Assessing Capacity and Spending for the FPHS

November 6, 2022
Public Health Finance Roundtable

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PUBLIC HEALTH
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Agenda

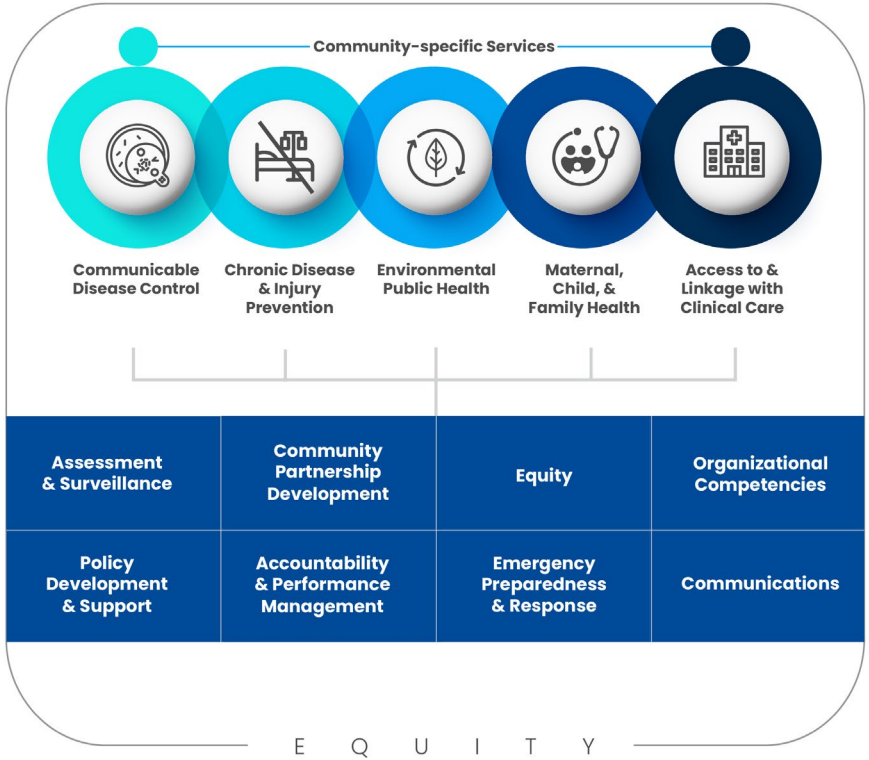
- **Foundational Public Health Services (FPHS)**
  - Overview of the FPHS Framework
- **Cost and Capacity Assessments**
  - Rationale for Assessment
  - General Process for Assessment
  - Examples of Data Obtained
  - Examples from Prior States
  - Policy and Practice Implications
- **Discussion**

Foundational Public Health Services

a "minimum package of services" that must be available in state and local health departments everywhere for the health system to work anywhere, and for which costs could be estimated

Cite: *Public Health National Center for Innovations (PHNCI), https://phnci.org/transformation/fphs*

Overview of the FPHS Framework



PHAB Advancing public health performance

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Center for Public Health Systems

February 2022

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Cite: *Public Health National Center for Innovations (PHNCI), https://phnci.org/transformation/fphs*

Cost and Capacity Assessments

Collect data on 1) current implementation and spending for 'foundational' services, 2) spending and staffing associated with "full implementation" of 'foundational' services

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Rationale for Assessment

- Governmental public health has been underfunded across nearly all federal, state, and local systems; *basic infrastructure is in disrepair*.
- Expertise, capacity, and authority to deliver necessary population-based services varies by location; *where you live matters*.
- There is a lack of understanding for service-level details and resource needs; *it is unclear what resources are needed and where*.
- Different public and private partners have roles in service delivery, and it is unclear who delivers services at the local level; *clarity on providers and optimal arrangements is needed.*

General Process for Assessment

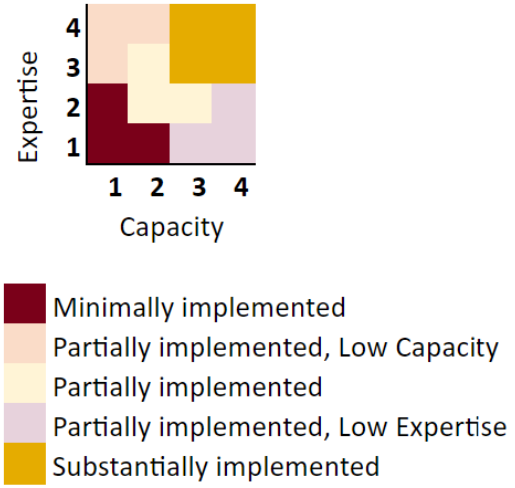
A cost and capacity assessment aims to:

1. Discover current level of implementation (*expertise and capacity to deliver*) for 'foundational' activities;
2. Identify how 'foundational' responsibilities are delivered, and by whom;
3. Allocate current effort and spending across 'foundational' responsibilities; and
4. Estimate effort and spending needed to fully implement 'foundational' responsibilities.

Examples of Data Obtained

Self-Assessed Capacity (*Assessment & Surveillance*)

Headline Responsibility	***Use data to identify health priorities and share results.***	**SA_cap_A_1_0**	**3**	**2**
Program Activity	*Convene public health partners, communities, and individuals, to develop a state or community health assessment that prioritizes public health issues, as well as their root causes and the conditions that influence those issues, for the population, and specifically in the jurisdiction.*	**SA_cap_A_1_a**	3	2
Program Activity	*Collaborate with partners, communities, and individuals, including those most impacted by health disparities and underlying inequities to understand public health issues from the perspective of lived experience.*	**SA_cap_A_1_b**	2	2



Examples of Data Obtained

Current Effort and Spending (*Emergency Preparedness & Response*)

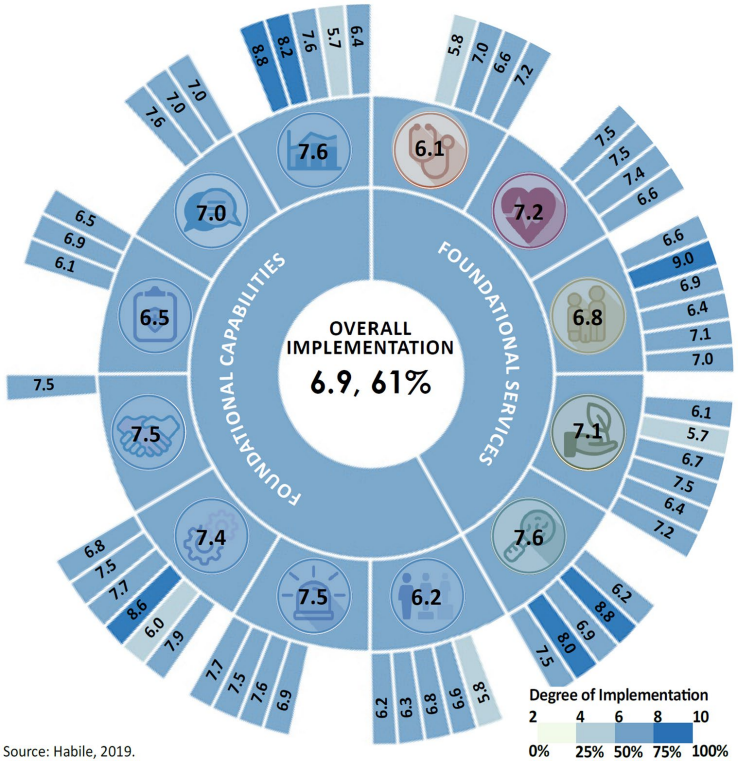
- Effort allocated across 'foundational' responsibilities (*labor costs distributed with FTE*)
- Other expense categories allocated across 'foundational' responsibilities

Develop, exercise and maintain preparedness and response plans.		
FY21_FTE_I-3-0	1.00	1.00
FY21_Labor_I-3-0	$ 51,979.00	$ 34,090.00
FY21_Contract_I-3-0	$ -	$ -
FY21_ODC_I-3-0	$ -	$ 7,746.00
FY21_Pass_I-3-0	$ -	$ -
FY21_Capital_I-3-0	$ -	$ -
Total	**$ 51,979.00**	**$ 41,836.00**
Labor	***$ 761,156***	***$ 6,517,513***
Contractual	***$ 21,797***	***$ 1,556,859***
ODCs	***$ 37,625***	***$ 1,353,863***
Pass/Trans	***$ -***	***$ -***
Capital	***$ 17,297***	***$ 29,635***
Total	**$ 837,875**	**$ 9,457,870**

Examples from Prior States

Agency-level Findings (*Colorado example*)

- Results help agencies identify:
  - How FPHS is implemented, overall;
  - Which activities are more or less implemented, relative to one another, and compared to peers;
  - Opportunities for cross-jurisdictional delivery; and
  - Clear gaps in service delivery.



Source: Habile, 2019.

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Cite: *Colorado Association of Local Public Health Officials (CALPHO), http://www.calpho.org/2019-needs-assessment.html*

Examples from Prior States

Impacts of Assessments (*Washington success story*)

- Washington's governmental public health needs assessment identified a need of approximately **$450 million per biennium** (*approx. $30 per capita per year*) to fully fund FPHS.
  - Washington's Public Health System Transformation policy body assigned responsibility for funding FPHS to state government.
- Over the last several biennia, Washington refined its state decision package to its legislature with varying levels of success.

Biennium	Request	Funding
2017-2019	$60 million	$12 million
2019-2021	$296 million	$28 million
2021-2023	$285 million	$175 million
2023-2025	--	$324 million

Policy and Practice Implications

- Obtain evidence to support advocacy efforts for investment in basic infrastructure.
- Establish uniformity across jurisdictions to assure expertise, capacity, and authority for a minimum set of public health services in any location.
- Obtain clarity in what resources are necessary for each jurisdiction to fully deliver ‘foundational’ services.
- Identify optimal arrangements of public and private partners to best deliver ‘foundational’ services.

Discussion

What opportunities are present for cost and capacity assessments?

What barriers impede widespread participation in assessments?

What questions do the public health finance community have?

Thank You!

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HEALTH FINANCING MECHANISMS IN LMICS

Public Health Finance Roundtable
LSU School of Public Health
November 6, 2022
Deliana Kostova

Background

- Total spending on health in LMICs is low
  - *In 2019, total per-capita healthcare spending was ~$40 on average in low-income countries, $135 in lower-middle-income countries, and $477 in upper-middle-income countries, compared to $3,135 in high-income countries*

- Health spending in LMICs is funded by a variety of sources
  - *public (local and national governments)*
  - *private (out-of-pocket payments)*
  - *external health aid (e.g., bilateral and multilateral aid and grants)*

Background

- Health funding and disease burden are mismatched
  - *NCDs cause the majority of the disease burden in LMICs, but their share of health spending in 2018 was only 13% in low-income countries and 29% in middle-income countries*
  - *Share of overall NCD spending that occurs out of pocket is ~50% in LICs and 40% in MICs*

- Health funding in LMICs, especially external aid, tends to be siloed across diseases
  - *Mostly vertical funding dedicated for infectious diseases, reflecting donor priorities*
  - *Horizontal funding for health system strengthening (e.g., improving healthcare access, infrastructure, or workforce capacity) has a much smaller share, approximately 10% of external health aid*
  - *Vertical aid for NCDs in LMICs is more effective in improving NCD burden in the short term, but horizontal aid may be better aligned with longer-term UHC objectives*

Health financing mechanisms

- Tax revenues
- Insurance schemes
- User fees
- Domestic budget reallocation
- External grants
- Guarantee loans
- Health system bonds
- Health development index bonds
- Public-private partnerships
- World Bank health intervention loans

Tax revenues

- The main source of funding for national health systems
- Depends on tax base and administration capacity
- Tax revenues for the health sector can be raised from taxes on income, or from sales taxes on specific goods

Example: in 2019 cigarette taxes brought in nearly $1.3 billion in revenues in Brazil and over $2.8 billion in the Philippines

Insurance schemes

- The pooling of health risks and payments across a population
- Funded by tax revenues, insurance premiums, and/or mandatory payroll contributions

Example: In 2003, Ghana instituted a National Health Insurance Scheme, planning to fund it through a combination of a sales tax levy, payroll contributions by formal sector workers, and premium payments. However, because of high premium exemption rates and low formal employment in the country, the scheme was mostly tax-funded, with 76% of financing obtained from tax revenues, 24% from formal worker contributions, and nearly zero from premiums.

User fees

- AKA cost-sharing
- User fees need to be applied thoughtfully to balance their conflicting roles as an income stream and a barrier to use
- Can help to cover variable costs for primary care facilities

Example: Namibia, which has relatively well-funded government health spending among countries in Sub-Saharan Africa, recovered approximately 2% of costs from user fees in public health facilities.

Domestic budget reallocation

- This approach involves intragovernmental negotiation between ministries of health and ministries of finance for reallocation of public spending

Example: In 2018, Panama realigned the national budget to strengthen primary care by introducing a national program for cardiovascular disease prevention. The program covered tens of thousands of patients across 37 public health facilities and subsequently nearly doubled the hypertension control rate.

External aid/grants

- AKA development assistance for health or foreign health aid
- Can be skewed toward a vertical focus on specific infectious diseases
- Slowly emerging transition toward primary care/NCDs

Example: UN Catalytic Fund for NCDs and Mental Health was launched in 2021 to support country-led initiatives for NCD healthcare integration; it will disburse $250 million in funding over a 5-year period to national or regional governments in 25 LMICs. Private philanthropy (e.g. Bloomberg Philanthropies, RTSL) award grants for hypertension control, salt reduction and trans-fat elimination.

Guarantee loans

- Traditional private loans for health initiatives may not be readily available in LMICs due to risk rating
- Health partner institutions (e.g. USAID) can serve as credit guarantors to loans taken by public or private sector healthcare entities
- Such loans can increase healthcare providers' access to capital, increasing their ability to provide more health products and services

Example: The USAID Development Credit Authority provided a $3 million guarantee to Centenary Bank in Uganda to expand access to credit for private health providers in the country.

Health system bonds

- A mechanism through which local governments can raise funds for the health sector
- A government entity issues and sells a bond to investors, using the resulting funds to strengthen the health sector while paying interest to the investors according to predetermined terms and conditions
- Most feasible in areas where the local tax revenue is stable and sufficiently high to pay back the bond debt

Health development impact bonds

- Loans conditional on fulfilling a set of preestablished health outcome targets
- The implementing partner (e.g. a health sector entity) raises private capital to finance a health program by selling a development impact bond to private investors
- If program targets are achieved, external development donors reimburse the implementing partner, who in turn reimburses the investors

Example: In 2018, the Utkrisht impact bond was established in Rajastan, India, aimed at improving maternal and newborn health outcomes. It raised private capital to contract local health facilities to achieve rigorous quality accreditation standards. Once accreditation standards are achieved, USAID pays back the private investors.

Public-private partnerships

- Integrate the private sector in fundraising, or in the provision of some government health services with the goal of lowering costs
- May benefit service delivery, facilities management, and logistics and distribution

Example: UNITAID is a health fundraising consortium of the governments of Brazil, Chile, France, Norway and the United Kingdom. UNITAID uses an airline-ticket tax in participating countries to promote health services for cervical cancer, tuberculosis, HIV and malaria.

World Bank health intervention loans

- Subsidies to health insurance schemes
- Results-based purchasing support to government health institutions

Example: In 2015, Argentina received $350 million in World Bank loans to improve the integration of NCD healthcare services through the Protecting Vulnerable People Against NCDs project. In Tajikistan, the World Bank provides performance-based financing for the government to contract 450 rural health centers in scaling up NCD services, expanding access to services for 15% of the country's population.

Key References

WHO. 2020. Global spending on health: Weathering the storm. https://www.who.int/publications-detail-redirect/9789240017788

Institute for Health Metrics and Evaluation (IHME). Financing Global Health 2020: The Impact of COVID-19. Seattle, WA: IHME, 2020. https://www.healthdata.org/policy-report/financing-global-health-2020-impact-covid-19

WHO. 2021. Global expenditure on health: Public spending on the rise? https://www.who.int/publications/i/item/9789240041219

Dieleman JL, Graves CM, Templin T, Johnson E, Baral R, Leach-Kemon K, Haakenstad AM, Murray CJ. 2014. Global health development assistance remained steady in 2013 but did not align with recipients' disease burden. Health Affairs 3(5). https://www.healthaffairs.org/doi/10.1377/hlthaff.2013.1432

Kostova D, Nugent R, Richter P. 2021. Noncommunicable disease outcomes and the effects of vertical and horizontal health aid. Economics and Human Biology 41:100935. https://www.sciencedirect.com/science/article/pii/S1570677X20302057

Global Burden of Disease Health Financing Collaborator Network, 2019. Past, present, and future of global health financing: a review of development assistance, government, out-of-pocket, and other private spending on health for 195 countries, 1995–2050. Lancet 393(10187):2233-2260. https://www.sciencedirect.com/science/article/pii/S0140673619308414

World Bank, 2006. Health financing revisited: A practitioner's guide. Washington, DC. https://openknowledge.worldbank.org/bitstream/handle/10986/7094/370910Health0f101OFFICIAL0USE0ONLY1.pdf?sequence=1&isAllowed=y

USAID, 2019a. Greater than the sum of its parts: Blended finance roadmap for global health. https://www.usaid.gov/cii/blended-finance.

USAID, 2019b. Investing for impact: capitalizing on the emerging landscape for global health financing. https://www.usaid.gov/cii/investing-impact

USAID, 2019c. Unleashing private capital for global health innovation. https://www.usaid.gov/cii/private-capital

Assessing the System of Health Accounts for Public Health

American Public Health Association

Public Health Finance Roundtable

Kristy T. Hayes, DrPH

November 2022

Disclaimer

The opinions expressed in this presentation are the author's own and do not reflect the view of the U.S. Centers for Disease Control and Prevention.

Reliable Financial Data for Public Health

- Drives
  - Financial analysis
  - Financial transparency
  - Accountability
- Promotes
  - Program quality improvement
  - Evidence-based decision making
  - Sustainability of the public health system and institutions

Photo by Owen Beard on Unsplash

System of Health Accounts (SHA)

- Framework for reporting data on health expenditures
  - Meant to be comprehensive and internationally comparable
- Follows the International Classification of Health Accounts and links the pathway of health expenditures
- Developed in 2000 and updated in 2011 by OECD, Eurostat, and WHO
  - Reclassified preventive care
  - More policy relevant
  - Stronger emphasis on the purpose to determine if an activity falls within the prevention
- Published supplemental guidance in 2017
  - Guidance on distinguishing between prevention and other health expenditures
  - Address ambiguities that remained in the updated 2011 version

SHA: Total Health Spending

Health consumption	
HC.1	Curative care
HC.2	Rehabilitative care
HC.3	Long-term care
HC.4	Ancillary services
HC.5	Medical goods
HC.6	**Preventive care**
HC.6.1	**Information, education, and counselling programs**
HC.6.2	**Immunization programs**
HC.6.3	**Early disease detection programs**
HC.6.4	**Healthy condition monitoring programs**
HC.6.5	**Epidemiological surveillance and risk and disease control programs**
HC.6.6	**Preparing for disaster and emergency response**
HC.7	Governance and health system and financing administration
HC.0	Other health care services not elsewhere classified

Purpose

Use the SHA framework to examine preventive care expenditures to better understand the definition and classification of public health expenditures among OECD countries

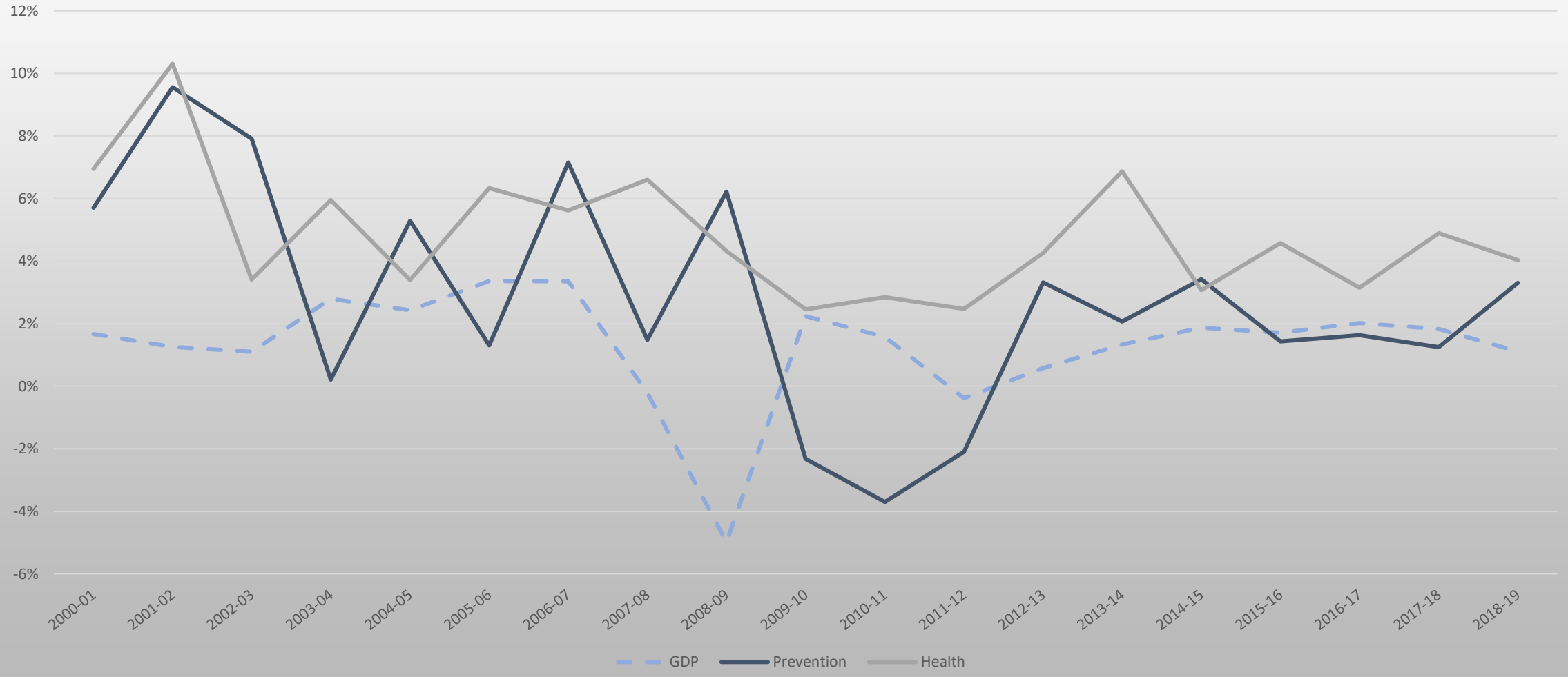
Countries in the Organization of Economic Co-operation and Development (OECD)

- Established in 1961 to stimulate economic progress and world trade
- Members consist of 38 mostly high-income countries
- Represent 80% of the world's trade and investment

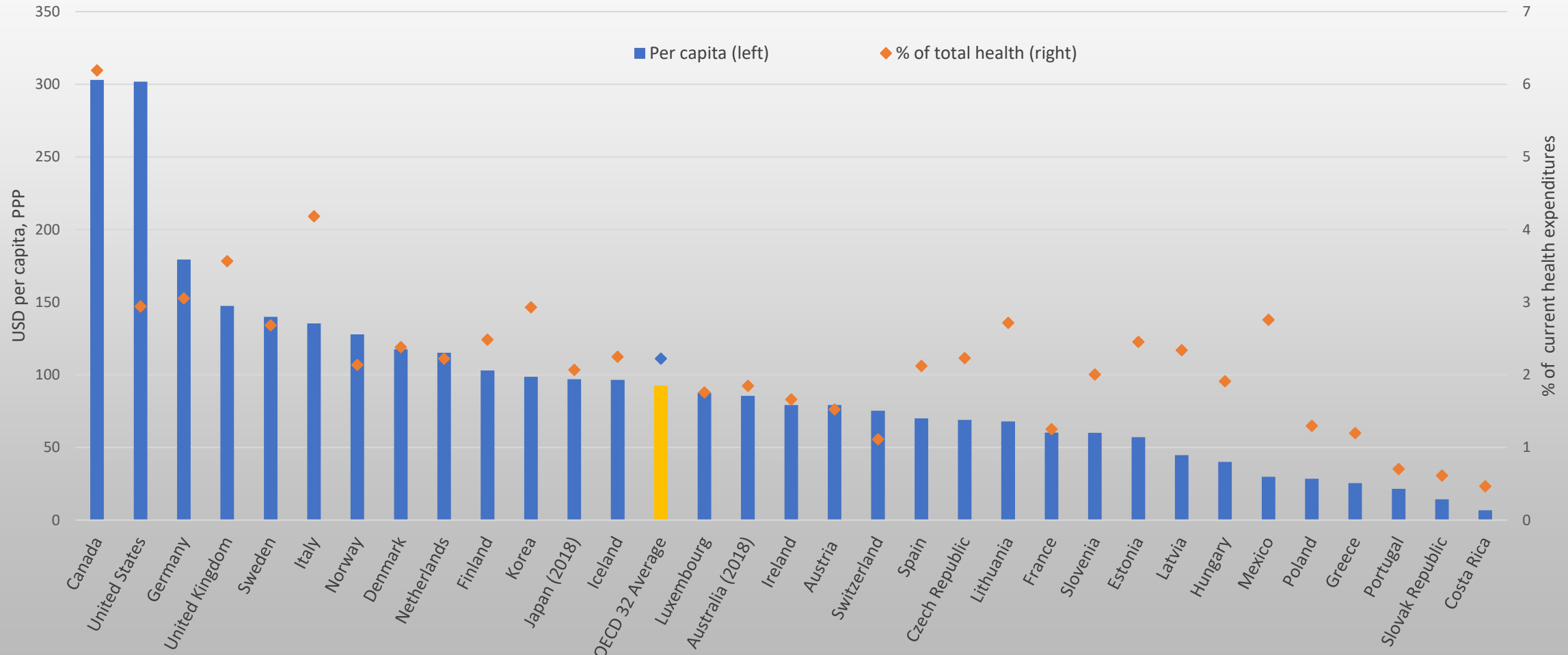
Descriptive Analysis

- Growth rate of GDP and preventive and total health spending
- Prevention expenditure by country
  - Per capita
  - As a share of total health expenditure
- Proportion allocated to preventive care
  - Allocation within preventive care by category
- Distribution of preventive care by category

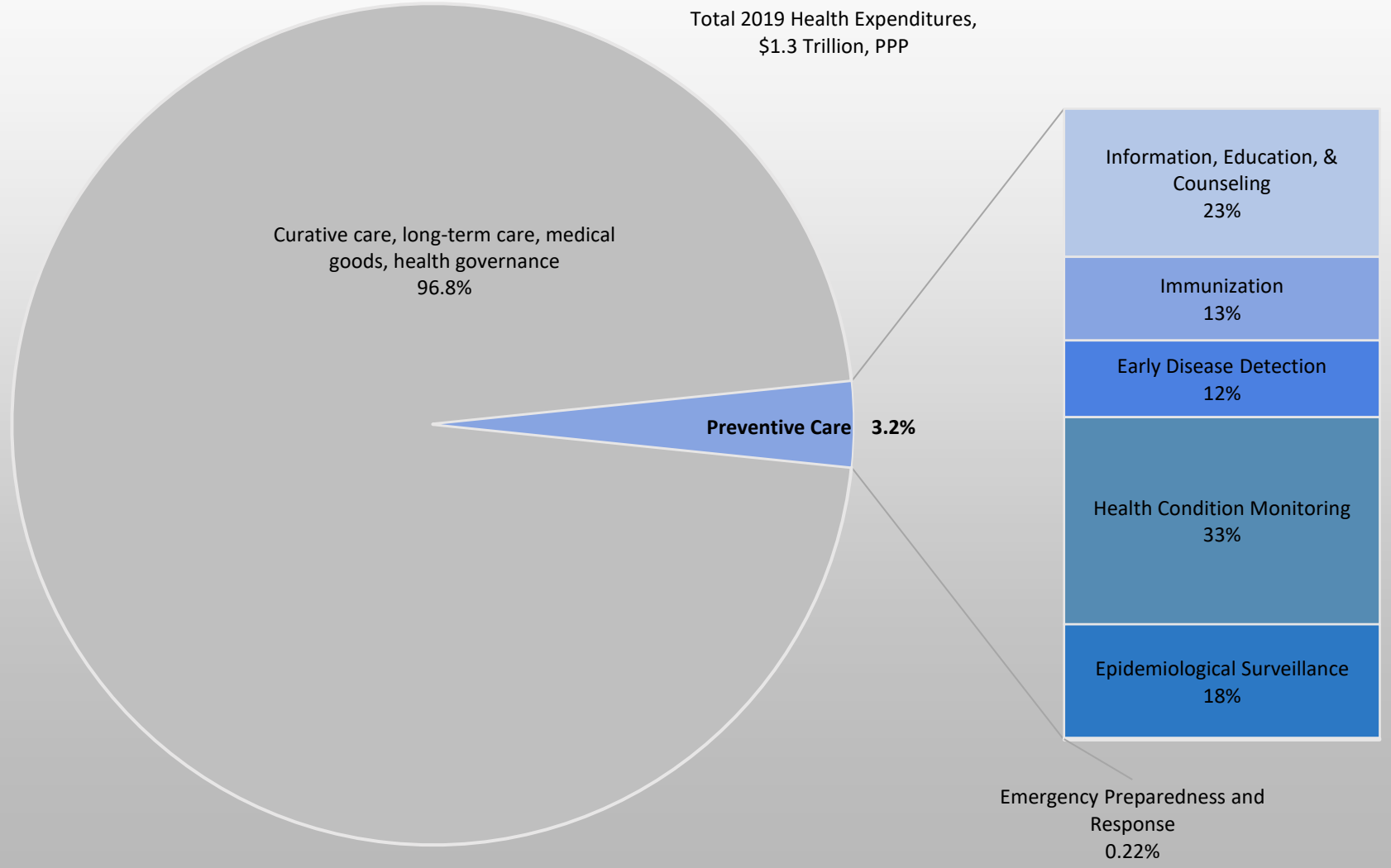
Growth rate of GDP, Total Health and Preventive Care Spending Among 23 OECD Countries



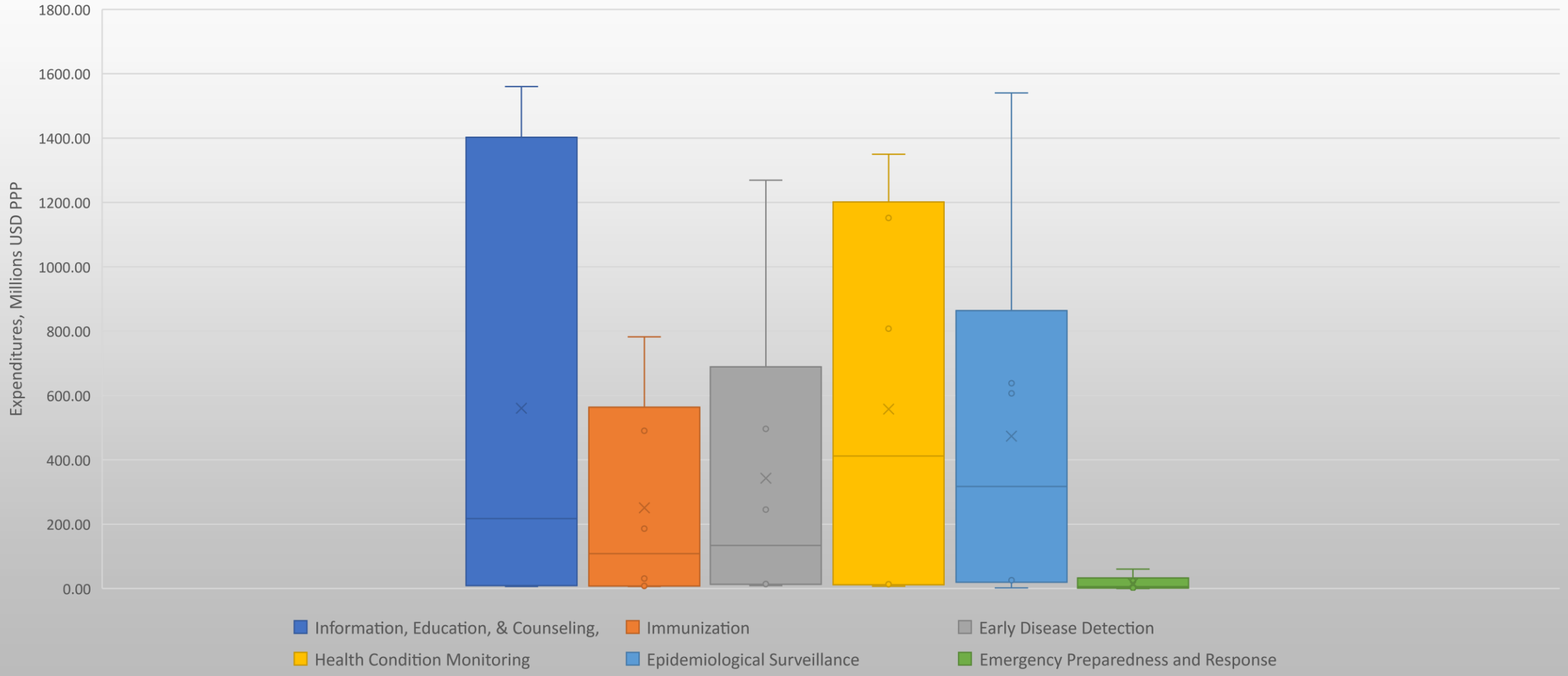
Preventive Care Expenditures Per Capita and Share of Total Health Spending Among 32 OECD Countries, 2019



Proportion of Funds Allocated to Prevention Activities Among 21 OECD Countries, 2019

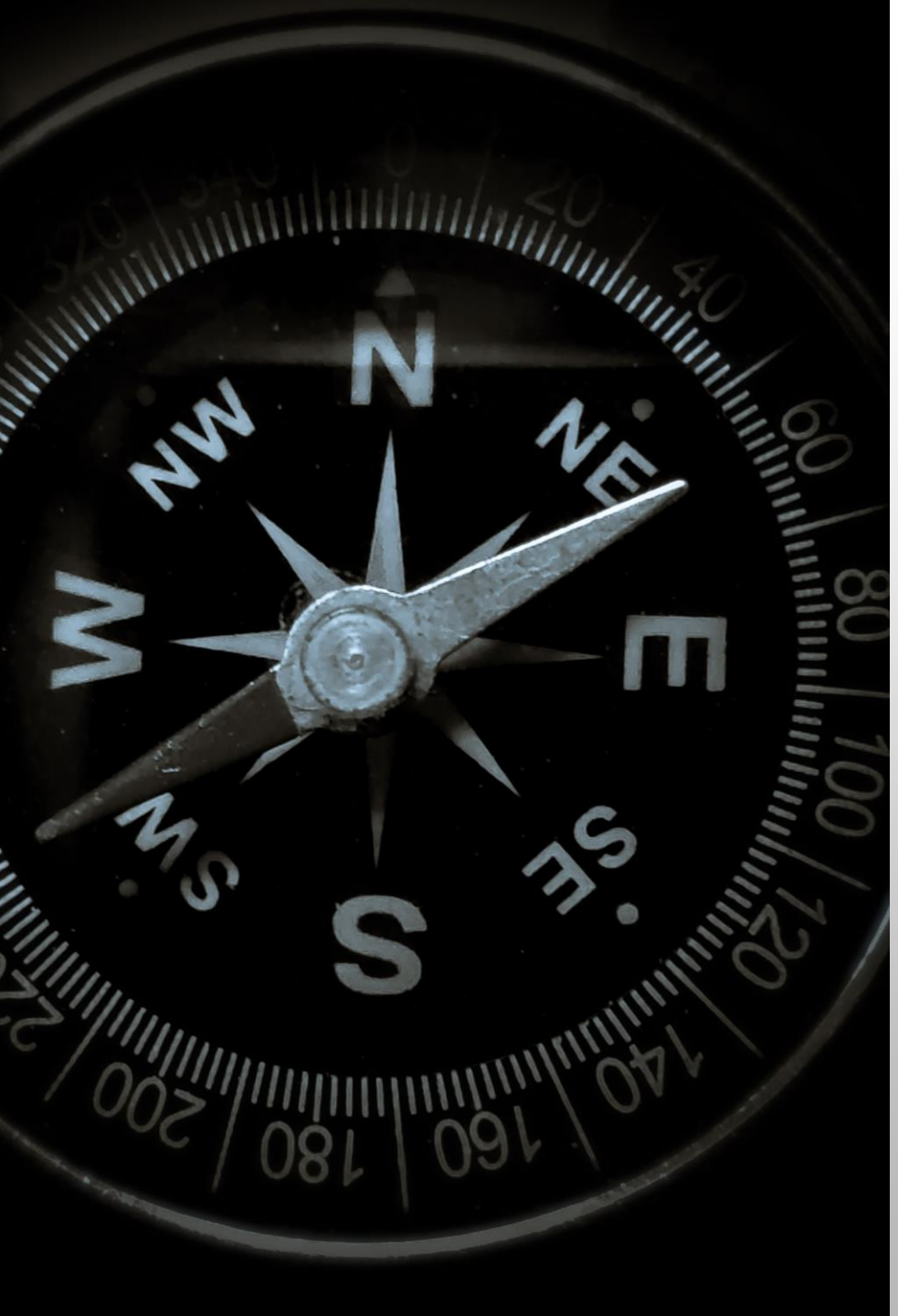


Distribution of Preventive Care Funds by Category Among 6 OECD Countries, 2019



Consistent Reporting

- From 2000 to 2019 out of 38 OECD countries,
  - 23 countries consistently reported total preventive care expenditures
  - 30 countries reported any amount during the time period
- In 2019, 21 countries reported an amount for any subcategory
  - 6 countries reported in each subcategory in preventive care



Reliable and Credible Data

- Boundary of preventive care expenditures
  - Restricted to traditional public health practice
  - Excludes fiscal and regulatory measures
  - Undervalues epidemiological surveillance
  - Underestimates emergency preparedness and response
- Does not distinguish differences in health financing mechanisms
  - Public health sector and public health services

Available and Accessible Data

- Analysis of expenditures are mainly on high-income countries
- LMIC data are currently not easily accessible or outdated
  - Difficult to examine trends overtime or cross-country comparisons

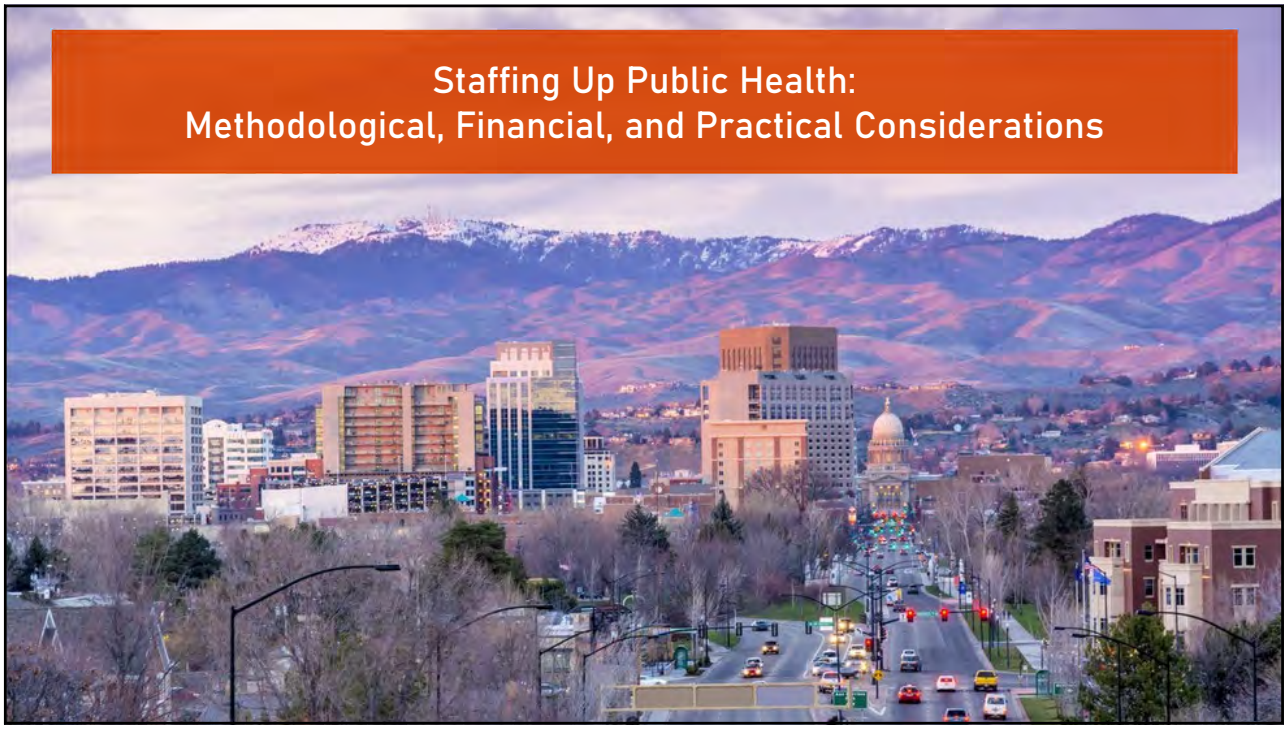
Implications

- SHA provides a foundation to initiate discussions to account for public health expenditures
- More research is needed to understand patterns and nuances of public health spending
- Grow the evidence base to promote sustainable and predictable funding

THANK YOU!

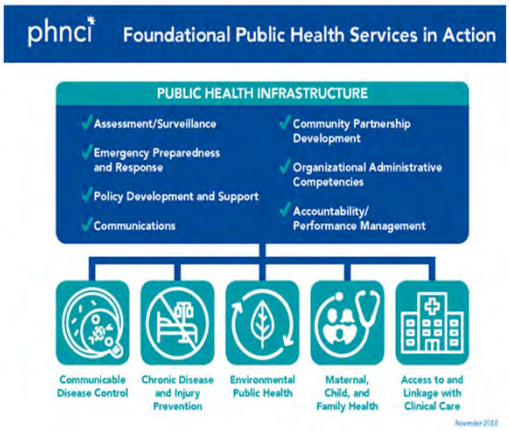
QUESTIONS?

Staffing Up Public Health: Methodological, Financial, and Practical Considerations



Project Background & Goals

- Phase I: Provide local and state staffing **estimates** that are needed to implement the Foundational Public Health Services
- Phase II: Create a public health workforce **calculator** that will allow health departments to determine the number and type of staff to provide sufficient levels of public health services



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Project Partners

- de Beaumont Foundation
- Public Health National Center for Innovations at PHAB
- Quantitative and qualitative research experts
- Center for State, Tribal, Local and Territorial Support at the Centers for Disease Control and Prevention (since July 2021)
- University of Washington (since July 2021)

Guidance provided by a Steering Committee and Research Advisory Committee. Qualitative interviews and focus groups also informed the work.

Staffing Up Quant Team

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Staffing Estimate

- How many FTEs are needed in state and local health departments to perform the Foundational Public Health Services (FPHS)
- Generate totals and ratios based on the number of staff needed per 100,000 people
- Recommendations are intended to provide an infrastructure that you can surge on during a crisis (e.g., a pandemic), but not inclusive of that surge

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The Findings

State and local governmental public health agencies need an **80% increase** in workforce to provide minimum public health services to the nation.*

- Local health departments need 54,000 of these additional FTEs
- State health departments need 26,000 of these additional FTEs

*This estimate does not account for additional workforce needs beyond core infrastructure and programs. Also does not account for COVID-related workforce (or other emergencies to come)

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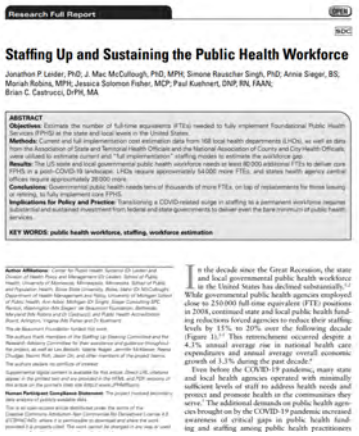
	Local	State	Total
Infrastructure			
Assessment	4,500	4,500	9,000
All Hazards	3,000	2,000	5,000
Other Foundational Capabilities	17,500	8,000	25,500
Foundational Areas			
Chronic Disease & Injury	8,000	5,000	13,000
Communicable Disease	4,500	1,500	6,000
Environmental Health	7,500	2,000	9,500
Maternal and Child Health	5,500	1,000	6,500
Access/Linkage to Care	3,500	1,000	4,500
Total	**54,000**	**26,000**	**80,000**

Phase I Findings & Methods

- Full report:
  - https://phnci.org/national-frameworks/staffing-up
- *JPHMP* manuscript:
  - https://journals.lww.com/jphmp/Fulltext/9900/Staffing_Up_and_Sustaining_the_Public_Health.60.aspx



Research Full Report

Staffing Up and Sustaining the Public Health Workforce

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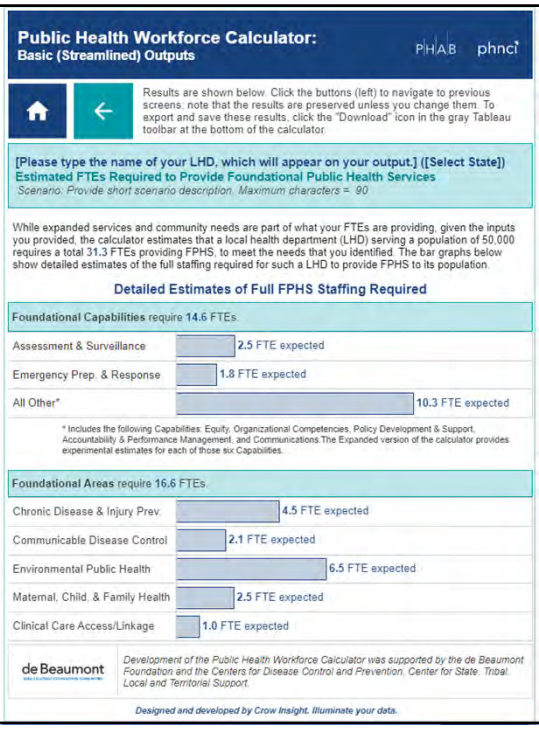
ABSTRACT

Short link: https://z.umn.edu/SU2022

Phase II: Public Health Workforce Calculator

- New tool for health departments to estimate their own workforce needs
- Plan for the type and number of staff needed to provide the FPHS in their communities
- Support advancing equity among health departments by ensuring adequate staff to provide the FPHS

https://phnci.org/transformation/workforce-calculator



Public Health Workforce Calculator:
Basic (Streamlined) Outputs

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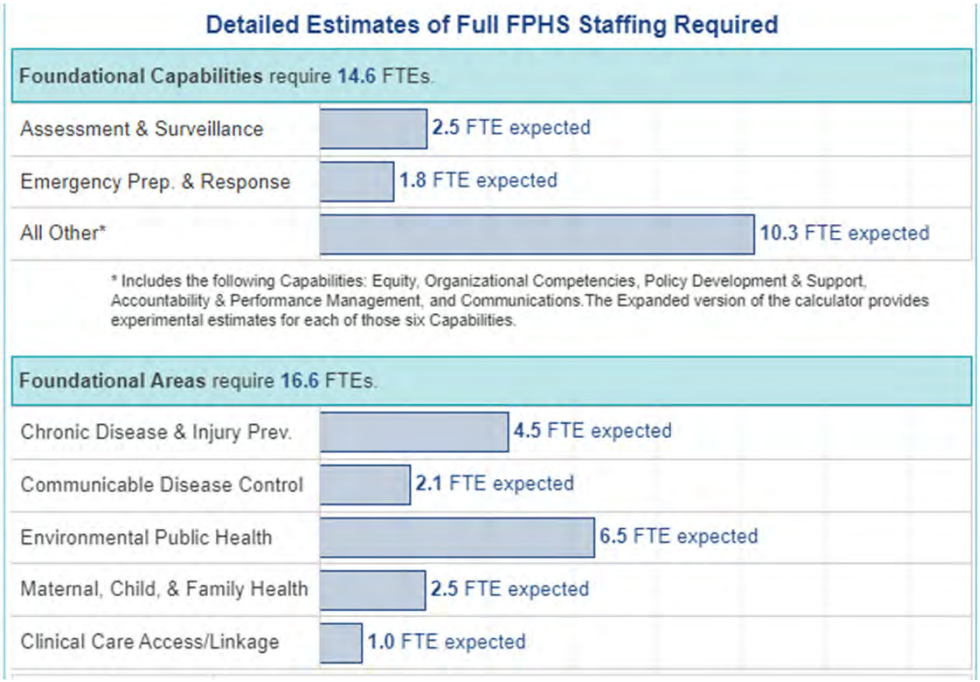
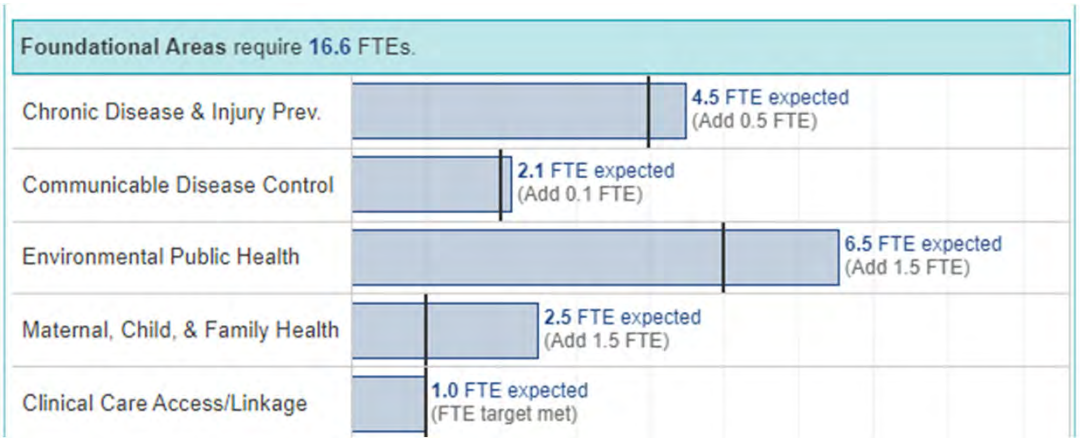
Results are shown below. Click the buttons (left) to navigate to previous screens; note that the results are preserved unless you change them. To export and save these results, click the "Download" icon in the gray Tableau toolbar at the bottom of the calculator.

[Please type the name of your LHD, which will appear on your output.] ([Select State])
Estimated FTEs Required to Provide Foundational Public Health Services
Scenario: Provide short scenario description. Maximum characters = 90

While expanded services and community needs are part of what your FTEs are providing, given the inputs you provided, the calculator estimates that a local health department (LHD) serving a population of 50,000 requires a total 31.3 FTEs providing FPHS, to meet the needs that you identified. The bar graphs below show detailed estimates of the full staffing required for such a LHD to provide FPHS to its population.

Detailed Estimates of Full FPHS Staffing Required




Foundational Areas require 16.6 FTEs.
Chronic Disease & Injury Prev.
4.5 FTE expected
(Add 0.5 FTE)
Communicable Disease Control
2.1 FTE expected
(Add 0.1 FTE)
Environmental Public Health
6.5 FTE expected
(Add 1.5 FTE)
Maternal, Child, & Family Health
2.5 FTE expected
(Add 1.5 FTE)
Clinical Care Access/Linkage
1.0 FTE expected
(FTE target met)


Methodological Considerations

Methods

Models used best available data sources

- ASTHO and NACCHO Profiles, PH WINS, 21C full-implementation data
- Only recently available/possible
- Best performing model: fit a power curve to log of FTEs and population size, by FPHS

Data sources naturally limited

- Full-implementation estimates are estimates
- No full-implementation estimates in ASTHO NACCHO Profiles
- 21C state generalizability? (n=170 locals in CO, OH, OR, WA)
- Upper/lower population cap & Decentralized governance

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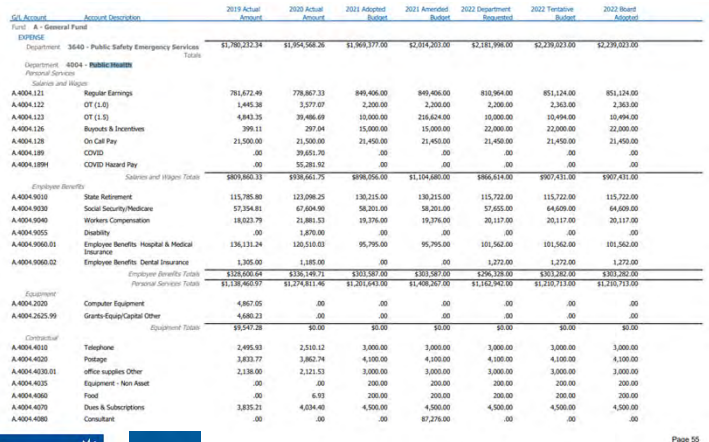
Accounting for FPHS



GrL Account	Account Description	2019 Actual Amount	2020 Actual Amount	2021 Adopted Budget	2021 Amended Budget	2022 Department Requested	2022 Tentative Budget	2022 Board Adopted
Fund: A - General Fund								
EXPENSE								
Department: 3640 - Public Safety Emergency Services	Totals	$1,780,232.34	$1,954,568.26	$1,969,377.00	$2,014,203.00	$2,181,998.00	$2,239,023.00	$2,239,023.00
Department: 4004 - Public Health								
Personal Services								
Salaries and Wages								
A.4004.121	Regular Earnings	781,672.49	778,867.33	849,406.00	849,406.00	810,964.00	851,124.00	851,124.00
A.4004.122	OT (1.0)	1,445.38	3,577.07	2,200.00	2,200.00	2,200.00	2,363.00	2,363.00
A.4004.123	OT (1.5)	4,843.35	39,486.69	10,000.00	216,624.00	10,000.00	10,494.00	10,494.00
A.4004.126	Buyouts & Incentives	399.11	297.04	15,000.00	15,000.00	22,000.00	22,000.00	22,000.00
A.4004.128	On Call Pay	21,500.00	21,500.00	21,450.00	21,450.00	21,450.00	21,450.00	21,450.00
A.4004.189	COVID	.00	39,651.70	.00	.00	.00	.00	.00
A.4004.189H	COVID Hazard Pay	.00	55,281.92	.00	.00	.00	.00	.00
	Salaries and Wages Totals	$809,860.33	$938,661.75	$898,056.00	$1,104,680.00	$866,614.00	$907,431.00	$907,431.00
Employee Benefits								
A.4004.9010	State Retirement	115,785.80	123,098.25	130,215.00	130,215.00	115,722.00	115,722.00	115,722.00
A.4004.9030	Social Security/Medicare	57,354.81	67,604.90	58,201.00	58,201.00	57,655.00	64,609.00	64,609.00
A.4004.9040	Workers Compensation	18,023.79	21,881.53	19,376.00	19,376.00	20,117.00	20,117.00	20,117.00
A.4004.9055	Disability	.00	1,870.00	.00	.00	.00	.00	.00
A.4004.9060.01	Employee Benefits Hospital & Medical Insurance	136,131.24	120,510.03	95,795.00	95,795.00	101,562.00	101,562.00	101,562.00
A.4004.9060.02	Employee Benefits Dental Insurance	1,305.00	1,185.00	.00	.00	1,272.00	1,272.00	1,272.00
	Employee Benefits Totals	$328,600.64	$336,149.71	$303,587.00	$303,587.00	$296,328.00	$303,282.00	$303,282.00
	Personal Services Totals	$1,138,460.97	$1,274,811.46	$1,201,643.00	$1,408,267.00	$1,162,942.00	$1,210,713.00	$1,210,713.00
Equipment								
A.4004.2020	Computer Equipment	4,867.05	.00	.00	.00	.00	.00	.00
A.4004.2625.99	Grants-Equip/Capital Other	4,680.23	.00	.00	.00	.00	.00	.00
	Equipment Totals	$9,547.28	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Contractual								
A.4004.4010	Telephone	2,495.93	2,510.12	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00
A.4004.4020	Postage	3,833.77	3,862.74	4,100.00	4,100.00	4,100.00	4,100.00	4,100.00
A.4004.4030.01	office supplies Other	2,138.00	2,121.53	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00
A.4004.4035	Equipment - Non Asset	.00	.00	200.00	200.00	200.00	200.00	200.00
A.4004.4060	Food	.00	6.93	200.00	200.00	200.00	200.00	200.00
A.4004.4070	Dues & Subscriptions	3,835.21	4,034.40	4,500.00	4,500.00	4,500.00	4,500.00	4,500.00
A.4004.4080	Consultant	.00	.00	.00	87,276.00	.00	.00	.00

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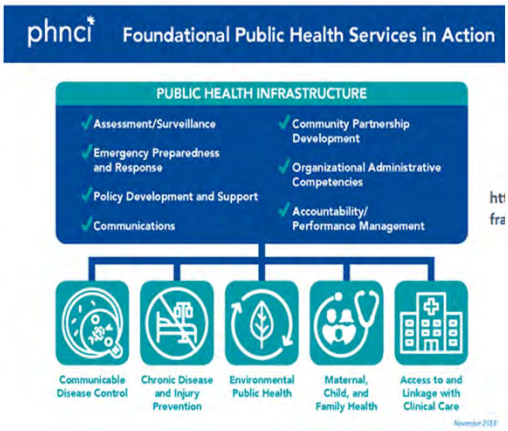
Accounting vs. Accounting for FPHS

- 4004 Public Health *Personal Services*
- 4004 Public Health *Contractual*
- 4005 Family
- 4006 Disease Control
- 4007 Community Health
- 4008 Health Education
- 4054 Public Health CWSN
- 4059 Early Intervention
- 4082 Public Health WIC
- 4189 Other Public Health
- 4320 Mental Health



Financial Considerations

Costs

Rough Estimate: $4 Billion

80,000 FTEs x $50,000 per year

Too much?

$3 billion in ARPA to "create a new grant program that will facilitate federal investment in the people and expertise needed at the state and local levels to expand, train, and modernize the public health workforce for the future."

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Practical Considerations

True Costs Not Linear

If capacity begets capacity,
infrastructure requires infrastructure

True costs =
Money + Money^2 + Money^3 + Uncertainty

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True Costs Not Linear

Money	Money^2	Money^3
$ for 80,000 FTEs	Who supervises?	Supervisor supervisors?
	Who interviews?	HR, IT capacity?
	Where do they work?	New efficiencies?
	Using what supplies?	Unforeseen challenges?

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True Costs Not Linear

Money	Money^2	Money^3
$ for 80,000 FTEs	Who supervises? Who interviews? Where do they work? Using what supplies?	Supervisor supervisors? HR, IT capacity? New efficiencies? Unforeseen challenges?

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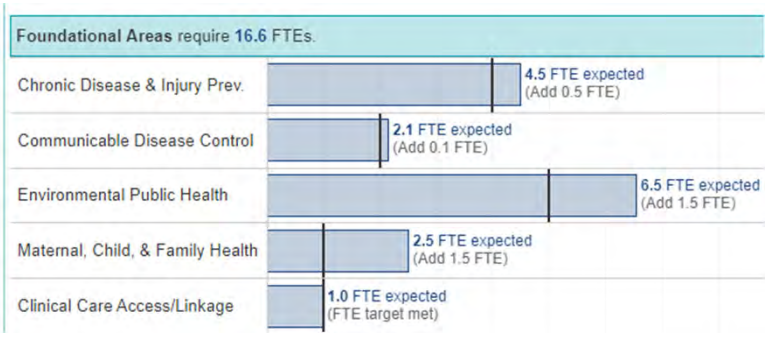
What about those results?



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End results may be the beginning

Results are what you make of them

- Easy to agree with things that reinforce our beliefs.
  Easy to dismiss things that don't
- Calculator is not "right" if it says you need more FTE than you have and "wrong" if it doesn't
- Think deep:
  - How is your department or jurisdiction structured?
  - What do *you* know about your community that the calculator does not?
  - Are there some calculator scenarios or sub-estimates that align and others that don't? Why?
  - Interrelationships between FPHS & your community-specific services

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