

## **Objecting to Public Health – Stories from Four Pennsylvania Counties**

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### **Stories from Four Counties**

This should be a very nice story to tell: most people – from the average citizen to the elected official – believe in the importance of protecting and improving the public’s health, and they also believe that where, how and when you do so really matters. Yet it’s not true – not for many, and maybe most, Pennsylvanians. The message that Drexel University researchers often heard throughout three years of working with wonderfully committed organizations and individuals in four Pennsylvania counties is that – for very many people – attending to public health locally is at best unimportant and wasteful, and, at worst, threatening.

One of the national goals for improving the health and quality of life of all Americans is to ensure that all public health agencies – including local ones – have the infrastructure to provide essential services effectively (U.S. Department of Health and Human Services, *Healthy People 2010*). Why? First, there are environmental threats: natural disasters (floods included) and man-made ones (bioterrorism especially) that would require direct, local, “hands-on” intervention; and many causes and sources of air, water, and ground contamination. Second, there are existing, and potentially catastrophic, threats of disease epidemics.

Third, there are many behavioral risk factors, such as smoking, poor diet, physical inactivity, and excessive drinking, that are linked to the leading causes of death in the United States. Confronting these behavioral risk factors through health education and promotion, and

using preventive health measures like hypertension screening, can substantially reduce the rates of serious disease and death in the United States population (Chowdhury et al. 2007). Public awareness and knowledge of these risks, and concerted action to deal with them, does vary substantially by state and locality – often owing to the depth and quality of public health agency presence at the local level.

The reasons why the public should favor more local public health presence in Pennsylvania are easy to enumerate. The math alone is simple: 67 counties, six countywide health departments, and four multi-functional municipal ones in four other counties. As the readers of this Journal likely know well, the remaining 57 counties rely mostly on the Pennsylvania Department of Health to provide public health services through a network of regional offices and small county-based health centers. The national picture is different. The United States has more than 3,000 county and city health departments and more than 3,000 local boards of health (National Association of County and City Health Officials 2006). In the majority of states, most local public health work is done at a county level because prevention and protection are most often best done at this level.

From October 2004 through December 2007, faculty from the Drexel University School of Public Health (Drexel) collected information from and about the residents of four of the counties without a countywide health department. Drexel conducted four separate studies to assess ways to enhance local public health services, including the feasibility of establishing county health departments, in Lancaster, York, Berks and Dauphin Counties – which we will refer to as “the four counties.” In important ways, the four counties are similar. They are, respectively, the 6<sup>th</sup>, 8<sup>th</sup>, 9<sup>th</sup>, and 15<sup>th</sup> most populous counties in Pennsylvania. They each have a large rural population, but each has a central city (also the county seat) that is a service hub for the County. The central city in each – Lancaster, York, Reading, and Harrisburg – is both the most populace place and the locus of many of the most pressing public health concerns in the county.

Each of the four counties has important environmental health concerns related to water and air quality, ground contamination, and lead poisoning. Age adjusted death rates for cancer, diabetes, and stroke in each of the four counties exceed both the average rates for Pennsylvania

as a whole and the goals of Healthy People 2010. Drexel's research of primary data sources affirmed that concerns about chronic disease and the lack of accessible prevention and treatment services in the four counties are serious issues. For example, in the most recent study, in Berks County, more than 60% of the persons who completed a survey cited the following areas of unmet need: access to health care via health insurance and support services; oral health education and access to dental care; nutrition education and counseling; and mental health education and treatment services. These are all significant health service needs – population based needs – now going unmet or receiving inadequate attention and resources in Berks County. Findings in the other counties were not very different. In short, improving the health of the four counties' residents needs more attention than it has received via the current configuration of public health in Pennsylvania. We, like many in the field of public health, believe that the attention can be provided best if it were provided locally.

The methods that Drexel used to collect and analyze information via targeted surveys, interviews with key informants, and common data sources evolved over time, but there were several elements common to each study. Each had five major components: 1) the analysis of programmatic needs and service gaps, community interest and support, from primary data sources; 2) the analysis of health status data and reports from secondary sources; 3) an assessment of programmatic activities, organizational structure, and financing in selected county health departments in Pennsylvania and Maryland; 4) the analysis of potential operational costs and revenues of a new countywide health department; and 5) the identification of next steps to build support for acting on the study findings and recommendations. (In the Dauphin and Berks County studies, Drexel also considered the technical and financial feasibility of non-governmental approaches to enhancing public health.) The methodology proved to be an effective way to identify key public health needs, to elicit the views of persons in the best position overall to comment on public health deficits in each county, and to present the research findings in a straightforward way.

In many instances, the findings from the surveys and interviews were consistent with information Drexel collected from public data sources. In some instances, however, the findings – the perceptions of problems and issues vs. the public health “record” – were contradictory or

disconnected. Sometimes the data pointed to issues that have not yet been realized by the people at large – even by the one hundred (or more) key informants that Drexel targeted in its research in each county. In many instances, there is simply not enough information to know if issues raised in interviews and surveys are valid. This in and of itself points to a need for greater capacity for public health related data collection and disease investigation at the local level.

Four themes emerged from Drexel’s research. First, *access to personal health care and management of chronic disease* are significant issues facing the residents of the four counties. Many residents have no regular health care provider, and residents of these counties fare worse than their counterparts in other parts of the Commonwealth on many health issues (as is clear from Department of Health data). There are significant disparities in health access and status by race/ethnicity as well as geography, with residents in the central city in each county and the far rural areas of the counties facing the greatest challenges. There are some areas of core public health, e.g., tuberculosis, STDs, lead poisoning, which may not be getting the resources or attention necessary to truly understand, prevent, and treat.

Second, *environmental health* is a key issue for many, and the concerns expressed during the studies are in this instance supported by public data sources. For example, Berks County ranks poorly in assessments of air pollution and lead, and there are concerns about industrial environmental hazards and potential cancer clusters. Radon levels in Berks County are higher than in other parts of Pennsylvania, and Lyme disease is a critical issue, with rates second highest in the Commonwealth. The environmental health experience in the other three counties studied is similarly worrisome.

Third, *public health epidemiology and investigation resources* are insufficient to meet any of the four county’s needs. Too often, the data are not available to pursue or confirm the validity of health concerns raised by individuals and groups – and there is no readily available agent to collect that data and investigate in a timely and effective way. For example, hepatitis C was cited in Berks County as a major issue in the interviews and surveys of key informants, but the data on county prevalence of the disease are limited. This points to a major gap in public health epidemiology and data collection. It also points to the need for an

agency focused specifically on the county's experience to determine whether or not there is a true public health problem in the county. Issues raised over cancer clusters and health impacts of environmental hazards would similarly benefit from a more locally focused and more expansive public health approach.

Fourth, *coordination of health services and leadership for public health* is lacking within each of the four counties. Despite all the services that are available from the Pennsylvania Department of Health – and there are many – and from the many private agencies doing the business of public health, there is no one, clear, organizing body or focal point for public health activities, no “go to” place in any of the four counties. In each of the four counties, one organization or a network of like-minded organizations has stepped in to try to make up for this deficit. In Lancaster County, it is the United Way of Lancaster County and the Partnership for a County Health Department. In York County, it is the Healthy York Network, a component of the broader initiative, York Counts. In Berks County, it is the Berks County Community Foundation. In Dauphin County, it is the State Health Improvement Partnership (SHIP). These organizations and coalitions have helped to focus activity and attention on the public's health within the respective counties; but they are not public health agencies. Because no county government agency has this responsibility, there is no clear authority or public accountability at the county level. Public health authority and accountability at the county level is the norm in most places in this country, but, as we have noted, not in Pennsylvania.

By any accounting, each of the four counties has a rich, though loosely tied, public health infrastructure. Yet the services, both public and private, to promote and protect the health of the residents are not available equally everywhere in these counties, nor in some cases, sufficiently. The public health services provided by the Pennsylvania Department of Health are significant assets. But the professional staff resources and public health programs available to the residents of the four counties are significantly fewer than those available, for example, to the residents of the six Pennsylvania counties with countywide health departments.

To gauge the contrast of the four counties' experience with the scope and scale of local public health department activity in counties with

health departments, Drexel interviewed and collected information from the Pennsylvania Department of Health’s Southcentral and Southeast District Office staff and carefully analyzed the Annual Program Plans of Montgomery, Chester, and Erie Counties, and of the cities of Allentown and York. What Drexel found are public health program activities in these localities that go far beyond the services that the Pennsylvania Department of Health is able to provide locally.

When Drexel began its first study, in Lancaster County, in October 2004, we expected to find compelling evidence why having a county health department to protect a population of almost 500,000 residents made good sense. The needs to assure access to personal health services for disadvantaged persons, to investigate and ameliorate environmental hazards, and to prepare for and respond to emergencies are certainly clear – to everyone connected to the public health world, even indirectly. Yet this story does not sell well. It has not been sold to the majority of Pennsylvanians, ever. And it has not been sold, yet, in Lancaster County or in the other three counties we studied. An important but neglected reason is that the objection to public health as a local government undertaking has a firm and – maybe – impregnable basis. That may not have always been so; but after several decades of public sentiment largely – and sometimes aggressively – opposed to government programs and taxes, it certainly is the true story for many residents in the four counties.

### **The Contrarian Viewpoint**

Despite clear and strong evidence for why more local attention to public health would benefit the residents of the four counties, the reaction to the idea of creating a county health department, or otherwise expanding public health services, has often been negative. The reasons fall into three general categories. The primary one is the deep and abiding fear of an additional tax burden, in the future if not also the present. A second objection is a libertarian objection to the expanded, intrusive presence of government in “private” business matters, and associated concerns about service duplication, inefficiency, and waste. A third is the failure to explain why a government public health agency has any real value at all since no crisis exists and no harm from the absence of one can be convincingly shown.

First, the fear of taxes. What is the money angle behind all this? – a question that so many wanted to raise. In fact, the fear of new taxes and expanded government spending seemed to live independently from any reality, and seemed deaf to any meaningful answer that might be offered. Drexel presented several organizational and financial models for each study. The models described county health departments ranging in staff size from 32 to 73, and in annual operating costs and revenue from \$5 million to \$8.3 million. The variation was driven fairly equally by size of population and what might loosely be called “political feasibility.” Support for creating a county health department, based on surveys that Drexel distributed, varied among the four counties: 46%, 53%, 66%, and 69%. In those same counties, in the same order, the following percentages of respondents were *undecided* about whether or not to support creating a health department: 40%, 45%, 30%, and 22%. Yet the percentage of survey respondents who said that they *opposed* creating a county health department was very small, ranging from only 2% to 9%.

In one sense, these data make a reasonably encouraging case FOR creating county health departments. But the Drexel surveys were targeted to key informants – persons and organizations which would best understand the domain of public health. So we expected to see both understanding of the key issues confronting the county in question, and appreciation for the utility of a local government response to the county’s public health needs. In that sense, the support shown by the respondents is less encouraging than one might expect – at least for two of the four counties. The prime reason why so many were undecided is very straightforward: a concern for what it might cost county taxpayers.

For the county where interest in expanding public health services seemed the least (46% support), the scope and scale of county health department activity we modeled was kept small (52 staff and \$5 million in operating costs and revenue). For the county where interest in expanding public health seemed the highest (69%), the health department model we developed called for a much larger organization (72 staff and \$8.3 million in operating costs and revenue). The amount of local tax contribution to the total annual operating budget varied significantly as well, from \$150,000 to \$826,000 – depending on the level of support reported on the surveys and elicited via interviews (markers of “political feasibility”) more than any other variable. Finally, the *per capita* annual local contribution – a direct draw from county tax revenue – also varied

substantially by county: \$0.30, \$1.00, \$1.50, and \$2.00. By any calculus, these amounts are quite small – and ridiculously so given what this small investment might buy in prevention, protection, and treatment.

Drexel offered financial models that showed how reliance on local funding sources – taxes and fees combined – could be kept quite modest, in contrast to the national experience, and even more modest than is the case in the Pennsylvania counties with health departments. The opportunity to fund operations through effective use of grants (under Pennsylvania Acts 315, 12, and 537, and various categorical programs) is very real, and very significant. The table below shows national and Pennsylvania revenues by sources for county health departments, and contrasts that with the revenues that Drexel *estimated* for the four counties it studied, assuming that each would in fact establish a county health department (National Association of County and City Health Officials 2006).

**Table 1**

<b>County Health Department Revenue: All Sources (Percentage of Total)</b>			
	National	Pennsylvania	<b>The Four Counties</b>
Federal and State Grants	36%	67%	<b>77%</b>
Local Sources	47%	23%	<b>19%</b>
Other Support	17%	10%	<b>4%</b>

What we heard, though, was a recurring drumbeat of worries. What will it cost? We answered: much less than you think, and we showed how much. How much more will it cost in the future? We answered: no more than the commissioners and citizens of the county choose. What if the state cuts its financial support? We answered: it has not happened since the law enabling the creation of county health departments was enacted in 1951. Will we end up paying what the taxpayers in, for example, Chester County have to pay for their county health department – which started small but has grown to cost \$11 million per year, with the county paying \$1.6 million annually from county taxes (Chester County Health Department Program Plan 2007)? We answered, again: not if you don't choose to do so. How will restaurants afford the



licensing fees, and won't we have to pay more for the food we eat there? We answered: on average, food establishments would be expected to pay less than \$200 per year in licensure if they met the county's health code standards. We suggested that \$200 per year per establishment would not have a noticeable effect on any one person's food bill.

And along go the many questions about money. The frustrating part of the process is not the many questions that are posed. The frustrating part is that so many people seem to reject the credibility of the answers, even though there are four county health departments (Bucks, Chester, Montgomery, and Erie) and four municipal health departments (Allentown, Bethlehem, Wilkes-Barre, and York) which, if studied, will confirm the logic and realism of the answers. Perhaps the contrarian view is so deeply set in the four counties we studied – and throughout the country – that any NOT unpleasant answer about taxes and government spending must be seen as lacking in credibility.

The second objection to enhancing public health services, especially through a county government approach, is related to the first, but it is broader. It is an objection to an expanded, intrusive presence of government in “private” business matters. It is closely associated with concerns about service duplication, government inefficiency, and waste. One commentator said: “The (existing private) agencies cover everything that needs to be done; we don't want duplication of services” (Drexel University School of Public Health 2007). Another said: “Companies are engaged in wellness programs (disease prevention, obesity, and smoking cessation) which fill the needs” (Drexel 2007). And another said: “I am a service provider and I am concerned that if a county health department were created, it could hurt the level of services that agencies like mine provide. If money goes to the county health department instead of to these agencies, the agencies might not be able to survive” (Drexel 2007).

This point of view, correct or not, is based on a suspicion of government itself. This distrust seems to go deep. We sensed – and sometimes were told – that a county health department would certainly find public health problems, like lead and groundwater contamination. If the county looked and found such things, property owners and businesses would be forced to fix the problems. The focus then becomes fixed upon enforcement by a hypothetically nose, arrogant, untrustworthy county agency, not on the threat to public health and safety. We tried to make

the case that enhancing local public health was about protecting little children, not building big government. But the suspicion remained.

We recommended in one study that a concerted effort be made to develop relationships with the region's major businesses based on the business interest in having a supply of healthy workers in the community. We referenced a recent article from *Health Affairs* by Paul Simon and Jonathan Fielding entitled "Public Health and Business: A Partnership that Makes Cents." The authors make a strong case. "Businesses should have a financial interest in supporting organized public health efforts, and collaborative efforts can increase the reach and effectiveness of public health" (Simon and Fielding 2006). We saw this "business case" as one way of confronting an innate anti-government bias on the part of many.

We heard this bias expressed about restaurant inspections, in particular. Owners we interviewed objected to having to comply with new codes and county inspectors. That is not surprising. But some citizens – even some commissioners – who are connected to restaurants only as patrons also objected to more frequent and more comprehensive restaurant inspections. The general view is that food service establishments that are unclean and unsafe will not be patronized. The corollary, we must suppose, is that popularity (in the view of some, maybe many) is an empirical assurance of safe and sanitary food handling. As one commentator from York County noted: "Have we had outbreaks of food poisoning linked to restaurants that the media has failed to report?" (Dunn 2006). Of course, the answer might well be: who knows? Yet we were told bluntly on several occasions that county government should not get into the business of food service inspections, period. This seemed especially shortsighted for communities that depended economically on tourism and, in turn, on their reputations as inviting, safe places to visit – and in which to eat.

The last major objection is the lack of hard, local evidence to demonstrate why and how a government public health agency has any real value at all. If no crisis exists, then no harm from the absence of one can be shown. It is as though no local police are needed because no crimes are being committed. No local fire department is needed because no homes or businesses are on fire. Of all the objections, this is the hardest to overcome because there are no numbers, no symbols, no

stories that make a compelling case for more public health at the local level when there is no sense of an actual or looming threat. As one commentator said, “I travel all over the county and have heard nothing about the need for public health services of any kind” (Drexel 2007).

Playing into this last objection is the urban-rural divide in each of the four counties. The health and social problems in Lancaster, the cities of York, Reading, and Harrisburg, are viewed by many as the problems of the poor and minorities only. The deep divides along racial and socioeconomic lines, embodied geographically in the differences among those cities and the surrounding suburbs, outlying towns, and rural communities, constitute a psychological firewall for many of the majority population. That’s a Harrisburg problem, or a Reading problem. We often heard that. The logic is that there is no public health threat in the county if the threat is contained within the poor populations of the central cities. And so there is no need for a county health department that taxpayers outside those cities need to support.

As one cogent commentator in York County noted, “The idea of a county health department has been around for at least 40 years. It never gained any significant support in the past, probably because no significant need was ever identified” (Dunn 2006). That commentator went on to say that the need for more effective immunization programs was not demonstrated because there have been no “disease outbreaks resulting from the lack of such programs” (Dunn 2006). This commentator was not expressing an anti-government bias. He noted that “over the past 40 years ... highly successful county programs have come into being. These include planning, solid waste disposal, parks and recreation. In all of these cases, unmet needs were (first) identified” (Dunn 2006) – and so county government intervention was warranted. Not so with and for public health – precisely because its value lies preeminently in its prevention ethos. If you do not envision prevention as an unmet local need, you will not buy into the idea that local public health matters.

### **Confounding the Contrarians – Can It Be Done?**

In the four studies that Drexel completed, we tried to assess how much – and how little – local conditions affect the perceptions of both

public health needs and the opportunities for enhancing county-based and countywide programs. Public health issues for residents of Lancaster County bear a resemblance to the issues for residents of Berks County, for example. Issues facing the residents of the four central cities are very similar – all connected to racial and ethnic health disparities, and poverty. Issues of remoteness and too few health and social services facing residents in the northwest and southeast communities of York County are not unlike those facing residents of southeastern Lancaster County and upper Dauphin County. The stories from the four counties sound similar, but they are still different enough to help make the case for why public health is best understood within a very local context. The politics are different. The health care organizations interested in – even committed to – local public health are focused on the specific needs of their surrounding community. The key to answering the contrarian views is to know in fine detail the unique features of the issues faced by the different communities. That is something that only local people, local institutions, local collaborations can undertake.

From a distance, Drexel offered several generic but very real reasons for why the stakeholders in the four counties should build a more effective local public health presence. Creating a county health department, for example, would have several tangible benefits. It *could* bring into each of the four counties more than \$1 million in additional state categorical grants, and more than \$2 million of Acts 315/12/537 state grant support to benefit county residents. Put another way, each of those four counties annually foregoes more than \$3 million that could go directly to public health programs targeted to the needs of the residents if it does not create a county health department. Creating a county health department would also likely ensure:

- More effective *standards setting and consistency* in overseeing public health matters (communicable disease surveillance, disease prevention, inspection, and licensure of food service establishments, environmental health, etc.).
- More effective *county-wide coordination* of public health related services, by municipalities, school districts, hospitals, and other non-profit private agencies.

- More effective *local control* and priority setting through more effective *leadership* of health-related matters at the county level.

But one final question always remains: if having a county health department is such a great idea, why have so few Pennsylvania counties established one – especially since Act 315 was passed in 1951 to do just that?

There are likely several answers, all of which make the argument for why there should be more local public health presence in Pennsylvania a particularly hard one to win. Few in Pennsylvania really understand or care about public health, unlike in Maryland, New York, Michigan, North Carolina – and many other places throughout the United States. There are several possible reasons. First, medical schools and hospitals dominate the health world in Pennsylvania. Perhaps, in turn, because of this institutional medical dominance, except for the University of Pittsburgh, there have been no schools in Pennsylvania devoted to studying public health and encouraging its expansion, until the Drexel School of Public Health was established a decade ago.

Second, as we described above, there really is an abiding fear about government intrusion in private and business matters, and the costs associated with that intrusiveness. This is especially so in the less urbanized parts of Pennsylvania – meaning, most of it.

Third, we have been relatively lucky in terms of avoiding food borne and communicable disease outbreaks. It might also be that outbreaks are undercounted precisely because there is no consistently designated authority who the public knows to contact when a food borne illness occurs. In either case, there is insufficient regard and caution in the public mentality about such threats – and about the associated risks we then bear in having inadequate inspection, surveillance, and response systems.

The last point is important because if that changes, all of the contrarian arguments could be overcome. For similar, but less urgent and scary reasons, that is how the Montgomery County Health Department got started: concern (among a few committed doctors at first) about responding to Lyme disease, rabies, and HIV/AIDS – at a critical, challenging point in time, 1989-1991. That fear or concern can be enough of a tipping agent to change the balance. Anyone promoting an

enhanced local public health presence needs to be mindful of that. But prevention is a hard sell, and until recently, so was preparedness.

We must also acknowledge that “selling” the need for more local public health presence is compromised by our inability to make a sure case for how and why a county health department improves the population’s health in a clearly demonstrable way. It’s what we call the “It’s a Wonderful Life” test. If the “XYZ” county health department did not exist, could we clearly see how the population’s health would be dramatically worse off? Can anyone REALLY show what the precise effect a county health department has on a population’s health – in the same way that George Bailey was shown how his life mattered so much to so many in Bedford Falls? We asked that question, informally, of persons who work in county health departments, and we were given fine, but modest answers. None of the answers were so dramatic that they would “make the sale” for local public health to a community full of committed contrarians – not in our view.

At the end of the day, selling public health at the local level must be built upon, and carried along by, some authentic and pointed message of prevention and protection – just like the need for more local police is promoted. It must be a message about being closer geographically, about knowing the community intimately, and the community knowing where it can turn for help. It’s likely the only way to confound – if not silence or convince – the public health contrarians who reside throughout Pennsylvania, both average citizens and elected officials.

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