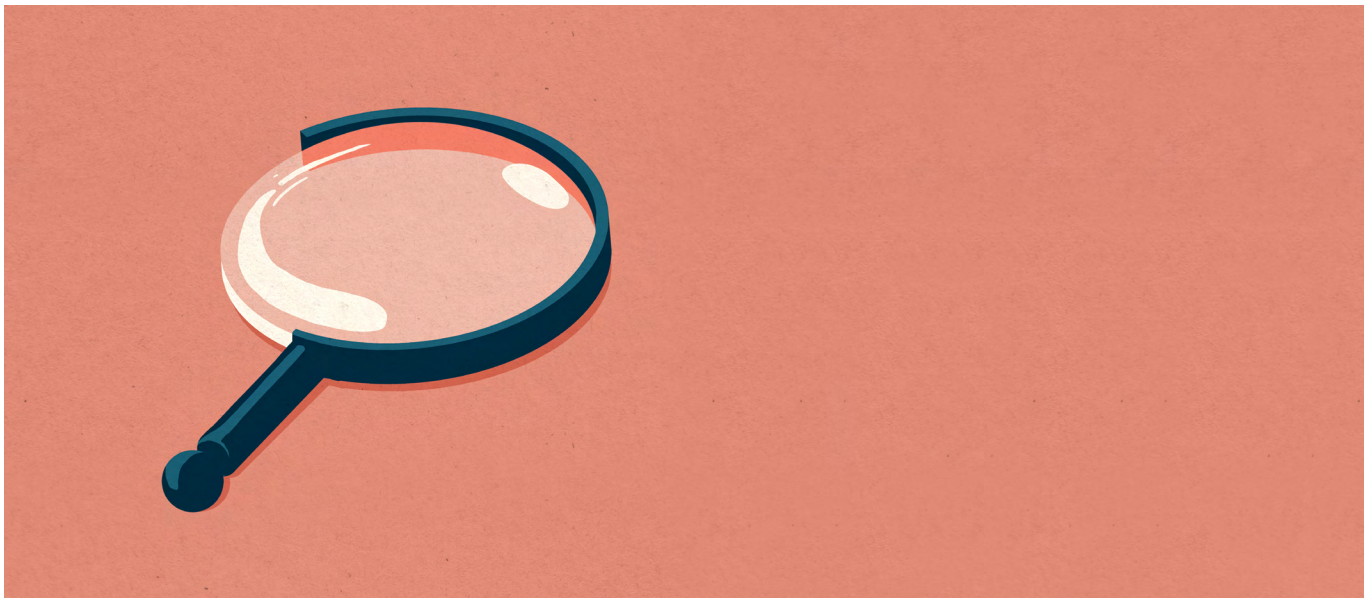

Counties are Ready for Their Closeup

Justin Marlowe

A quarter century ago, Jonathan Walters, a great observer of state and local government, said, "...counties have become the backstop of American government. In fact, a huge amount of responsibility for some of society's toughest, costliest, most thankless jobs has either been handed or simply devolved to county governments, and the results can be overwhelming."

Walters' words are especially salient as we face the challenges of the COVID-19 pandemic. Counties are on the front lines of the pandemic response. They run the epidemiology efforts to track and predict the spread of the virus. They operate public hospitals that serve our neediest. They're rolling out the COVID vaccine in real time. Meanwhile, they just administered the most scrutinized election in a generation, all while tending to public safety, rural roads, vital records, and other essential local services. The backstop of American government is now at the forefront of the American consciousness.

So how will counties leverage this moment in the limelight? Naturally, some have seized on the opportunity to push for more funding. County payrolls generally, and public health in particular, were slashed during and after the Great Recession. According to the National Association of County and City Health Officials, at the start of 2020 the public health workforce was about half of what it was in 2010. Then came COVID. The National Association of County Organizations estimates the pandemic has imposed a $144 billion hit on county budgets, brought on by a combination of lost tax revenues and new pandemic-induced spending. Today more taxpayers than ever are intimately familiar with what their county governments do. That familiarity might translate to much greater willingness to pay.

But that might be the wrong move. Instead of stabilizing revenue streams and securing long-term funding commitments from state legislators—in effect, shoring up the revenue side—counties have a unique opportunity to flip the script. Now is their chance to redefine what they do and how they do it, and then secure the revenues and, more important, the fiscal autonomy to get the job done.

Some recent public health initiatives illustrate this point. Most experts agree that our funding model for county-administered public health services suffers from two chronic problems. One is that the funding sources don't keep pace with costs. The property taxes, earmarked local sales taxes, state shared revenues, and federal grants that fund most county public health simply do not grow at the same rate as the costs to deliver those services. Moreover, many of those funding sources come with tight strings attached. For instance, many states will pay to vaccinate children against a variety of communicable diseases but won't pay for someone to monitor which children have been vaccinated.

Another major problem is inequity. Some jurisdictions have the resources and the political will to support a full suite of public health programming. Other jurisdictions cannot afford to offer basic services. Perhaps not surprisingly, those with the least fiscal capacity are also those with the highest concentrations of underserved populations who can benefit the most from chronic disease prevention, smoking cessation, communicable disease control, and other core public health programming. Many states send more dollars to counties with the greatest needs to try to alleviate those disparities, but those efforts often fall short. Layer in elected local public health boards and their competing priorities, and the types and quality of services delivered can vary tremendously from one county to the next.

About a decade ago, a group of public health professionals launched a new effort to address these problems. That effort is broadly known as "foundational public health services." The core concept is simple: State governments should ensure that every citizen has access to bundle of core public health services. "Ensure" means the state pays for those services through new investments, by removing the strings from existing dollars, or authorizing more local spending. Access means every citizen, regardless of their location or socioeconomic status, can avail themselves of those services.

The States of Oregon and Washington both launched their own versions of foundational public health services in 2015. Both states commissioned extensive background work to identify which services are essential, to define and describe those services in a shared language, to determine how to measure the effectiveness of those services, and to figure out what it would cost the state government to ensure access to those services.

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These were technical, bureaucratic exercises that went deep into everything from clinical public health definitions to local cost accounting methods. In the end, Washington State's price tag for statewide access was $450 million each year, or roughly $65 per capita. Oregon's was about $75 per capita.

With those price tags established, public health leaders went to their respective state legislators. Their pitch was that for the stated price tag, legislators could credibly claim that every citizen in their state had access to basic public health services. Further, they could also expect a guaranteed return on investment in the health of every citizen.

The effort worked well at first. Both states made one-time investments of $20 million to $30 million to "modernize" key parts of their state public health systems according to the foundational services blueprint. This led to improvements in areas like communicable disease control that paid big dividends once COVID hit.

But since then both states have pursued a different type of modernization. Washington Governor Jay Inslee's 2021 to 2023 biennial budget proposed reorganizing county public health departments into regional branches of the state health department in exchange for an annual state infusion of roughly $400 million. In other words, the state has promised to make the required investment, but will preempt some local control in exchange. Oregon has pursued the same goal of improving coordination across the state, albeit with grants to create incentives for broader regional cooperation among county health departments.

At a glance, it might seem like the foundational public health services effort has been a disaster for counties. Most county commissioners would probably prefer not to cede autonomy and resources to a regional government or to the state. But if the goal was to shift the conversation away from chasing dollars and toward keeping people healthy, then the effort was, in fact, a big success. This type of careful scrutiny of what counties ought to do and how they ought to do it will serve all of us well in the future.

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