Nonetheless, recent polls show that single payer is a popular solution with 54% in support and 63% -80% favoring government-provided health care—even if it means higher taxes (16, 81-84). Among physicians surveyed, 59% supported national health insurance (85) and 63% supported single payer (86). About one-quarter of Obama health care reform house party respondents asserted a preference for single payer—despite the fact that it was not mentioned on the participant questionnaire (27). Medicare beneficiaries, arguably those with the closest experience to single payer coverage, report fewer problems obtaining medical care, less financial hardship, and higher overall satisfaction with their coverage compared to people covered through their employers (87). Single payer legislation passed in two separate sessions of the California legislature in 2006 and 2008.

Industries that would lose substantial revenues under a single payer system are politically opposed to it (88). The private health insurance industry would be sharply curtailed, while the pharmaceutical, hospital supply, and other health-related industries would experience prices more in line with those in the rest of the world. Other opponents include interests who ideologically favor free market approaches and who mistrust the government.

An alternative proposal would establish a public insurance plan similar to Medicare, available to people under age 65. Enactment of a public plan competing with private insurance is predicted to attract 42.9 to 131.2 million people—including those switching from private insurance—but would not necessarily eliminate the uninsured (89). A 2009 proposal for a public plan option makes a case for public insurance improving benefits, efficiency, and universal enrollment with different levels of individual and government cost sharing (90).

Public health will benefit from a stronger role for the public sector in controlling health care costs. APHA should evaluate proposals for a new public insurance plan according to its guiding principles for health reform.

As a change agent for public health, APHA recognizes that changes to the financing system will not necessarily guarantee important changes to policies and programs affecting social determinants of health or fully cover all needed social services. APHA should support financing mechanisms that guarantee a viable publicly-financed program, in order to achieve universal coverage, and to facilitate organizational reforms that can incorporate evidence-based multidisciplinary disease prevention strategies.

IV. APHA’s Role in Health Reform

A. Existing APHA Health Reform Policies and Resolutions

Access to health care is a human right (91, 92). APHA has long advocated for universal coverage for affordable health care with health reform policy statements dating back to at least 1950. APHA has committed to supporting health care system reforms, including reforms in the coverage and financing of health care, and reforms in the health care delivery system. APHA also calls attention to the importance and impact of the range of public health activities from preventive services to healthier communities to elimination of the social and economic inequalities that undermine health.

In March 2009, APHA released its *Agenda for Health Reform*, embracing broad health reform goals (93). As the United States once again approaches the prospect of a

transformative leap to achieve universal coverage for health care, APHA can assert public health's critical role in improving the health of the nation.

B. APHA 14 Points on Health Reform

In 1993 APHA leaders developed 14 Points on Health Reform, described below, that established public health's essential criteria for reform (94). This section annotates the 14 points with existing APHA policies that support them. The Points should continue to guide the public health community in ensuring that national health reform policy proposals address core public health needs.

1. **Universal coverage** for everyone in the United States
 2. **Comprehensive benefits** including health maintenance, preventive, diagnostic, therapeutic, rehabilitative, behavioral, palliative, long-term care, and end-of-life services for all types of illnesses and health conditions and all other necessary services to meet patients' total health needs.
3. **Guaranteed protection** against very high health care costs
4. **Integration of health care and public health** through publicly-accountable mechanisms to assure maximum responsiveness to community needs
5. **Clearly identified roles for federal, state, and local government** health agencies
6. **Incentives and safeguards** to assure effective and efficient organization and integration of services and a high-quality health system
7. **Fair payment to providers** using mechanisms which encourage appropriate treatment by providers and appropriate utilization by consumers
8. **Ongoing evaluation and planning** to improve the delivery of health services with consumer and provider participation
9. **Inclusion of disease prevention and health promotion** programs
10. **Support of education and training** programs for all health workers
11. **Affirmative action** programs in the training, employment, and promotion of health workers
12. **Non-discrimination in the delivery** of health services
13. **Education of consumers** about their health rights and responsibilities
14. **Attention in the organization, staffing, delivery, and payment of care** to the needs of all populations including those confronting geographic, physical, cultural, language, and other non-financial barriers to service

C. APHA's Role for the Future

APHA shares values with many groups seeking to fix our ailing health care system. Our record of support for the inclusion of care options *not* covered by any conventional public or private health plans enables APHA to advocate for enriching more general proposals for "universal health care." By calling for "*health reform*,"(93) APHA can broaden the policy agenda to include key policy areas that impact Americans' ability to achieve optimum health.

APHA must play a key role in advocating for a strong public health infrastructure and a system that improves population health. While often neglected in the past, public health is now frequently referenced by policymakers, both regarding health care delivery system improvements and support for clinical preventive services such as immunizations, and also regarding broader public health functions that safeguard and improve population health, from monitoring and surveillance of health conditions to addressing social and economic inequalities.

To meet 21st Century needs, APHA requests the creation of a public health taskforce. This body would be charged with studying existing health reform proposals and making recommendations to ensure that any health system reform provides an adequate

infrastructure to support democratic, community input into issues of health care access, quality, resource distribution, and priorities.

APHA must articulate and advocate for our long-standing policies. The *14 Points* can serve as a measure to identify gaps in policy proposals. Central issues for APHA involvement include:

- ④ **Advocating for a strong public health infrastructure** to improve population health.
- ④ **Building a robust multi-disciplinary health planning infrastructure** that guides policy and program development on behalf of our communities.
- ④ **Restoring strong regulatory oversight.** It will be critical for public health advocates to insist on, and participate in, government regulations and other public interest oversight of health care programs to provide optimum protection for all Americans.
- ④ **Incorporating non-medical social determinants of health** into programs and policies that support each community's ability to offer healthy living options to all its residents.

Equally important, APHA should build bridges with other community stakeholders understanding that policy compromise will be inevitable and reform is likely to be implemented in phases. As such, APHA should contribute to *all* health reform proposals and models. APHA has the capability and responsibility to mobilize the efforts of our members, leaders and staff, and to build partnerships with allies and policy-makers, to assure that the present historic opportunity for transformational change is realized.

V. Action Statements

Therefore the American Public Health Association:

Urges the U.S. Congress and DHHS to consider and adopt APHA's 14 Points on Health Care Reform and to adopt the recommendations of the *2009 APHA Agenda for Health Reform* to support population-based services that improve health, and to reform health care coverage and delivery.

Urges Congress and the Administration to enact a program of universal coverage for health care that includes all residents, that is affordable for all payers, and provides access to comprehensive and high quality health care services and social supports, consistent with APHA policies and principles.

Urges the President and Congress to defend and support publicly funded and publicly administered health care plans, and public health programs.

Urges the President and Congress to address the chronic underfunding of the nation's public health system, relying on the CDC, DHHS, WHO, APHA and other sources to supply an evidence-base supporting prevention and public health services.

Requests that the DHHS and the White House Office of Health Care Reform create a taskforce to provide ongoing democratic community involvement in framing policies on health care access, quality, resource distribution, and priority-setting.

Urges the CDC, DHHS, and WHO to gather and report data on how the social determinants of health impact public health, including chronic and preventable diseases, and further urges funding to identify, evaluate and replicate relevant best practices that demonstrate positive health outcomes.

Urges CDC and DHHS to conduct health impact assessments for all new federal policies and programs across sectors including housing, transportation, environment, land use, agriculture, labor, education, trade and the economy, as an important method for assessing the impact of social determinants of health, and recognizing that health is

intricately tied to community design and directly affected by these policies and programs, as noted in the 2009 APHA Agenda for Health Reform.

Urges the U.S. Congress and the National Conference of State Legislatures to pursue legislation to consider the community health impact of budget decisions and new laws (e.g., zoning, agriculture, water, urban development, economic development, education). Urges the DHHS and the CDC to identify multidisciplinary best practice preventive health education practices (e.g. weight management education, diabetes education, asthma education) and join APHA in recommending that they be covered health benefits for all Americans. Urges Congress to allocate resources to convene a workgroup of professional organizations including, but not limited to, APHA, Association of State and Territorial Health Officials (ASTHO), Council of State and Territorial Epidemiologists (CSTE), and the National Association of County and City Health Officials (NACCHO) to develop recommendations for developing evidence-based effective community health assessment practice.

Pledges to support DHHS in developing and disseminating information about the HITECH Act to ensure that more of our nation's safety-net providers can avail themselves of electronic medical records and technology to improve the coordination of patient care.

Urges DHHS to engage in a new era of health care regulatory and participatory oversight including restoring community health planning as a process that empowers communities to participate in identifying their health care needs, making service providers accountable for meeting them, and evaluating their impact on community health status.

Proposes the U.S. Congress enact legislation to create a federal office to provide regulatory oversight to help health care consumers. Pledges and urges APHA membership units and members to engage in the health care reform debate by building and working with coalitions and providing input to guide health care reform policy agendas and advocacy work to protect vulnerable populations and communities and to identify public health initiatives to include in existing reform agendas. **References**

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