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Generation Y, Shifting Funding Structures, and Health Care Reform: Reconceiving the Public Health Paradigm through Social Work

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Public health agencies are facing a convergence of forces that require a reexamination of the existing paradigm. The need to replace an aging workforce with a new generation that possesses a different worldview, in the context of budget austerity, will be challenging. In addition, the uncertainty of health care reform poses a challenge for public health leadership. This “perfect storm” provides the opportunity for the social work paradigm to come in and fill the void.

Keywords: Workforce, millennials, budget cuts, future of public health

Currently the field of public health is facing a number of major transitions including changing funding structures, shifting demographics of the American workforce, and health care reform. These changes provide local health departments (LHDs) an opportunity to be proactive rather than reactive in ensuring continued, and perhaps even improved, provision of public health services. There have been some anticipatory warnings of the workforce challenges facing LHDs (Association of Schools of Public Health [ASPH], 2008; Association of State and Territorial Health Officials [ASTHO], 2007; Institute of Medicine, 2002). However, none of this work examines the impact these demographic changes will have on the public health paradigm. This work will fill that gap. It begins with an examination of current public health priorities followed by a brief review of public health funding challenges. The article then addresses the potential impact of this demographic shift by providing an overview of the characteristics and values of the generations that compose the public health workforce, placing particular emphasis on Generation Y, or those born between 1980 and 2000. This article concludes by proposing a shift in the current public health paradigm that improves the likelihood of attracting and retaining a new generation of workers, proactively addresses new funding structures, and anticipates the impact of health care reform.

CURRENT PRIORITIES FOR LOCAL HEALTH DEPARTMENTS

National, state, and local governments; advocacy organizations; and stakeholders have used a standard framework for understanding the core functions and essential services of public health. Within individual jurisdictions variations in the wording or specific number of essential services are observed. However, the basic framework for all jurisdictions is outlined below:

Assessment: Determine community strengths and identify current and emerging threats to the community's health through regular and systematic review of the community's health indicators with the public health system partners.

Assurance: Address current and emerging community health needs and threats through governmental leadership and action with the public health system partners. Take necessary and reasonable action through direct services, regulations, and enforcement. Evaluate the improvement plan and actions and provide feedback to the community.

Policy development: Establish a community health improvement plan and action steps with the public health system partners to promote and protect the health of the community through formal and informal policies, programs, guidelines, environmental changes, and programs and services. (Wisconsin Division of Public Health, 2005)

To realize the core functions, the American Public Health Association (APHA; 1998) describes the 10 essential public health services as follows:

1. Monitor health status to identify community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure a competent public health and personal healthcare workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

Together the core functions and essential services have guided local public health practitioners for nearly two decades.

Activities LHDs engage in to fulfill the core functions and essential services may include immunizations; epidemiology; outbreak management; food, water, and environmental safety; assessment and education; licensing and statute enforcement; collaboration with the community; and more recently, bioterrorism and disaster preparedness.

Although the burden on LHDs has been increasing, the field of public health is currently being affected by two forces that require further analysis. First, community residents, policy makers, and other stakeholders need to gain a more robust understanding of how local public health is supported financially, especially in the context of the Patient Protection and Affordable Care Act. Second, LHDs will be faced with replacing retiring Baby Boomers over the course of the next 15 years. The differences in demographics and personal values between the future workforce and the current workforce are an issue that will be explored. These two forces are linked in such a way that it will require LHDs to reexamine core functions and essential services, redefine the job descriptions and skill sets of public health workers, and prepare for a major generational shift by

creating work environments that are attractive to Generation Y workers. Part of that generational shift may be a move away from the public health nursing model and toward a social work model. To accomplish this, LHDs need to seek out funding sources that allow for greater flexibility than had been afforded by traditional funding sources.

SHIFTS IN FUNDING SOURCES

The National Association of City and County Health Officers (NACCHO) regularly publishes a report on the state of LHDs. A review of this data makes clear that a significant shift in funding sources has occurred among LHDs beginning in 1992 and continuing through 2008. Table 1 shows the percentages of budget sources from 1992, 2005, and 2008. In looking at the funding trends over time, tax dollars, as a proportion of budget, are decreasing while fees and grants are increasing (NACCHO, 1995, 2006, 2009). The funding terms *hard money* and *soft money* could be applied to Table 1. Specifically, the local tax levy and state and federal pass-through funds can be viewed as hard money. More specifically, *hard money* refers to taxpayer dollars provided to LHDs for essential services, often required by federal state or local law. Barring a policy change, these services and funds would be available year after year.

Other sources of funding identified in Table 1, such as grants, insurance reimbursements, or fees, vary depending on demand, socioeconomic conditions of the LHD jurisdiction, and economic and political factors at the state and national level. These funding sources can change depending on federal funding priorities, charitable foundation priorities and financial strength, and reimbursement rates. These funding sources can be thought of as soft money. Over time, LHDs have become more dependent on soft money. To maintain the core functions and essential services required of LHDs, new streams of revenue had to be tapped.

This analysis leads to the essential question surrounding public health funding which is , Is the current model of public health core functions and essential services sustainable? Part of the answer can be found by examining the values and characteristics of the current and the next generation of public health workers.

THE CURRENT PUBLIC HEALTH WORKFORCE

The public health workforce is aging. The NACCHO (2010) found that, on average, 20% of LHD employees will be eligible for retirement in the next 5 years. NACCHO (2010) also reported that nearly 90% of top executives at LHDs are either Baby Boomers or Gen Xers. Although data is not available, one could infer that this holds true for the majority of local public health workers

TABLE 1
Changes in Local Health Department Funding

<i>Funding Source</i>	1992	2005	2008
Local tax levy	34%	29%	25%
State government & federal pass through	40%	36%	37%
Licensing and personal fees for service	7%	6%	11%
Federal grants or contracts awarded directly to LHD	6%	7%	2%
Other (private foundations, private insurance, etc.)	3%	12%	7%
Medicare/Medicaid reimbursement	10%	11%	15%

Source: National Association of County and City Health Officials (1995, 2006, 2009).

as well. But who are these people? Note that the literature differs on the years that define a generation by a year or two. However, there is general agreement on the basic timeframes that represent each generation.

Baby Boomers

Baby Boomers were born from 1945 through 1964. Approximately 78 million Americans between the ages of 46 and 65 constitute this generation, the second largest cohort group addressed in this article (U.S. Census Bureau, 2008). Characteristics and values of Boomers, as they are commonly called, include a tendency to micromanage others and a lack of respect for authority (Blythe et al., 2008; McGuire et al., 2007). They also dislike laziness and believe in paying one's due to earn respect and seniority. Boomers tend to be competitive and are master networkers. Despite their competitiveness, they seek consensus when making decisions in the workplace (Blythe et al., 2008; McGuire et al., 2007).

Generation X

Gen Xers were born between 1965 and 1980 and represent approximately 48 million Americans (U.S. Census Bureau, 2008). A much smaller generational cohort than Boomers, Gen Xers are between age 30 and 45. Common characteristics and values of this generation include a willingness to take risks and an emphasis on teamwork and collaboration. They tend to be less socially adept than their Boomer counterparts but are relatively comfortable with technology. Quality of life is important to them, and they are not loyal to their employers (Blythe et al., 2008; McGuire et al., 2007).

Baby Boomers and Gen Xers fill the majority of management positions in LHDs, yet the literature points out that the next generation of public health workers, Generation Y, has its own characteristics and values that differ significantly from those of the two generations dominating the public health workforce. Current public health managers will need to accommodate these differences if only because of the sheer numbers of Gen Y workers entering workforce (Crumpacker & Crumpacker, 2007).

Generation Y

Generation Y includes nearly 80 million Americans representing approximately 27% of the U.S. population, whereas Boomers represent about 78 million Americans (U.S. Census Bureau, 2008). Generation Y is entering the workforce with different expectations, communication styles, and work styles. Generation Y also has different values, norms, and attitudes regarding authority, acceptance of change, and work-life balance as compared to previous generations (Hu et al., 2004). Of paramount concern to Generation Y is flexibility (Sherman, 2006). Generation Y is confident and optimistic and wants, perhaps even expects, to progress rapidly in the organization. However, their confidence is coupled with a need for "immediate feedback and almost continuous recognition" (Crumpacker & Crumpacker, 2007). Ironically, though Gen Ys tend to be well educated and often multitask using several modes of communication simultaneously, they need to work on their communication skills (Crumpacker & Crumpacker, 2007; Tyler, 2007). For example, text and instant messaging requires judicious use of space. As a result a whole lexicon for communicating in these media has developed. This, in turn, has led to a generation of young people who rely on technology to ensure correct spelling and grammar when communicating in other media (Tyler, 2007). They also need to hone their problem-solving skills (Crumpacker & Crumpacker, 2007; Tyler, 2007). Generation Y employees like challenges but resist authority and prefer managers who serve as mentors and coaches (Hu et al., 2004). They also prefer managers

who work collaboratively with their staff (Center for State and Local Government Excellence [CSLGE], 2008). They dislike being micromanaged and are most comfortable in environments in which they can demonstrate their expertise (Sherman, 2006). Work–life balance is very important to Generation Y, and if pushed to choose between “work” and “life” at any given moment they will most likely choose “life” (Crumpacker & Crumpacker, 2007). Multiculturalism has always been part of the Gen Y world so a diverse workplace seems normal to them (Sherman, 2006). Finally, if their needs and those of customers and clients are not met, organizations can expect high turnover of Generation Y employees, as they are loyal to their careers, and their professional growth, not to their employers (Sherman, 2006). Crumpacker and Crumpacker (2007) suggest that

as Generation Y gains a foothold in the workplace, organizations will need to change to accommodate their norms instead of expecting young workers to change to accommodate existing organizational norms. In this regard, sheer numbers and skills alone provide Generation Y employees leverage. (p. 363)

Given this, it would be fair to assume that recruiting, retaining, and managing Gen Y workers provides an interesting opportunity for LHD management. Perhaps most significant for current public health managers is Gen Y’s loyalty to their careers and their ideals, not to their employers. If Gen Y recruits do not believe the LHDs they work for are meeting the needs of the populations they serve as well as their personal career goals and aspirations, Gen Y employees will leave for employment opportunities that do. Despite this, one survey by the Center for State and Local Government Excellence (CSLGE, 2008) found that the majority of respondents would be interested in working for local (58%) government. Even so, 52% to 57% of the American public perceives it to be difficult to get jobs with state and local governments (CSLGE, 2007). Not only do people perceive the governmental hiring process to be complicated, many applicants enter the private sector instead due to the long lag time from initial interest in a position to being hired (CSLGE, 2008). Adding to the challenge of recruiting and training Gen Y is the fact that many people feel there are few opportunities for innovation or creativity in state and local government, which is not attractive to Gen Y employees looking for opportunities to demonstrate their expertise (CSLGE, 2007). LHDs that are successful in managing a multigenerational workforce will exhibit characteristics of transformational leadership.

THE UNKNOWN IMPACT OF HEALTH CARE REFORM

As the Affordable Care Act (ACA) began to be rolled out in 2010, more questions than answers arose in the public health community. Although it is understood that ACA will cover more uninsured when the health insurance exchanges become operational by 2014, and that there are new financial incentives for physicians to engage in more preventive care; the role of local public health practice was not clearly defined. In theory, near universal coverage may eliminate the need for LHDs to provide such services as free immunizations, well-baby services, cancer screening, and smoking cessation programs, especially if physicians and health systems are incented to provide more access to preventive care.

In the future, LHDs may be focused more on environmental issues and consumer protection activities such as food and restaurant inspections, air and water quality, and case managing people in the health care exchange environment. The continued blurring of the lines between public health and social services agencies may result in more merging of departments and municipal, county, and state level. More nurses will be needed in the private sector to offset the increased demand placed on health systems by the increase of 30 million new customers in the private insurance market. Thus, in the next 20 years, fewer clinical services, more levels of government bureaucracy,

and an increasingly diverse U.S. population means that social work will play a greater role in the provision of public health.

A NEW PARADIGM FOR LOCAL PUBLIC HEALTH DEPARTMENTS

Previous sections of this article highlight how public health efforts are funded and how different generations of Americans' perceptions of work are affected by personal values, attitudes, and beliefs. Based on the above demographic and economic trends, both of which are happening concurrent health care reform debate, LHDs would benefit from a paradigmatic shift in the way it conceives of its core functions and essential services. Although the core functions and essential services remain relevant, workforce issues and funding cuts have made providing services to all residents a challenge. In addition, we know that social determinants of health are strong predictors of poor health outcomes. Researchers have found that poverty, when controlling for education and health behavior, is a predictor of poor health outcomes (Lantz et al., 2001). Thus, to have a more impactful role in the future, public health needs to reconceive the delivery of core functions and essential services to address the socioeconomic and "upstream" contributors that factor into health. This requires a new perspective and a sense of urgency among LHD leadership to address these challenges now—especially in the context of the new health care reform law.

New Strategic Focus Areas

The current core functions of assurance, assessment, and policy development are not meant to be replaced. However, the combination of reduced funding, the values of the Generation Y workforce, and the scope of need warrant a reprioritization. Through a variety of tools including the Mobilizing for Action and Partnership Program (MAPP), LHDs have begun to develop strategic policy focus areas for 21st-century LHDs (Gass et al., 2010). These strategic policy focus areas include addressing health equity, optimizing the use of technology, and enhancing and mobilizing partnerships (Fairchild et al., 2010). These strategic focus areas can serve as a guide to action, a new way of operating and of disseminating information about the old core functions of assessment, assurance, and policy development. For example, addressing health equity would incorporate a social justice component. As for optimizing technology, public health must begin to look past traditional forms of communication. Newer technologies, favored by Generation Y, must be explored. YouTube, podcasts, text messaging, and targeted Facebook and Twitter campaigns will reach a wider audience of young people. Finally enhancing and mobilizing partnerships will be the only way local public health will be able to sustain itself in the future. Leveraging the resources of technology firms, advocacy and religious groups, colleges and universities, foundations, and other governmental agencies such as police, fire, and public works will stretch funds and show the value of LHD contributions to the larger population.

Conceptualizing strategic focus areas necessitates adjustments to the essential services as they are currently presented. These proposed changes are not meant to eliminate the traditional essential services, but to serve as reframing the work of local governmental public health in a way that is attractive to future generations of public health workers. The services provided by public health entities of the 21st century can be articulated in the following five categories:

1. *Environmental stewardship is an important part of the future of public health.* Generation Y has no memory of a world where global warming was not an issue. In today's society, where willful ignorance toward the issues affecting our climate and environment occurred, Generation Y has the human capital to finally end the debate about pollution. But it is

- not just global warming, previous generations have abandoned industrial worksites all over the United States. Although rehabilitation of brownfields has occurred, it will be up to Generation Y to make sure that the land is used responsibly and equitably.
2. *Responsible urban development is linked with environmental stewardship, such that new development must be green, energy efficient, and sustainable.* In addition, LHDs can work with developers, city development authorities, and academics to development and implement Health Impact Assessments for new projects, similar to environmental impact assessments.
 3. *Quality, affordable housing is something that LHDs can ensure.* Through lead abatement and indoor air quality initiatives, LHDs can work to eliminate many chronic diseases attributable to older housing stock. Technology innovation such as portable lead testers, free distribution of high-quality vacuum cleaners, and partnerships with “green” contractors can improve the health of the population with no direct medical intervention.
 4. *Access to healthcare.* With the increased attention to prevention prominent in the new health care law, LHDs should be front and center in implementing prevention efforts. Working with the community, local public health can serve as the gateway to preventive services. LHDs, in concert with Federally Qualified Health Centers, should be the focal point of prevention, and providing access to care for those who need it.
 5. *Responsible economic development addresses issues related to the rebuilding of America’s economic infrastructure.* One example that affects many urban and rural areas is a lack of healthy food options. The goal is to provide access to fresh produce, dairy, and other quality foods at competitive prices. Either through grocery stores or farmer’s markets, this type of development will create jobs while alleviating the shortage of healthy foods. Another example would be for LHDs to champion the expansion of “green” manufacturers, such as wind, solar, and battery. Again, this will create jobs while developing technologies that will improve the health and well-being of the entire population.

DISCUSSION

This article calls for LHDs to reconceptualize the core functions and essential services that guide the work of public health agencies. This reconceptualization into strategic policy focus areas recognizes that LHDs need to do things differently to proactively respond to two fundamental changes confronting virtually all organizations, changes in funding structures and changes in the workforce. Baby Boomers and Gen Xers currently hold leadership positions in LHDs. However Gen Ys are coming and have very different expectations. Their values are consistent with the strategic policy focus areas outlined above. Gen Ys are technologically savvy and are engaged in their communities using their expertise to fight for social justice. They seek a balance in their lives, focusing on their careers but also on their personal lives. To inspire them to achieve great things in the workplace, LHDs must view them as just one of the many “communities of partners” (Fairchild et al., 2010) with whom they partner to realize successful outcomes for each of the strategic policy focus areas. Inspiring young workers requires LHDs to rethink how they lead people. Traditionally administration of public agencies has been characterized by bureaucratic processes focused on rationality and efficiency and concomitant leadership practices. This can unwittingly undermine morale, particularly that of the Gen Y workforce, and, in turn, the effectiveness and efficiency of the agency. Leadership in public health agencies must instead share a vision of the future as articulated in the strategic policy focus areas and provide workers the resources to make that future a reality. Leadership must also create a workplace culture that is collaborative and empowers employees. Leaders must also show that they respect their employees as individuals, openly communicating with them including listening respectfully to what they have to say. Finally leaders need to be open, trusting and ethical.

The challenge for public health leaders is to make these changes in an uncertain budget environment. Over the past decade, disproportionate increases in funding for terrorism preparedness have crippled the ability of local public health departments to focus on disease prevention (Levi et al., 2007). However, this should not be seen as a complete setback for public health because it exposed how vulnerable our population is when the focus shifts from disease prevention. Between the need to increase local public health budgets and capacity through grants and new opportunities to transform the focus of the American health care system to a prevention-focused model, a once in a generation opportunity to shape the future of our country lies at the feet of current local public health leadership. By embracing the flexibility that exists outside of traditional local tax levy funding, local public health leadership can ensure the viability of local public health for years to come.

Public health has a vital role to play in the future viability of the U.S. and other nations around the world. However public health must capitalize on the convergence of two powerful forces, changing funding structures and a changing workforce, to ensure its viability well into the future. Reconceptualizing the Core Functions and Essential Services into strategic policy focus areas is a first step in formulating a new future for public health agencies and the populations they serve. To realize the desired outcomes, public health agencies need to embrace a social work paradigm and a workforce with dramatically different values, attitudes and beliefs that what currently exists.

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