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Defragmenting Public Health

Eric W. Hayden

Massachusetts is unrivaled when it comes to treating and curing sickness. But it faces challenges in preventing disease and protecting residents from threats to public safety. Amid concerns about vulnerability to bioterrorism, pandemic flu, mosquito-borne disease, and the next storm disaster, the delivery capacity and effectiveness of public health service assume increased importance and relevance. While federal funds are usually available in a major crisis, the primary bulwark against threats to the public health is the individual state. That’s where the U.S. Constitution assigns the job.

The Romney administration has targeted the state’s overly localized school system, pushing incentives to get small school districts to consolidate rather than waste millions of dollars by running their own separate operations. A similar push is long overdue in the public health sector. This needs to be on the agenda of Governor-elect Deval Patrick.

Despite the state’s renown as a preeminent medical center, it has a balkanized public health system, with 351 health departments, one for each city and town. In addition, there is a state health department, which is part of the executive branch. But reflecting the long-standing tradition of home-rule, each local health department is an independent agency functioning under its local government. This is true even though half of our communities have fewer than 10,000 people, and only a handful more than 100,000.

While the larger municipalities can afford public health staffs, too many have to make ends meet with just one or two part-time public health officials. Nonetheless, their tasks are the same as those handled by the much larger staffs of the biggest cities, tasks that include conducting septic and other safety inspections, providing communicable and chronic disease control programs, screening and immunizing, running school health programs, delivering maternal and child health services, directing information and educational programs, and collecting data and statistics. Is it any wonder that, in most of our communities, few of these jobs ever really get done?

In short, and notwithstanding the dedication of the state and local health personnel, the Massachusetts public health system isn’t what it should be. It is fragmented, suffers from gaps in delivery quality across communities, and badly needs accountability measures as well as credentialing and licensing requirements. Absent major improvements, residents are seriously at risk in the event of a devastating attack, disease outbreak, or natural disaster.

Is there a better way?

Looking at what other states do, there’s no single best practice model. Indeed, about half are also decentralized. However, many states are moving to more centralized approaches, typically

some form of "regionalization" where clusters of towns combine to provide public health services. This creates synergies and cost-savings that Massachusetts misses by pushing everything down to the local level.

States making progress toward regionalizing public health include Connecticut and New Hampshire, which also share the New England home-rule culture but have moved beyond the parochialism of Massachusetts.

Despite its strong tradition of local autonomy, Massachusetts has had some experience with regional approaches to public health that provide a potential base on which a more integrated and efficient public health delivery capacity might be built. These include several multi-community collaborations established (but no longer funded) to implement state-wide tobacco control initiatives. More recent has been the seven emergency preparedness districts created post 9/11 to manage the distribution of federal funds.

There are three other potential prototypes. The Nashoba Associated Boards of Health contracts with each of its 14 member municipalities to assist their respective individual boards of health to carry out their functions. Barnstable County has the state's only county wide public health department. The 15 participating towns have their own public health departments but share a county health commissioner and staff, which provide supplemental advisory and specialized support services. Finally, there's the Franklin Regional Council of Governments, where 26 municipalities in the western part of the state hire the Council's health staff on a fee-for-service basis to conduct inspections and other public health activities. Encouraging as they are, these three prototypes cover only about 5 percent of the state's population living in some 15 percent of its communities.

Any or all of these examples –or a combination thereof- would work as the basis for regionalizing public health delivery across the entire state. However, a necessary first step is to develop a consensus about the urgency of replacing the current mosaic with an integrated system capable of responding quickly and effectively to handle a major public health crisis.

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