A voluntary public health expenditures reporting system existed in the United States for over 25 years, tracking and reporting trends in health department expenditures, revenue streams, functions, and programs. Today, no such system exists and no data are available to help us understand how and where public health dollars are being spent and the trends during good and bad economic times. This article discusses the history of and lessons learned from the former public health expenditures reporting system and more recent demonstration projects that experimented with reporting by essential public health services. The article also explores how what we have learned can be used for developing and implementing a system today to meet public health and public policy needs.

KEY WORDS: ASTHO reporting system, essential services, expenditures, policy makers, public health, researchers, state health departments

A recent Governing magazine article\(^1\) about new bioterrorism funding and the eroding public health infrastructure posed the question: How much funding does the public health system need? The authors pointed out that nobody really knows for sure. Also noticeably absent from the article was any mention of the current national investment in public health. This exclusion was not the result of the authors’ or editor’s discretion. This information—specifically a comprehensive accounting of spending by the nation’s public health agencies—simply does not exist. Policy makers continue to make resource allocation decisions for public health without reliable information on and analysis of what public health agencies currently spend, how those dollars are spent, and if such expenditures are having any impact. Likewise, without such information, public health practitioners and advocates are handicapped in their efforts to convince policy makers that more resources are needed.

For approximately a quarter of a century, data on state and local public health expenditures were systematically collected, analyzed, and disseminated to policy makers, researchers, public health practitioners, and the media. These data primarily were intended to support state and national policy decisions, most notably to provide a basic level of accountability for spending of federal grants and contracts and other public funds. The data also provided answers to a multitude of ad hoc queries by congressional offices, the US Public Health Service and other federal agencies, state and local health departments, state legislatures, schools of public health and other academic institutions, researchers, the press, and others. To a lesser extent, but still significant, the data were used to advocate for improvements in public health programs and systems.

The tracking of public health expenditure information was part of a larger information collection and management system known as the ASTHO Reporting System. The Association of State and Territorial Health Officials (ASTHO) established the system in 1970 to provide accountability for its members’ spending of congressionally appropriated dollars. Funded by the federal government and operated by the Public Health Foundation for most of its existence, the reporting system evolved over the years to become nationally recognized as a primary source of information on the

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services, activities, and resource deployment of the nation’s state health departments.

After more than 25 years of data collection and a seven-figure investment made in the early 1990s to revamp the system and strengthen the quality and policy impact of the data, the federal government eliminated funding for the system in 1995. Other than information from a handful of pilot studies in the late 1990s, there has been no source of information since 1995 about the total dollars state and local public health departments are spending to protect the nation’s health.

The elimination nearly a decade ago of what was once thought to be a critical source of information for public health policy development raises a number of important questions: What have we missed by not having these data? What do we currently know about our public health investments today? What, if any, are the current needs and drivers for information in this area? How can we advocate for a greater investment in public health when we do not even know what currently is being spent? Can and should the gaps between what we know and what we need be filled? If so, how?

The current fiscal climate, increasing demands for governmental accountability, and a number of national initiatives are driving some in the public health community to reexamine the need for public health finance data. These drivers include:

- **Budget shortfalls.** Almost all states have experienced severe revenue shortages in 2002 and 2003. What impact are these budget crises having on public health investments and outcomes?
- **New bioterrorism preparedness dollars.** States have received an unprecedented influx of monies from the federal government for strengthening bioterrorism and other emergency preparedness. How are states and local jurisdictions spending these dollars? Are these dollars supporting other public health programs or strengthening the overall public health infrastructure?
- **Performance standards.** State and local public health systems are increasingly measuring their performance through the National Public Health Performance Standards Program (NPHPSP) and other state-based initiatives. How do investments in public health impact performance of public health systems?
- **Healthy People 2010.** The nation’s public health agenda includes a chapter devoted to improving the public health infrastructure. Objective 23.16, in particular, calls for the establishment of a national system for collecting state and local public health expenditures for essential public health services.
- **Public health systems research agenda.** Among the highest ranked overarching themes emanating from initial efforts by the Centers for Disease Control and Prevention (CDC) and its partners to develop a public health systems research agenda was to “evaluate the costs to achieve and maintain acceptable/optimal levels of performance. (This activity includes exploring reasonable models to collect agency financial data).”2(p4)

Although the subject is addressed to a limited degree, the main purpose of this article is not to answer the question of whether we should re-institute a national system for collecting public health finance data, nor to recommend how to do so. Rather, this article is intended to provide important background information on previous efforts to collect and report national public health finance data—namely through the ASTHO Reporting System and related efforts—and describe the implications of such efforts for potential future data collection initiatives. Determining whether tracking public health expenditures is important and feasible and how this can be done successfully should be based on sound evidence rather than on anecdotal recall. The article aims to furnish a detailed accounting of what data were collected, why, and how. How was the information used? What lessons did we learn? What worked well? What didn’t? Should the public health community be concerned that there is no system today? What have we learned that would help the public health community reestablish a system of tracking public health expenditures if it chose to do so? What pitfalls should be avoided? What are important considerations before we can move forward?

### In the Beginning

In 1970, the Association of State and Territorial Health Officials (ASTHO) established the ASTHO Reporting System to provide Congress with accountability for the comprehensive public health services block grant administered by the Department of Health, Education, and Welfare (HEW) under section 314(d) of the Public Health Service Act. At the time, the 314(d) block grant was an important funding mechanism for state and local public health services, serving as the precursor for many of the Department of Health and Human Services’ (DHHS’) categorical and block grant funding sources in existence today. The reporting system was
supported by the federal government (first HEW, then later DHHS), but relied on voluntary reporting of information from the nation’s state health departments (SHDs).

Despite the continual evolution of the system and its data elements, the one constant on which users relied was the collection of data on state health department expenditures, by revenue streams and by major program areas (eg, personal health, environmental health, laboratory, etc.). The reporting system tracked state-specific spending of a uniform list of federal funding sources as well as other government and nongovernment sources. Such information enabled policy makers and researchers to monitor the contributions of the federal government, compared to state and local governments, third-party payers, and other sources, to state public health initiatives. It was the only system to provide this information on an annual basis.

A unique aspect of the system was its ability to track program-by-program spending by each state health department. The reporting system annually inventoried each SHD program, as defined by the SHD, and collected data on total expenditures for each program. A uniform classification system enabled similar programs across states to be grouped together and analyzed. The structure of the financial reporting instruments was considered a compromise between enabling flexibility for vastly different organizational and program structures across state health departments and providing some comparability across states.

The Public Health Foundation (PHF), which operated the reporting system initially on behalf of ASTHO and later independently, employed fairly rigorous and consistent data collection, analysis, and publication procedures throughout the lifespan of the reporting system. The intent was to obtain the highest quality data possible within the limitations of a voluntary reporting system. One of the most important aspects of the data collection infrastructure was the network of data collection coordinators and other contacts in state health departments maintained by PHF. These individuals usually included senior staff members in the department (eg, deputy directors and chief financial officers) who were familiar with the department’s overall program structure and accounting and other data systems. These liaison staff typically served in their capacities for several years and grew intimately familiar with the reporting system and associated data requests.

PHF also used a consistent process for managing the data reported by the states. This included tracking and follow-up of each state’s reporting status; coding and entry of data into a computer database; computer edit checks to identify errors, omissions, and inconsistencies in the reported data; a professional review of the data by experienced staff to catch errors or inconsistencies not otherwise flagged by a computer edit check; and a verification process that allowed each state to review the accuracy of reported data and compare it to data reported in previous data cycles.

Data collected through the ASTHO Reporting System were published routinely in a variety of formats over the years and disseminated to policy makers, researchers, and public health practitioners. The Public Health Agencies report series—initially a four-volume set, but later reduced to one consolidated report—provided comprehensive information on state health department and local health department (to the extent reported by SHDs) programs, expenditures, and sources of funds. Published annually, this report was a comprehensive reference document featuring individual state profiles as well as more than 30 state-by-state tables displaying information on SHD organizational structure and characteristics, expenditures, and sources of funds for a variety of program categories.

In the mid-1980s, PHF began publishing the Public Health Chartbook, which depicted key fiscal and organizational information on SHDs and long-term spending trends in a graphic format. This format was more useful for advocacy with policy makers, particularly by ASTHO leaders and government relations staff. Routinely, these charts were used by ASTHO for meetings with congressional representatives and staff. By the late 1980s, PHF began publishing analyses from ASTHO Reporting System data in a bimonthly newsletter format, Public Health Macroview, whose circulation eventually grew to over 11,000 health professionals in city, county, state, and federal agencies, universities, and others in the health care field. Macroview eventually supplanted most of the Public Health Agencies series as the primary publication and dissemination mechanism for the ASTHO Reporting System.

While the ASTHO Reporting System provided comprehensive information about SHD programs, activities, and finances, the fiscal information garnered the most interest by the public health and policy communities. ASTHO used fiscal data from the reporting system annually to lobby for increases in public health funding. In addition, PHF maintained a database of ad hoc requests it received for information from the reporting system, and fiscal information—particularly per capita public health spending and 10-year trends in state and local health department spending by source of funds—was the most often requested.

**Evolution of the System**

Throughout the years, PHF periodically made changes to the ASTHO Reporting System datasets to account for the changing health care environment, policy and
political priorities, roles of public health agencies, and resulting needs of its information users and data providers. The reporting system was governed and periodically evaluated by national advisory bodies and task forces made up of both the users and providers of the data. PHF employed a strict methodological process for developing or modifying datasets and survey instruments that aimed for the collection of only those data considered useful for answering key policy and research questions. Fundamental principles relating to respondent burden, data quality, internal compatibility and consistency, and data utility governed the system and its changes.

Initially, the reporting system was a single-purpose data collection and reporting vehicle providing Congress with an accounting of states’ expenditures and services under the 314(d) grants. Buoyed by multiple evaluations and improvements over the years, it later became nationally recognized as the primary source of information on the services, activities, and resources of the nation’s state health departments.

The final years of the reporting system saw a major transformation in the system. Consistent with recommendations from a review panel in 1986 and from the 1988 Institute of Medicine report, The Future of Public Health, PHF redesigned the core dataset of the ASTHO Reporting System, essentially starting from scratch. With a major investment of resources from the DHHS (i.e., from CDC and the Health Resources and Services Administration [HRSA], which jointly funded the reporting system), PHF, in collaboration with hundreds of experts from federal, state, and local health agencies, completed a three-year overhaul of the reporting system’s core dataset in 1992. The result was the Public Health Impact Data Base (PH > IMPACT), named for its focus on documenting the impact of health department interventions on important public health problems and national objectives.

The new dataset measured public health interventions and reductions in risk factors that have been shown in the literature to have a relationship to improved health status. It focused on nine broad public health problem areas: (1) infant mortality, (2) adolescent pregnancy, (3) cancer, (4) cardiovascular disease, (5) AIDS and HIV infection, (6) sexually transmitted diseases, (7) vaccine-preventable diseases, (8) injury, and (9) environmental health. The final set of measures addressed 103 of 300 objectives in 17 of 22 priority areas of Healthy People 2000.3

Key among the fundamental changes brought about by the new dataset was the expansion to data sources beyond the ASTHO Reporting System. Many of the measures identified for the PH > IMPACT dataset were outcome, denominator, or risk factor measures that could be obtained from existing data sources, such as the National Center for Health Statistics, other CDC centers, and the US Census Bureau. Other sources of data included national public health associations and industry trade groups. The ASTHO Reporting System would continue to be the source of data for measures that could be obtained only from state health departments. PHF designed seven new survey instruments to collect data for which SHDs were the source—including information on the financial resources SHDs were devoting toward the nine problem areas as well as total expenditures of the SHD and local health departments in each state.

PHF collected three years of data from SHDs under the revised data collection system (FY 1991 through FY 1993), as well as data from many of the other data sources. The plan was to publish the data in the chartbooks and newsletters routinely published by PHF, as well as in a new series of monographs aligned with each of the nine problem areas. However, before PHF could complete its analysis of the data, CDC and HRSA decided to halt their financial support for the system. The federal government committed more than $1 million to the design, development, and initial analysis of data from the new system, then pulled the plug before the data could be published. Twenty individual state health departments contributed nearly half a million dollars to keep the system afloat following DHHS’ halt of support, while PHF and ASTHO leaders lobbied DHHS extensively about the need to support the new system’s continued development and operation, but to no avail.

While the rationale for defunding the reporting system was not documented, there are believed to be several reasons for the decision. First, during the debates over health care reform in the early 1990s, the Office of the Assistant Secretary for Health introduced proposals to build a stronger public health system, which later were incorporated in the President’s health reform initiative. These proposals, calling for dedicated funding for eight core public health functions, would have resulted in a new framework of federal funding for public health agencies. It also offered the promise of a new fiscal reporting mechanism that would be more comparable across jurisdictions (addressing one of the main criticisms of the reporting system). DHHS officials justified ending funding for the reporting system so that resources and effort could be concentrated on designing an improved system. Second, perhaps taking for granted the long-term viability of the system, PHF may not have done enough over the years to promote the value of the reporting system and utility of its data to state health officials and other policy makers. Third, the centers and bureaus that funded the reporting system were programmatic divisions of DHHS agencies (e.g., chronic disease and health promotion, and maternal and child health) that grew weary of continuing
The face of public health has changed considerably in the decade since the demise of the ASTHO Reporting System. Our health care delivery system has undergone radical changes and likely will continue to do so.

**A Look Back: What Did We Learn?**

The face of public health has changed considerably in the decade since the demise of the ASTHO Reporting System. Our health care delivery system has undergone radical changes and likely will continue to do so. We are facing many new and emerging public health threats, such as SARS, terrorism, and vaccine shortages. Economic forces are impacting the availability of resources for public health. Yet through continual research and efforts, such as those of the Task Force on Community Preventive Services, we now know so much more about what works in public health. The Internet and IT revolution have radically improved our ability to access and transmit information. Recent initiatives and the development of tools, like the National Public Health Performance Standards Program, are enabling us to measure the performance of public health systems and offer great potential to examine the relationships between financial investments, public health performance, and health status.

In light of these developments, certainly the time is right for asking questions about the nation’s financial commitment to public health and whether we can and should measure this commitment. Before DHHS and its public health partners make decisions about the types of financial data needed to help measure and strengthen the performance of the public health system and the methods to collect such data, it is important to understand the lessons learned from past data collection efforts, namely the ASTHO Reporting System. Primarily, what were the chief strengths and weaknesses of the ASTHO Reporting System vis-à-vis the collection of public health fiscal data?

The following strengths and limitations are derived from the lead author’s personal experiences as a PHF staff member collecting, analyzing, and publishing the data for 10 years; PHF background documents; discussions with other PHF staff who managed the system for more than 20 years; and interviews with long-time providers and users of the data in states, with policy-level staff at CDC, and with academic researchers.

**Major strengths**

1. The ASTHO Reporting System was the only uniform, comprehensive source of information on state and local health department expenditures. It provided a rich source of longitudinal public health data, particularly SHD expenditures and profile data (eg, organizational make-up, statutory responsibilities, and relationships with the local public health system). Federal grant reporting systems collect data about expenditures by states under specific funding streams, but even if aggregated do not provide a complete picture of SHD spending. Other systems collect and report state government spending for public health (eg, census of state government finances, the National Association of State Budget Officers’ [NASBO] Fiscal Survey of the States, and the 1997 State Health Care Expenditure Report by the Milbank Memorial Fund, NASBO, and the Reforming States Group), but none of those systems provide a comprehensive picture of state public health spending nor the level of granularity in program expenditures provided by the ASTHO Reporting System. For example, the NASBO data only captures personal health care expenditures by states and does not include spending of state agencies from other sources of funds (eg, fees and reimbursements, local sources, etc.).

2. The information available through the ASTHO Reporting System provided a basic level of accountability to policy makers for expenditure of public funds. Many policy makers, researchers, and public health advocates relied on the reporting system for information about how state and local health departments were spending dollars from federal grants and from state coffers, as evidenced by the use of the data by ASTHO in its advocacy and by the plethora of requests received by PHF over the years. Such accounting was especially important for block grant programs that provided states with greater flexibility to spend the dollars. For example, the reporting system tracked how SHDs spent their Preventive Health and Health Services Block Grant funds among the categorical program areas that were rolled up into the block grant. Such accountability demonstrated that overall cuts in funding to the block grant affected state spending in specific program areas that were previously funded by categorical funding streams.

3. The ASTHO Reporting System applied a consistent and rigorous approach to the data collection that facilitated the reliability of the data over time, yet provided enough flexibility to accommodate
vastly different organizational structures of state health departments. As previously described, PHF employed time-tested procedures for collecting, processing, editing, verifying, and analyzing the data, and for publishing information. The liaison staff in each SHD became well acquainted with the procedures and intricacies of the system and helped ensure that the data were reported consistently from year to year. PHF also maintained a core reporting system staff that not only were able to consistently implement the data collection procedures, but who became intimately familiar with the organizational and program structure of each SHD and could easily recognize errors or inconsistencies in the reported data. At the same time, the comprehensive inventory of programs accommodated each SHD’s unique program structure, greatly reducing the burden of reporting and enhancing the likelihood of comprehensive and accurate reporting.

4. The consistent approach in reporting by state health departments ensured reliable longitudinal data, both nationally and among individual states. While there may be inconsistencies across states both in how they are organized and structured and in how they report their data (see number 1 of Major limitations, below), the consistent approach applied year to year by each individual SHD enhanced the utility of the data over time. This consistency allowed for analysis of whether expenditures were increasing or decreasing across the country, and for certain program categories, over a given time period. Similarly, policy makers, advocates, or researchers could analyze spending patterns in individual states to identify shifts in spending or financial impacts of policy decisions.

5. Ownership of the ASTHO Reporting System resided with public health practitioners. The system brought together both providers and users of the data in its dataset design process to reach consensus on the information needed by decision makers. Advisory panels made up primarily of state and local public health practitioners provided ongoing direction for the system. For a number of years, the reporting system fostered a strong sense of ownership among state health departments, which resulted in nearly 100% response rate to the voluntary data collection effort. This consistent response by the SHDs, more than any other factor, demonstrated the value placed on the system by the public health community.

Major limitations

1. The vastly different organizational structures and responsibilities of state health departments, coupled with the flexible reporting format afforded by the ASTHO Reporting System, compromised the comparability of the data across the states. Each state health department had its own unique organizational structure and responsibilities. Each SHD had a unique set of statutory requirements and authority vis-à-vis state Medicaid, mental health, substance abuse, and environmental health programs, to name just a few. PHF could account for some of these differences in its analyses because it captured each SHD’s responsibilities for these major program areas. However, there were many other population, political, and economic differences across states that affected the role of the SHD that could not be captured by the reporting system. For example, some SHDs served a much larger safety net role than others, depending on the characteristics of the population, availability of personal health care providers for the indigent, and the political landscape. In addition, the SHDs’ highly variable program structures made comparisons difficult, at best. For example, some states had specific hypertension screening programs and the reporting system classified their programs accordingly. Other SHDs might have included their hypertension screening clinics under a larger chronic disease program category, but such a nuance was indistinguishable by the reporting system. Consequently, any analysis of how much the states were spending on hypertension screening programs and state-by-state comparisons of these programs would be flawed.

2. The quality and comprehensiveness of local health department expenditure data collected through the ASTHO Reporting System were suspect. The reporting system collected data from each state health department on total local health department expenditures in the state. While collecting local-based data through a central, state source reduced the data collection burden, the completeness and accuracy of these data were entirely dependent on the robustness of the states’ data systems. Some states’ systems were good; others, not so good. SHDs could readily provide accurate information about the resources they provided to the local health departments in their state. However, many had difficulty providing an accurate picture of the expenditures of local health departments in their state from sources other than the SHD. Generally, the less centralized the state’s local public health system was, the more difficulty SHDs had providing complete data. PHF typically had to estimate local public health spending for 8 to 14 states each year to account for nationwide spending.

3. The unit of analysis, the state health department, was only one component of the public health
system. As depicted in number 1 of the limitations, the scope of authority and resources of each state health department varied tremendously from state to state. Even in states where the SHD had the broadest public health authority and level of responsibility, it was difficult to gauge the relative contribution of the SHD to the whole public health system. Within governmental public health alone, the SHD and local health departments are only a part of the broad system that addresses the health concerns of state citizens. Departments of social and human services, agriculture, environment, transportation, labor, and housing all provide programs and enforce regulations that contribute to the public’s health. The reporting system did not capture any of these expenditures (other than to the extent that they were under the authority of the SHD), nor did it attempt to estimate the magnitude of what was missing.

4. **The validity of data captured by the ASTHO Reporting System was unknown.** As described earlier, PHF used consistent methods to assure the reliability of data collected (i.e., consistency of measurement) as best as possible within a voluntary reporting system. However, no methods were employed to ensure that the data reported were valid—i.e., that the data were an accurate representation of what they purported to measure. PHF did not conduct any studies of validity, require any financial audits or other back-up documentation of the numbers reported, or conduct site visits to the states to assess the reporting procedures. Despite myriad efforts to strengthen the reliability of reporting, the accuracy of the numbers reported ultimately relied on the word of the SHD representatives who provided the data. Anecdotal evidence and interviews with senior SHD staff have indicated that, in general, states were comfortable with the quality of data they provided. However, in the years following the demise of the ASTHO Reporting System, a few former senior health officials indicated that gathering data for the ASTHO Reporting System in their state was viewed as a rote exercise for staff members who had little or no appreciation for the value of the data, describing the state’s reported data as “garbage.”

5. **Expenditure data from the ASTHO Reporting System were not tied to public health performance and health outcomes.** The data collected through the reporting system were descriptive in nature, by design. The data system did not lend itself to an analysis of the relationship between public health department expenditures and the performance of health departments, much less the health outcomes of the community. Hence, the system provided a basic level of accountability for expenditure of public funds, but was not able to demonstrate whether health department expenditures were spending those funds in a manner that was contributing to the improvement of community health status. However, the redesign of the reporting system and the implementation of the Public Health Impact Data Base was a first step in that direction.

### Life After the ASTHO Reporting System

At about the time CDC and HRSA decided to defund the ASTHO Reporting System, the DHHS’ Office of Disease Prevention and Health Promotion (ODPHP) commissioned PHF to conduct what would become a series of three pilot studies to examine ways to capture state and local expenditures for core public health functions. Specifically, the studies explored the use of the “essential public health services” taxonomy of the *Public Health in America* statement for characterizing public health investments comprehensively apart from specific programs. This taxonomy, following its adoption in 1994 by a coalition of national public health organizations and federal public health agencies, was starting to become a widely accepted vocabulary for communicating the functions and responsibilities of the public health system.

In the mid-1990s, health reform was the prevailing interest, and policy makers were asking exactly how much money actually was being spent on public health prevention efforts and what was an appropriate level of investment. DHHS was seeking to understand if the essential services framework could be effectively used to measure and improve the capacity and performance of the public health system, including the financial investments in public health by governmental health agencies. While the ASTHO Reporting System was now considered defunct, PHF’s experience in managing the system and its understanding of state and local public health organizational and accounting structures was an important building block for the new studies. It was thought that these pilot studies, if successful, could lead to a reconstituted reporting system.

PHF led three pilot studies between 1995 and 1999 under a contract with ODPHP. The first study developed tools for characterizing expenditures by the essential services and tested the use of those tools by state public health agencies in nine states. The second study, conducted in collaboration with the National Association of County and City Health Officials (NACCHO) and the National Association of Local Boards of Health, examined essential services and expenditures from the perspective of three local jurisdictions. The final study, which included ASTHO in addition to the previous study partners, assessed the utility of the essential services and related tools for capturing statewide expenditures—including the state health
department and all 24 local jurisdictions—in one state (Maryland). The methodologies and results of all three pilot studies were analyzed together by Atchison et al and reported in JPHMP in 2000.6

**Implications of Past Efforts**

The finding by Turnock,7 in 1997, that the essential services remain only a potential resource for explaining and analyzing public health action on an ongoing basis, still rings true today. However, progress is being made. Over 600 state and local public health agencies have already used the National Public Health Performance Standards, which are based on the essential services taxonomy, to measure and improve the performance of their public health systems. To develop and measure skills and competence of the public health workforce, the Council on Linkages Between Academia and Public Health Practice developed a set of core competencies for the public health profession using the essential services as its framework.8 As suggested by Atchison et al in 2000,6 it would be prudent to develop a related system for fiscal accountability.

The results of the three expenditure pilot studies in the late 1990s demonstrated that the essential services framework can be used successfully to characterize expenditures of state and local governmental public health entities.6 The projects produced a template for identifying public health expenditures with the fundamental, generic aspects of public health (essential services) rather than by categorical program areas. The template includes a refined set of decision rules and a descriptive process for bringing together partner organizations in the jurisdiction and mobilizing staff to generate the estimates. Each iteration in application led to increasing sophistication of the data collection tool, more uniformity of expenditure allocation, and a more precise definition of each essential service included in the taxonomy—although the application of the taxonomy remained inconsistent across study entities. The three pilot projects advanced the development and application of the tool in a small set of practice settings across the country. These projects support the proposition that establishing a uniform methodology that reasonably accounts for financial investments in public health is possible.6

*Public Health in America*8 and the essential services has become the most commonly used framework to describe and analyze public health practice. Numerous studies have recommended its use as a framework for fiscal, workforce, and performance accountability, and multiple initiatives have advanced this cause.9-12 Indeed, already it is being used in practice and academic settings for performance measurement and competence development. From the perspective of fiscal accountability, the essential services taxonomy and new tools for characterizing expenditures in this way appear to offer more promise for the future than the old ASTHO Reporting System. However, if we endeavor to move forward with a new system of public health expenditures reporting, it is important that we closely examine the lessons learned through our experiences with the ASTHO Reporting System and essential services pilot studies—and build on the strengths of these efforts and avoid the same pitfalls.

For example, Atchison et al,6 in discussing the lessons learned from the essential services expenditures pilot studies, cautioned about the need for continued examination of data reliability, validity, and comparability issues. The article cited the need to account for the vast differences in how state public health systems are organized and level of corresponding government responsibility. These certainly were issues of ongoing concern with the ASTHO Reporting System, and we should learn from what worked and did not work with that system. Data reliability was a documented strength of that system, ensured by the consistent application of the methodology and a strong liaison network in the states. However, both the validity and comparability of data collected through the system were frequently questioned for reasons cited earlier.

Despite the potential for developing a uniform national system of public health expenditures reporting and the success of the essential services pilot studies, some public health leaders remain skeptical about the value of the essential services framework and its application to expenditures. Following its review of the final pilot study conducted statewide in Maryland, the ASTHO/NACCHO Joint Council concluded that obtaining useful, comparable information on expenditures using the essential services framework is not feasible.13 The joint council cited the variation across state public health departments as the main reason for its skepticism. Three years later, ASTHO continued to express reservations about a major effort to collect financial data from the state health departments, cautioning about a repeat of the problems associated with the ASTHO Reporting System.13

The reasons for health officials’ skepticism run deep. In the current political environment, with more scrutiny over the use of taxpayer dollars, some health officials have expressed concern about possible misuses of the data from a system that lacks comparability from state to state. One could hypothesize that the expansion of the ASTHO Reporting System in the early 1990s beyond core organizational and financing issues (ie, its migration to reporting on public health outcomes and other measures gleaned from external data sources)—and public health agencies’ concerns about the leaps
that end-users could make from such analysis—may have been a factor in the system’s demise. Certainly the transition of the reporting system from the old categorical framework to the essential services made some health officials nervous. It is important to keep in mind, however, that nearly all of the nation’s state health officials have turned over since the demise of the ASTHO Reporting System and may feel little if any connection to it and its benefits.

Clearly, buy-in by state and local health departments is critical for any public health expenditures data collection initiative to be successful. State and local health officials should engage in an open dialogue with CDC and other public health partners about public health financing. The dialogue should address questions such as: Why do we need expenditures data and how will such data be used (eg, identify gaps in current funding, advocate for additional funding, help people understand what public health does)? What are the important methodological objectives for collecting the data (eg, accuracy, comparability across states, a national estimate, trends information)? What is the appropriate scope of the data collection (eg, state government agencies, local health departments)? Which is preferable to know: spending by categorical program area or by broad functional areas of public health (eg, essential services)? Will the data help answer the question of the right amount to spend on public health?

Just as important, however, policy makers must be involved in the dialogue at the outset, as fiscal accountability should be the primary purpose of the system. If a voluntary system does not produce data that meet the information demands of policy makers, the system likely will collapse. Some in the public health community contend that a lack of policy maker involvement in the shaping of the ASTHO Reporting System ultimately led to its downfall. An audience analysis should be conducted with staff from governors’ offices, state budget offices, legislatures, Congress, and federal agencies before the data collection instruments are developed. If these audiences’ information needs are met, the new system is more likely to be used and funding for it sustained. Additional questions for researchers and public health agencies’ own programmatic and planning purposes can be added to the system, provided that the core accountability goals are met.

Another important lesson learned from the ASTHO Reporting System is that any data collection effort must “begin with the end in mind,” quoting the famous leadership guru, Steven Covey.14 The design of the system must identify the analysis and presentation plans upfront, so that later the data can be presented in a way that people will use and understand it. This principle was emphasized in several of the evaluations of the reporting system, which resulted in improved outputs and increasing utility of the data over time. In discussions with state health department senior staff for this article, better “marketing” of the data for public health improvement was noted as an important goal for any future data collection effort.

Finally, with the ASTHO Reporting System, there was an inherent tension between the uses of the data. Over time, the system evolved into an “all purpose” system. On the one hand, financial data were used to advocate for public health improvement. On the other hand, the data were used for objective research, policy analysis, and decision making. While it is not necessary that independent systems be developed for these different purposes, it is imperative in creating any new system that decisions about the audiences, uses of the data, burden on providers of the data, and demands of potential sponsors of the system be made up-front. For example, it may not be appropriate for the federal government to fund a system that is used primarily for advocacy—particularly when much of those advocacy efforts are targeted to federal agencies. Alternatively, if research and policy analysis are the main objectives of the system, then the federal government could play a legitimate role in sponsoring the system. Also, these decisions should drive the level of rigor applied in the design and development of the datasets and analytic methods.

*** What Does the Future Hold? Some Things to Consider

New York Times, January 23, 2006—In his State of the Union speech last night, the President announced his plans for a major cutback in funding for state and local public health agencies. The President exhorted the Congress, “It is high time that we cut back on pork barrel public health programs in our states. These independent and unaccountable agencies receive far too much federal tax dollars for the good that they produce.” The President noted that his FY 2007 budget request, to be released next month, would eliminate all funding of block and categorical grant programs to states and localities. Because no source of data exists to show how state and local public health agencies spend the nation’s tax dollars, the impact of these cutbacks to the public health agencies and the public are unknown.

A far-fetched scenario? Maybe. But if the public health community is not able to address the increased demands for public health data discussed earlier in this article, it is not inconceivable that someday we will see such a scenario. Regardless of the plausibility of the scenario, it illustrates the danger that the public health community faces without a system to document where public health agencies’ financing comes from and where the dollars go. All of us in the public health community continually lament about the shortfalls...
The danger of not having a system to track public health expenditures is far greater than the danger posed by any potential misuse of the data developed.

in public health funding, the financial difficulties that health departments face, and the eroding public health infrastructure. We all know these things to be true. Yet, we have no solid basis to back up such claims in our advocacy to policy makers. If the public health community wants to be a player in the resource allocation game, it must develop and effectively use data on how its activities are financed. The personal health care delivery system does this effectively through the Centers for Medicare and Medicaid Services, which annually reports on the nation’s health care financing. Shouldn’t the lack of a similar accounting for public health finances suggest to policy makers that public health must be less important than health care?

In politics and in policy development, it is critical to “follow the money.” Our hope for this article is that the public health community will examine the past and current realities, consider the lessons we have learned from the ASTHO Reporting System about how to collect and use public health expenditures data, and recognize the need to demonstrate that public health is accountable for the dollars it receives and spends. The danger of not having a system to track public health expenditures is far greater than the danger posed by any potential misuse of the data developed.

A final word, as we move forward. The development of a Public Health Systems Research Agenda, the Healthy People 2010 public health infrastructure objectives, the National Public Health Performance Standards Program, and the Core Competencies for Public Health Professionals all offer important opportunities for public health systems’ improvement. The collection of public health finance data must be weighed within the contexts of each of these initiatives. For the first time, there is potential for the public health community to have access to information that will allow for the examination of the relationships between investments in public health, performance in state and local public health systems, workforce skills and competencies, and community health outcomes. This type of information is critical if public health advocates wish to demonstrate to policy makers the importance of a strong public health infrastructure. Policy makers are most interested in outcomes and where their investments will have the most impact on those outcomes. The extent to which we can begin to demonstrate the links between investments in and performance of public health systems and improved community health status will go a long way toward increasing our accountability with policy makers and improving the quality of our public health systems.

REFERENCES