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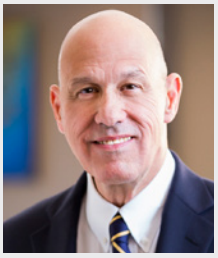
The New Public Health Imperative for Hospitals



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One of the COVID pandemic's most bitter lessons has been the complete inadequacy and dysfunction of the U.S. public health system, if the word "system" can even be applied. Prior to COVID, these shortcomings were hiding in plain sight. Now, they are evident to all and exacerbated as the nation struggles to protect the health of its citizens in the face of a pandemic entering its third year.

At the outset of the pandemic, research showed a $4.5 billion funding shortfall to provide what authors of a study in The Milbank Quarterly called "a minimum standard of foundational public health capabilities." Further, more than 85% of public health funding comes from state and local sources, leading to significant variation by geography. For example, states including New York, New Hampshire, and Montana spend more than $129 per person to public health, while states including Nevada, Missouri, and Indiana spend less than $59.

This geographic variation in funding indicates a significant inequity in the types and levels of public health services. Certainly, the existing public health infrastructure did not protect historically vulnerable populations from the effects of COVID, with Hispanic and Black individuals at least twice as likely to die from COVID as whites and almost three times as likely to be hospitalized, according to a Kaiser Family Foundation analysis of CDC data.

Public health agencies also suffer from chronic understaffing. In the decade prior to COVID, state public health agencies lost 16% of their full-time positions, and county and city public health agencies lost 20% of their positions in the past 15 years.

The result has been an inadequate, unequitable, and fragmented collection of services that, when COVID hit, was unable to deliver what the country desperately needed: prompt, consistent, and widespread testing and vaccination; effective contact tracing; and clear communication with the public about healthy practices.

The politicization of health has made a bad situation worse. As of September 2021, 26 states passed laws that limited public health powers, and 303 state and local public health department leaders resigned, retired, or had been fired.

Hospitals have always been the organizations that truly matter when it comes to healthcare delivery. And now, highlighted by COVID, hospitals have become the organizations that truly matter when it comes to public health.

Consider some of the core services of public health, as defined by the CDC:

- Assess and monitor population health status, factors that influence health, and community needs and assets
- Investigate, diagnose, and address health problems and hazards affecting the population
- Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it
- Strengthen, support, and mobilize communities and partnerships to improve health
- Assure an effective system that enables equitable access to the individual services and care needed to be healthy
- Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement
- Build and maintain a strong organizational infrastructure for public health

Over time, many of these services have become a more common part of health systems' purview. The slow but inexorable shift of financial risk from insurers to providers has created the economic incentive for hospitals and health

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systems to better understand population health status and the specific factors that influence it; to enhance access to care particularly in underserved areas; and to reach out into communities to manage health risks before they produce the need for more intensive levels of intervention.

Perhaps more important than economic incentive has been the mission incentive of not-for-profit providers. Almost universally, not-for-profit hospitals and health systems articulate a mission to improve the health and wellbeing of communities. Increasingly, this mission has led hospitals into the challenging public health arena.

The COVID crisis has taken these new health system responsibilities to a different level. Health systems were instrumental in developing and administering COVID tests, tracing COVID's path, educating communities about the virus and how to avoid it, and providing front-line care for the huge swath of Americans affected by the virus.

Moving forward, hospitals will be asked by communities all over the country to be the organizations that deal with a broader set of national problems related to the wellbeing of patients and communities—problems that COVID has made much worse, problems that the public sector has never been able to solve.

With this new set of responsibilities comes an entirely new set of strategic, operational, and financial implications for hospitals and health systems. Meeting these challenges will require a new level of health system ideas, a new level of health system aggressiveness, and a new level of health system ambition. More than ever, health systems will need to have to address social determinants of health; access and analyze data about health conditions, reimagine access to preventive care, develop care models tailored to specific populations. The costs will be enormous, and the need for intellectual capital considerable.

America is looking to someone or something to take on what is now a paramount set of national healthcare problems. It is up to the hospital sector to bring its charitable mission, its resources, and its passion to bear on this awesome responsibility.

Your comments are welcome. I can be reached at kkaufman@kaufmanhall.com.

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