

## Public Health 3.0 Issue Brief

### Introduction

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In October 2016, the Office of the Assistant Secretary for Health released a set of recommendations to achieve Public Health 3.0 (PH3.0), a paradigm for public health transformation that calls on local public health infrastructure to ensure the conditions in which everyone can be healthy.<sup>i</sup> The National Association of County and City Health Officials (NACCHO) welcomes the explicit focus on local public health in PH3.0 as an opportunity for county and city health departments to refine and embrace their role as champions of community health improvement. NACCHO is committed to supporting local health departments (LHDs) as they begin or continue to turn the PH3.0 vision into practice. This issue brief provides an initial response to the PH3.0 recommendations from a LHD perspective, including reactions from members and potential implementation opportunities and challenges.

### The Community Health Strategist

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In PH3.0, the Chief Health Strategist drives local public health transformation and brings together community members and partner organizations for collective impact on social determinants of health. In many communities, NACCHO's member local health officials (LHOs) already see themselves in this role, but as part of a team leading a broader coalition of community partners from behind, rather than a single "chief" in front of a pack. To be sure, the term *Chief* Health Strategist can elevate the profile of LHDs as champions of local health, but many LHOs prefer the term *Community* Health Strategist because it captures the collaborative, place-oriented nature of their work.

Ultimately, LHOs envision their role in PH3.0 as prioritizing leadership and knowledge support to advance population health in partnership with others in their communities. In this capacity, LHOs perceive many functions of the Community Health Strategist: interpreters of data and diagnosticians on a community scale; illuminators of health inequities and advocates for social justice; partners for non-health sectors working toward a culture of health; agents of policy change who broaden legislators' understanding of health; conveners and supporters of community organizations; identifiers of evidence-based strategies for local priorities; and assessors of health service access in the communities they serve.

### Clinical Services

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In the PH3.0 vision, LHDs' role in the provision of healthcare services is less clear. Indeed, expanded access to healthcare and the resulting transition away from safety net services is described as an impetus for the evolution from Public Health 2.0 to 3.0.<sup>ii</sup> While the era of Public

Health 2.0 focused on defining and developing essential functions of governmental public health agencies and ensuring universal access to healthcare, Public Health 3.0 focuses on ensuring universal access to health.<sup>iii</sup>

In reality, results from the 2015 NACCHO Forces of Change Survey reveal a more complicated relationship between LHDs and healthcare services. While some LHDs decreased their clinical services, most reported no change in level of delivery, and communicable disease screening or treatment increased. In addition, LHDs with a higher percentage of insured patients were less likely to reduce their clinical services.<sup>iv</sup> Thus, clinical services remain part of many LHDs' work, and the uncertain future of the Affordable Care Act following the 2016 election may require LHDs to reevaluate their clinical responsibilities again. Availability and affordability of healthcare services, particularly in light of potential healthcare reform changes, other contextual issues, and budget all factor into LHD decisions regarding clinical care. NACCHO acknowledges that each LHD has to determine what clinical role makes most sense for them in consultation with their community and governmental partners.<sup>v</sup> Nevertheless, a strong focus on clinical care may pull public health department resources downstream and impede fulfillment of PH3.0 principles. LHOs will need to balance their role as safety net providers of clinical services with the need for interpersonal, community, and policy-level interventions addressing the social and environmental factors driving poor health outcomes.

## Health Equity

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PH3.0 recognizes that, “In order to solve the fundamental challenges of population health, we must address the full range of factors that influence a person’s overall health and well-being. From education to safe environments, housing to transportation, economic development to access to healthy foods—the social determinants of health are the conditions in which people are born, live, work, and age.”<sup>i</sup> While the PH3.0 recommendations seek to shift the responsibilities of public health upstream, focusing on social determinants addresses the outcomes rather than the causes of inequity. Resolving the fundamental challenges of population health will require shifts further upstream to integrate narratives and actions that confront institutionalized racism, sexism, and other systems of oppression that create the inequitable conditions leading to poor health.<sup>vi</sup> NACCHO encourages integration of social justice into the PH3.0 vision of public health culture and practice, and its Health Equity Program strives to build LHD capacity to act on structures of inequality over the long-term.<sup>vii</sup>

## Funding and Relationships with State Health Departments

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LHOs cite difficulties obtaining sustainable, flexible funding as a major barrier to operating as community health strategists who can influence social determinants of health and health inequities. When reacting to the PH3.0 recommendations, member LHOs frequently reported receiving funds with stipulations that precluded their use, or that had to be used in ways that did not meet the health needs of their communities. State health departments also need flexible financial support, and have had to defend against major threats to existing federal funding sources like the Prevention and Public Health Fund.<sup>viii</sup> The PH3.0 recommendations reflect this concern and include “enhanced and substantially modified” funding as one of its five overarching components.<sup>i</sup>

State health agencies receive most federal funding for public health initiatives, largely through the Prevention and Public Health Fund, and distribute nearly half (44% in fiscal year 2011) to LHDs, usually along programmatic lines.<sup>viii,ix,x</sup> LHD input on allocation of funds and flexible funding without programmatic, health outcome-oriented restrictions would allow LHDs to better direct resources towards determinants of health. With regard to grants, NACCHO encourages the federal government to: (1) include LHD review and comment on federal funds that state governments distribute to LHDs, and (2) inform LHDs of public health-related grants that go to organizations and service providers in their jurisdiction.<sup>xi</sup> Along with restructuring and greater transparency of funds passing through levels of government, working toward PH3.0 necessitates strong relationships between state and local health departments. Because their governance structures and the scope of their respective responsibilities vary by location, PH3.0 presents an opportunity for each state to examine and improve its capacity to collaborate with LHDs for state-wide health improvement.

### Small and Rural Local Health Departments

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The scope of LHD jurisdictions and responsibilities also vary by location. Of the 2,800 LHDs in the U.S., about 60% serve jurisdictions of less than 50,000 people.<sup>xii</sup> As the path to PH3.0 evolves, the public health community must take care to avoid marginalizing this large segment of health departments and the populations they serve. Small and rural health departments already face resource limitations restricting their ability to engage in population health promotion. For instance, while recent Forces of Change Surveys found that LHDs as a whole have increased population-based primary prevention activities, small LHDs were consistently less likely to do so than large LHDs.<sup>iv,xiii</sup> The PH3.0 recommendations cite cross-jurisdictional sharing as one way to build capacity for community health promotion. Facilitating effective cross-jurisdictional sharing and structuring other emerging support systems for public health transformation in a way that accommodates differences in LHD capacity can bring PH3.0 principles to communities of all kinds.

### Accreditation

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Health department accreditation is one such support system for public health transformation. As an organization that supported the creation of the Public Health Accreditation Board (PHAB), NACCHO endorses and provides resources for accreditation as an important way to improve LHD performance.<sup>xiv</sup> Now that “enhanced accreditation” is one of the five overarching PH3.0 recommendations, a more specific interpretation of changes to accreditation that will better incorporate PH3.0 principles is needed.<sup>i</sup> Furthermore, achieving and sustaining accreditation, even under existing standards, is a challenge for many LHDs – particularly small and rural LHDs. Because accreditation is a central to the PH3.0 vision, the public health community should determine what expectations are reasonable for LHDs of different types to achieve, and provide resources to support accreditation efforts. NACCHO appreciates PHAB’s leadership in public health department accreditation and defining standards and measures for PH3.0 that considers the challenges many LHDs face.

## Conclusion

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Given the vast variety of stakeholders and settings in the U.S. public health system, NACCHO recognizes that federal recommendations for PH3.0 cannot be overly prescriptive. Moreover, while the new federal administration's vision may shift public health priorities, NACCHO appreciates that PH3.0's focus on community-level leadership will allow PH3.0 principles to live on and provide enduring guidance for building healthy communities and long-term national initiatives like Healthy People. This issue brief described some areas where LHDs acting as community health strategists and their partners may face challenges when translating the PH3.0 recommendations into reality. NACCHO pledges to work with its members and allies to find solutions that will allow LHDs to achieve their version of PH3.0.

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<sup>i</sup> Office of the Assistant Secretary for Health. (2016). Public Health 3.0: A Call to Action to Create a 21<sup>st</sup> Century Public Health Infrastructure. Retrieved October 31, 2016 from: <http://www.healthypeople.gov/ph3>.

<sup>ii</sup> DeSalvo, K. B., O'Carroll, P. W., Koo, D., Auerbach, J. M., & Monroe, J. A. (2016). Public Health 3.0: Time for an Upgrade. *American Journal of Public Health*, 106(4), 621-622.

<sup>iii</sup> Office of the Assistant Secretary for Health. (2016). Meeting Proceedings: Public Health 3.0 Roundtable on Data, Metrics, and Predictive Modeling. Retrieved November 15, 2016 from: [https://www.healthypeople.gov/sites/default/files/PH3.0\\_Roundtable-Summary.pdf](https://www.healthypeople.gov/sites/default/files/PH3.0_Roundtable-Summary.pdf).

<sup>iv</sup> National Association of County and City Health Officials. (2015). The Changing Public Health Landscape: Findings from the 2015 Forces of Change Survey. Retrieved November 1, 2016 from: <http://nacchoprofilestudy.org/wp-content/uploads/2015/04/2015-Forces-of-Change-Slidedoc-Final.pdf>.

<sup>v</sup> National Association of County and City Health Officials. Policy Statement on Clinical Services, adopted November 2012. Retrieved November 2, 2016 from: <http://www.naccho.org/uploads/downloadable-resources/12-17-Clinical-Services.pdf>.

<sup>vi</sup> National Association of County and City Health Officials. (2016). Health Inequity: A Charge for Public Health. Retrieved November 1, 2016 from: <https://nnphi.org/wp-content/uploads/2016/09/na16-whitepaper-final-print.pdf>.

<sup>vii</sup> National Association of County and City Health Officials. Policy Statement on Health Equity and Social Justice, updated November 2012. Retrieved November 2, 2016 from: <http://www.naccho.org/uploads/downloadable-resources/05-02-Health-Equity-and-Social-Justice.pdf>.

<sup>viii</sup> Jarris, P. (2015, June 17). ASTHO urges Congress not to cut PPHF [Letter to Members of Congress]. Association of State and Territorial Health Officials, Arlington, Virginia. Retrieved November 15, 2016 from <http://www.astho.org/Public-Policy/Federal-Government-Relations/Documents/2015-ASTHO-Urges-Congress-Not-to-Cut-PPHF/>.

<sup>ix</sup> Association of State and Territorial Health Officials. ASTHO Profile of State Public Health, Volume Three. Retrieved November 3, 2016 from: <http://www.astho.org/Profile/Volume-Three/>.

<sup>x</sup> Meit, M., Kronstadt, J., & Brown, A. (2012). Promising Practices in the Coordination of State and Local Public Health. *NORC at the University of Chicago*. Retrieved November 3, 2016 from: <http://www.astho.org/accreditation/promising-practices-in-coordination-final-report/>.

<sup>xi</sup> National Association of County and City Health Officials. Policy Statement on Allocation of Federal Grants, revised September 2008. Retrieved November 2, 2016 from: <http://www.naccho.org/uploads/downloadable-resources/91-05-Allocation-of-Federal-Grants.pdf>.

<sup>xii</sup> National Association of County and City Health Officials. (2014). 2013 National Profile of Local Health Departments. Retrieved November 2, 2016 from: <http://nacchoprofilestudy.org/reports-publications/>.

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<sup>xiii</sup> National Association of County and City Health Officials. (2014). Changes in Local Health Department Services: Findings from the 2014 Forces of Change Survey. Retrieved November 15, 2016 from: <http://nacchoprofilestudy.org/wp-content/uploads/2015/06/Changes-in-Services.pdf>

<sup>xiv</sup> National Association of County and City Health Officials. Policy Statement on Health Department Accreditation, revised January 2016. Retrieved November 2, 2016 from: <http://www.naccho.org/uploads/downloadable-resources/04-06-Health-Department-Accreditation.pdf>.

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