Health and Human Services Issues –

Public Health Programs

KPMG Peat Marwick
Government Services Management Consultants
for
North Carolina General Assembly
Government Performance Audit Committee
December 7, 1992

Issue Statement:

In 1989, the General Assembly transferred the State's public health programs from the Department of Human Services to the Department of Environment, Health, and Natural Resources. The appropriateness of this shift has been questioned by many parties. This paper assesses the appropriate organizational placement of the State's public health function and programs.

Background

North Carolina delivers public health programs through its Department of Environment, Health, and Natural Resources (DEHNR). Public health is one of four major organizational units in DEHNR along with Environmental Protection, Natural Resources, and Administration. (See organization chart for DEHNR at Exhibit 1.) For fiscal year 1992, the budget for health programs in DEHNR was $190.6 million with 1,118 positions. Technical assistance for local health departments is offered through seven regional offices located throughout the State. (See Exhibit 2.)

The two goals for public health programs in North Carolina are to:

- Protect the public health
- Maintain and improve access to minimum standard of health care

Protecting the public health includes the traditional public health functions such as epidemiology, health inspections of public facilities, disease control, and vaccinations. Governments have performed these functions for several decades. Protecting the public health also means creating and maintaining a healthy environment - one with potable water, free of radiation, sanitary food supply, and safe workplaces. As public concern for the environment has increased, its relationship to public health has grown stronger.

Maintaining and improving access to health care is a more recent function of the public health system and is related to the provision of social services for the poor. Access to health care is generally related to income and proximity to population centers large enough to support a regional health facility. Persons with higher incomes have more access to health care services, while the poor, particularly those living in rural areas, have limited access to health care. Medicaid addresses the inability of the poor to afford most health care services, but does nothing to address the physical location of health services in underserved communities.

Environment, Health, & Natural Resources

Organization Chart

EXHIBIT 1

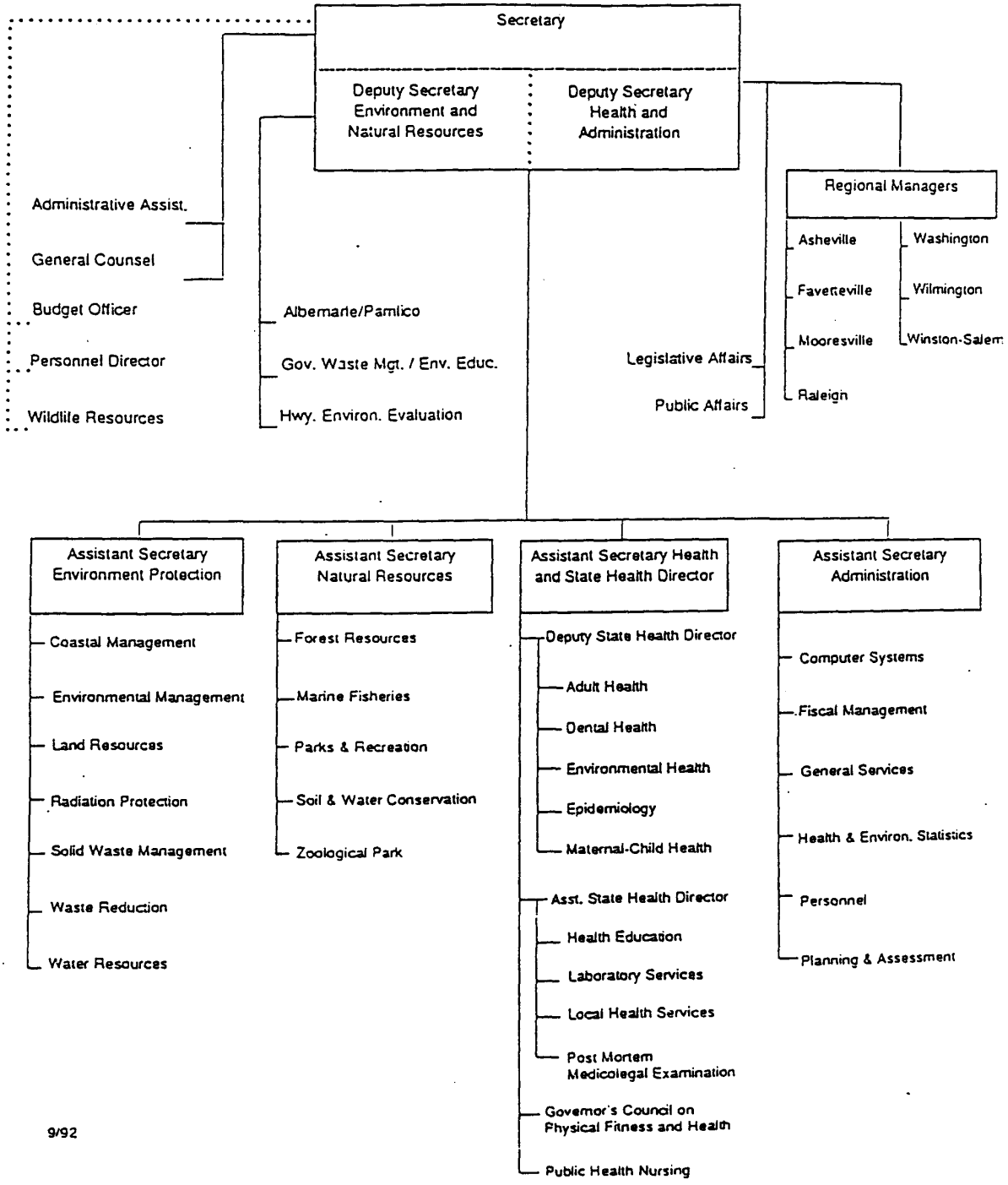

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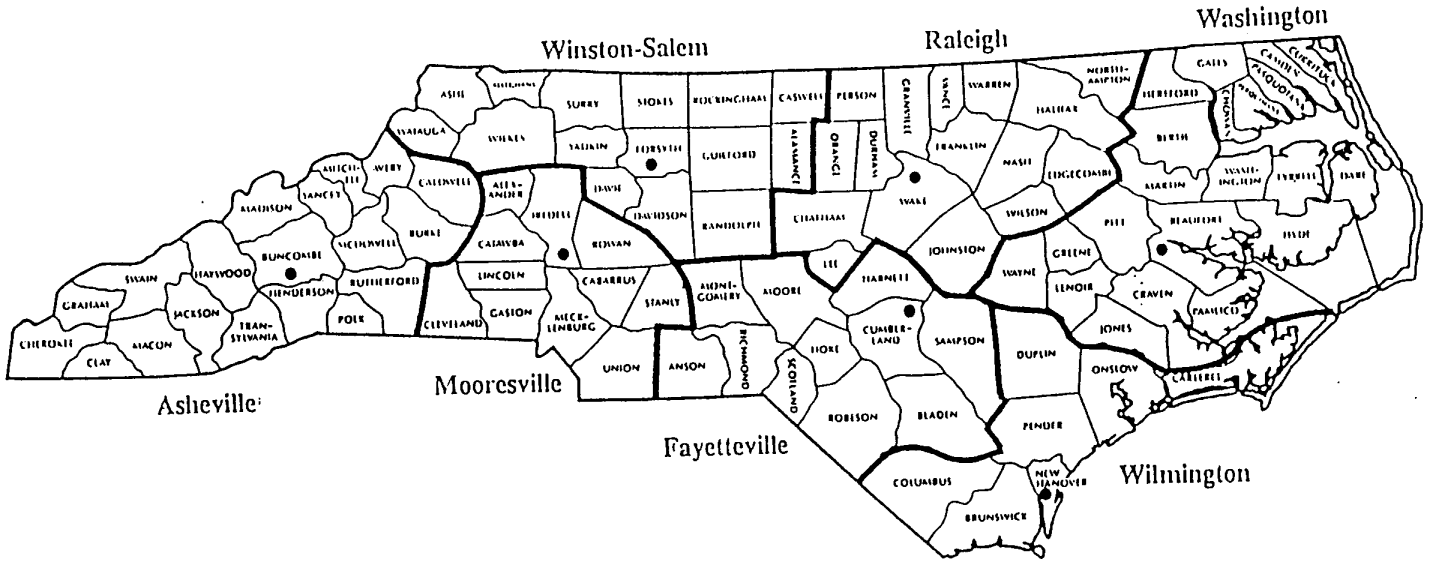
EXHIBIT 2

REGIONAL OFFICES

N. C. Department of Environment, Health, and Natural Resources



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Some public health programs interface with at least two other program areas in state government - human resources and the environment. The relationship between these program areas is illustrated in Exhibit 3. The absence of uniformity among states about where to place public health functions in a state government illustrates the lack of consensus on the proper placement of public health programs.

Prior to 1989, North Carolina's public health programs were located in the Department of Human Resources (DHR). (See Exhibit 4.) In 1989, the General Assembly voted to create a new Department of Environment, Health, and Natural Resources. This new department combined public health functions in DHR with environmental and natural resources functions in the old Department of Natural Resources and Community Development (DNRCD). Community development programs in DNRCD were transferred to other agencies in State government.

The initial reorganization proposal, which sought to move only environmental health programs to the newly created department, would have divided public health programs into two parts - personal health and environmental health. (See Exhibit 5 for an illustration of the initial reorganization proposal.)

The impetus for the reorganization came from local developers. Developers seeking approvals and permits from State and local governments found themselves dealing with both DHR and DEHNR. The boundaries of agency jurisdiction based on the proximity of a development project to a pond or the equipment used to pump water caused confusion for developers. Developers were looking for a "one-stop shop" for obtaining permits and approvals for development projects.

The initial proposal for reorganization of public health functions sought to address the concerns of developers. The State proposed to move public health programs that were part of the development approval process to a new department of the environment. The key public health programs slated for transfer to the new department were:

- Onsite sewage
- Water supply
- Solid and hazardous waste

Placing these programs together with other environmental program in DNRCD would give developers the one-stop shop they desired. It was hoped that with all of the development related approvals in one organization, developers would face a consistent set of rules and guidelines.

EXHIBIT 3

Public Health, Human Resources, and Environmental Areas Overlap

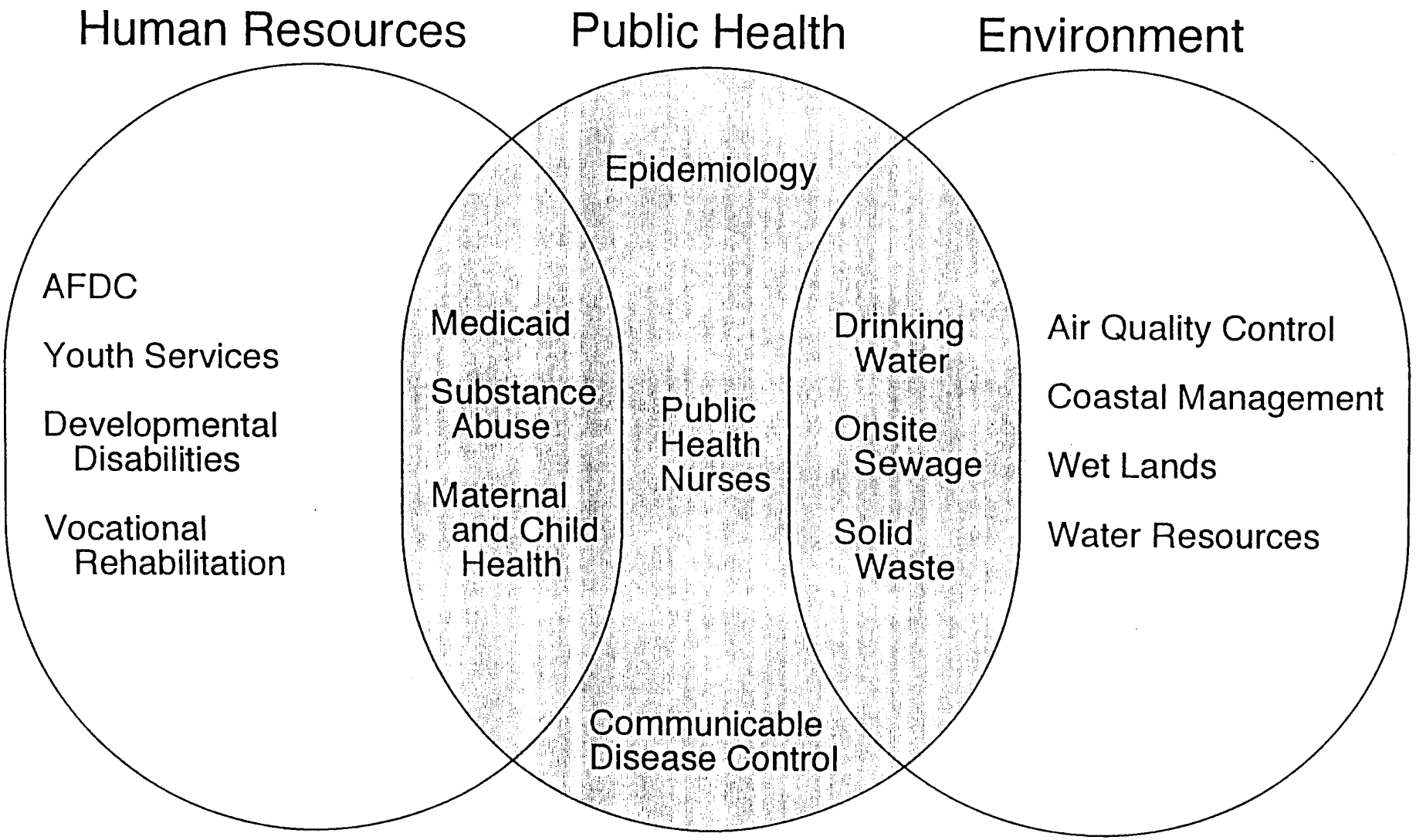


EXHIBIT 4

Prior to 1989 Public Health
Programs Were in Human Resources

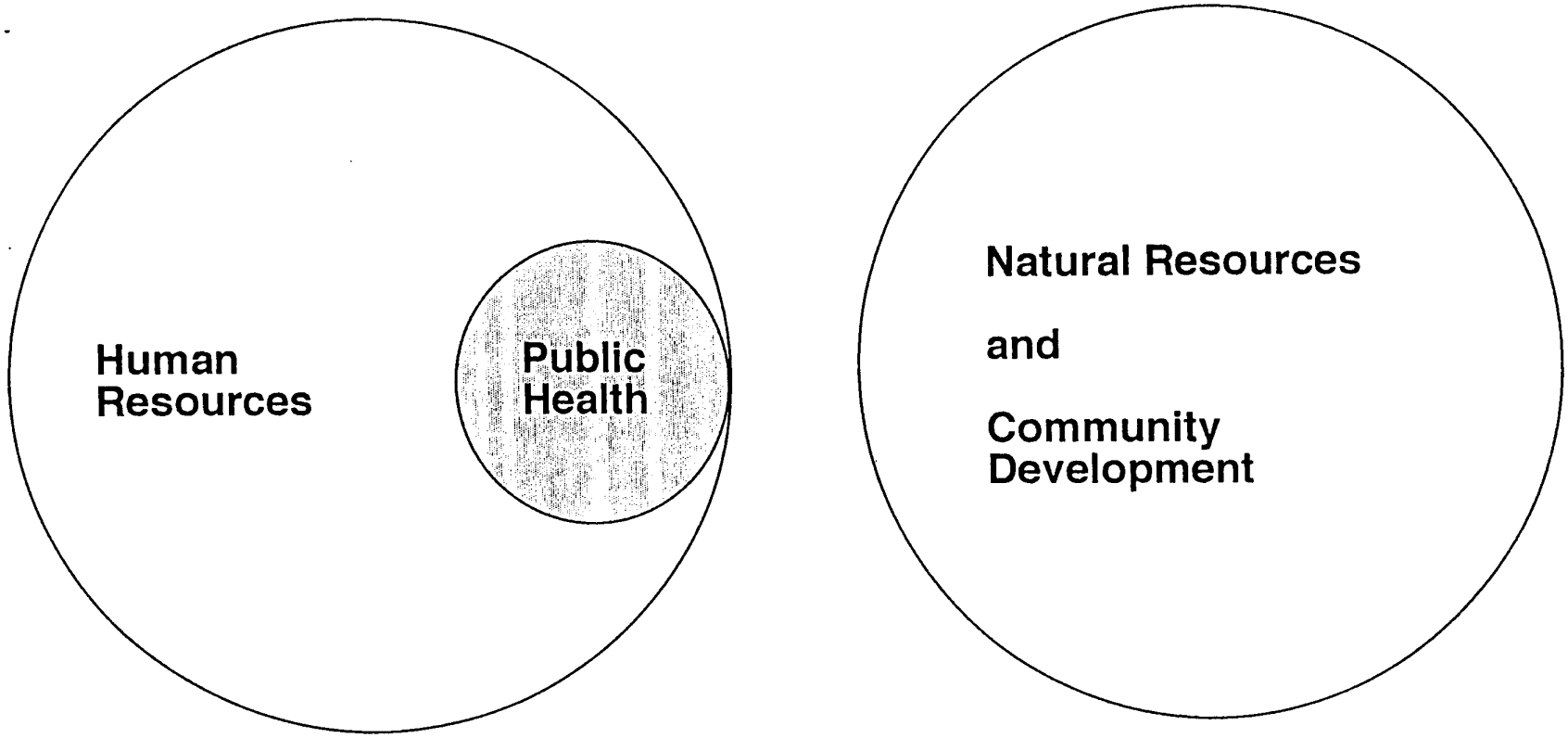
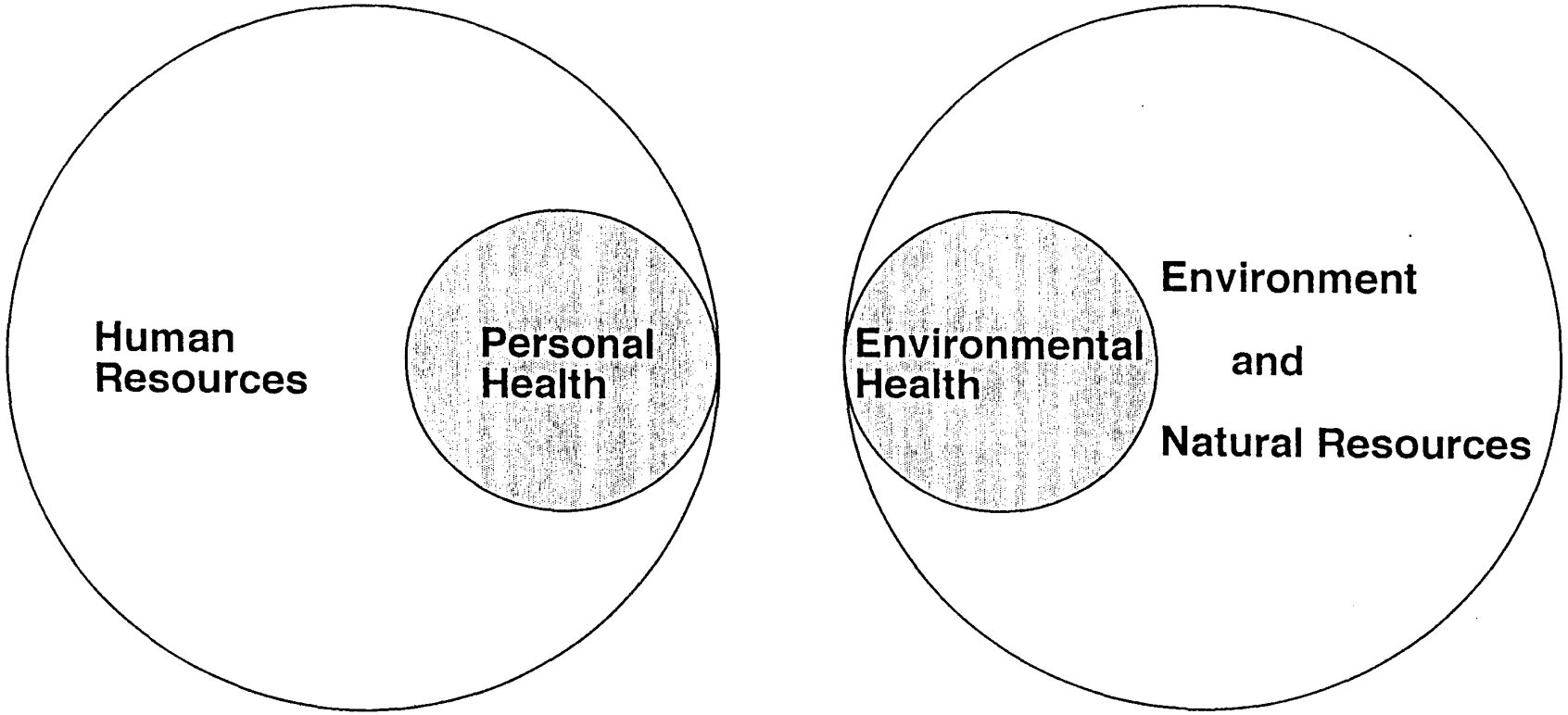


EXHIBIT 5

Initial Reorganization Plan Would Have
Divided Public Health Programs



The initial proposal for reorganizing public health programs solved a problem for the developer community but created a problem for local and county level health departments. Small county health departments employ sanitarians that are generalists. These sanitarians may conduct an inspection to approve a developer's permit on Monday, inspect a food establishment on Tuesday, a day care center on Wednesday, a rest home on Thursday, and a swimming pool on Friday. Under the proposed reorganization, the activities of the generalist sanitarians at the county health department would fall under the jurisdiction of two different State departments. Fearing that fragmentation of State oversight might complicate their jobs, local county officials and health departments urged the General Assembly to keep all public health programs (environmental and personal) together in one agency.

The resulting organizational structure addresses the concerns of developers and local health departments. The functional alignment under the current organizational structure is shown in Exhibit 6.

Findings

Finding 1: Several State public health programs are not located in DEHNR.

Among the public health related programs **not** in the Public Health section of DEHNR are:

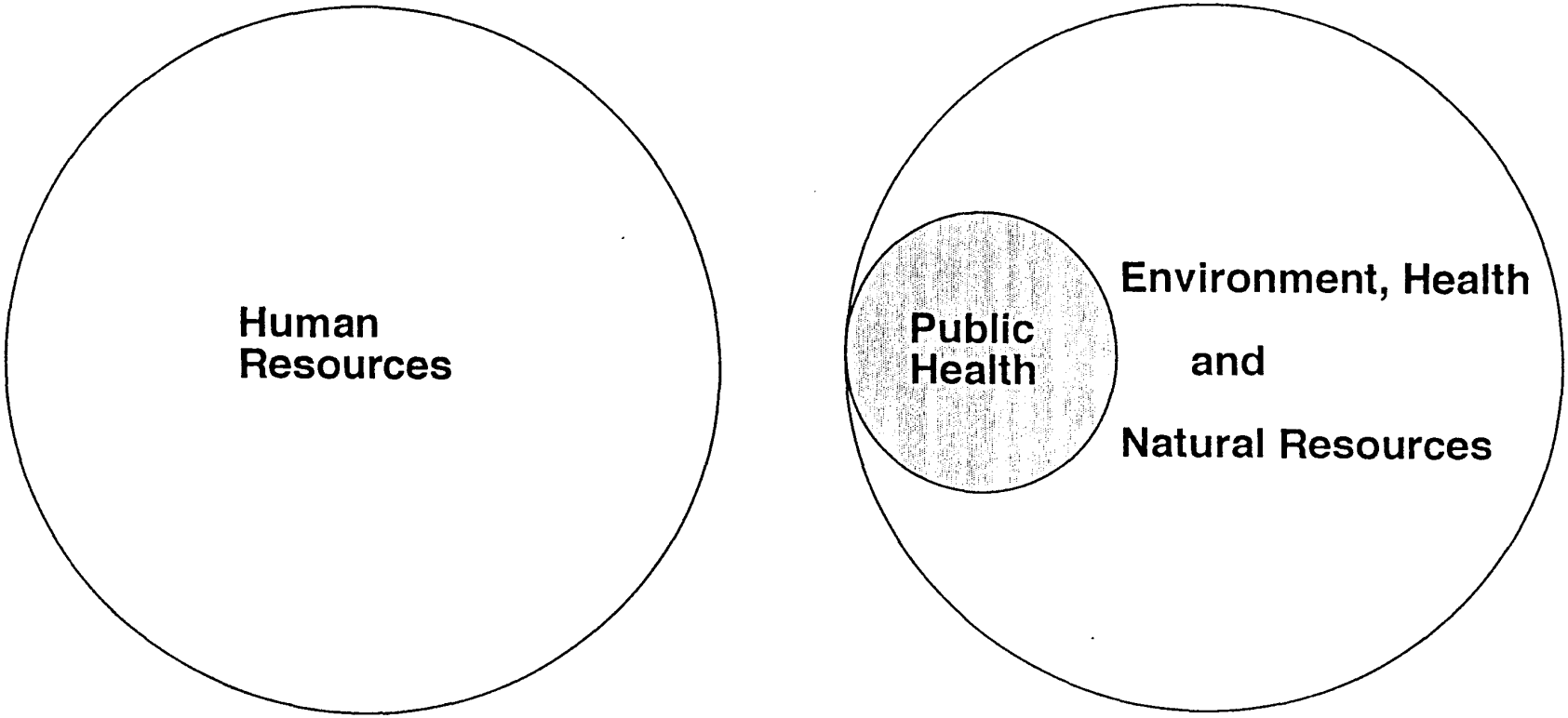
Program:	Department:
Rural health	Human Resources
Alcohol and drug abuse services	Human Resources
Health planning	Human Resources
Medicaid	Human Resources
Mental health	Human Resources
Health facility inspection and licensure	Human Resources
Radiation protection	DEHNR/Environmental Protection
Solid waste management	DEHNR/Environmental Protection
Health and environmental statistics	DEHNR/Administration
Area health education centers	UNC Medical School
Pesticide regulation and control	Agriculture

Although these programs are related to health, not all stand alone public health departments include all of these functions. Some states make it a point to keep medicaid separate from public health, because medicaid is seen as a third party payment or insurance function rather than a health function. Furthermore, a majority of the medicaid population is served through other income maintenance programs such as food stamps, aid to families with dependent children, and emergency assistance.

Pesticide regulation and control was considered for inclusion in DEHNR with public health programs but the proposal to move the program faced significant opposition.

EXHIBIT 6

Public Health Programs Are Now in Environment Health and Natural Resources



Finding 2: ***Among eight southeast states, three models for organizing public health programs predominate.***

They are:

Separate public health department:
- Alabama
- Mississippi
- Virginia

Combined public health/environmental department:
- North Carolina
- South Carolina
- Tennessee

Combined public health/human resources department
- Georgia
- Louisiana (health and hospitals)

These three models are prevalent throughout the United States.

The trend in public health organization has been either to join public health with environmental programs or to create a separate department. The District of Columbia, for example, is the latest jurisdiction to remove is public health programs from a consolidated human resources department and create a separate public health department. With the 1990 Institute of Medicine study, which recommended the creation of a department of public health in each state, and with the increasing concern about health costs, access and policy, more states are reorganizing to emphasize health by making it a separate entity rather than having it buried it in a huge department.

Finding 3: ***Local county health departments are satisfied with the location of public health programs in DEHNR.***

Based on discussions with the Wake County health program director and the head of the State's association of local health directors, county health directors are satisfied with the location public health programs in North Carolina. In particular, they believe that public health receives more attention in DEHNR where it is nearly 50 percent of the department budget than it would receive in DHR where it was less than 10 percent of the department budget.

Local health directors raised other issues associated with the organization of public health including:

Qualifications of the Deputy Secretary for Health: Deputy Secretary of Health should be a physician with training or experience in the area of public health.

Annual report to the legislature: Deputy Secretary should submit a report annually to the legislature on the state of the public health in North Carolina.

These recommendations were submitted to the 1992 Public Health Systems Issues Committee of the Legislative Study Commission by the Association of Public Health Directors.

Finding 4: ***Regional office staffing structure may not be appropriate for the needs of local health departments.***

North Carolina offers technical assistance to local health departments through seven regional offices. The technical assistance is in the areas of health promotion, environmental protection, successful methods for program implementation, and strategies for addressing regional problems. These offices employ 200 public health staff (at an estimated cost of $6.3 million in salaries and benefits). The administrative support budget for the public health staff totals about $650,000.

The need for technical assistance services for local health departments vary from location to location. According to some local health directors, the state's assistance is more useful for health departments in rural areas than for ones in metropolitan areas. Furthermore, the allocation of environmental and public health professionals in the regional offices, may not meet the types and levels of expertise needed by the local offices.

Finding 5: ***Several DEHNR programs serve the same constituency as DHR programs.***

Most DHR programs and some public health programs in DEHNR target low-income citizens. The key difference between public health programs and DHR programs that serve low-income citizens, is that public health programs are not means tested. Despite this difference, many of the programs operated by DEHNR serve the same clientele as the means tested programs in DHR. In DEHNR, the maternal and child health program and the women infants and children (WIC) program are targeted towards poor families many of whom are eligible for public assistance, food stamps, energy subsidies, and housing subsidies. Adult health care is aimed at low income adults with no health insurance. The developmental evaluation centers operated by DEHNR assist in determining whether a child should be placed in a DHR developmental disability facility. Many of the health education programs are directed toward the lesser educated, lower income citizens of North Carolina who are clients of DHR.

Recommendations

Recommendation 1: North Carolina should continue to provide public health services through DEHNR and reexamine organizational questions in two years.

Although there is some concern about the placement of public health programs with environmental programs, several factors argue for leaving the current organizational structure in tact. First, the new department is only three years old. Many of the problems associated with the transition are still being worked out. Over time, solutions to initial problems may be found.

Second, there is not widespread discontent with the current organizational placement of public health programs in DEHNR. Staff at DEHNR and DHR believe that the department can work as currently structured. Local health departments indicated that the current situation works, and developers are satisfied as well.

Third, moving public health programs to DHR would appear to deemphasize public health issues at a time when the North Carolina and the entire country are focused on health care reform. As less than 10 percent of the DHR budget, public health might be crowded out during the budget process if it were reunited with DHR programs. Currently public health is about 50 percent of DEHNR's budget.

After two more years of experience with the current organizational structure in DEHNR, North Carolina should revisit the organizational placement of public health programs.

Recommendation 2: Study the feasibility of streamlining the regional organizational structure for public health programs.

North Carolina should analyze the regional organizational structure for public health programs. With the change in the organizational placement of public health programs in 1989, public health personnel went from four regional offices in DHR to seven regional offices in DEHNR. Health directors indicate that in some regions the state may have too many public health consultants and not enough environmental health consultants to provide technical assistance needed by local health departments. The State may be able to achieve some savings through a more efficient allocation of staff in the regional offices.

References

Future of Public Health, Institute of Medicine, 1990, Washington, DC

1992/93 Public Welfare Directory, American Public Welfare Association, 1992, Washington DC