Tracking the Impact of Policy Changes on Public Health Practice

In the wake of the US presidential election, there has been extensive reaction in the scientific literature as well as the popular media regarding the potential policy changes of the new administration and their likely impact. It is human nature to react to change, as we have evolved as a species to react to threats—real or imagined. A key challenge for us in public health is to consider how we anticipate and respond to policy changes by showing their actual impact, rather than responding to our fears of what may happen.

ACTIVE SURVEILLANCE

In public health practice, when new public health threats emerge or have the potential to do so, we establish active surveillance systems. Surveillance is the act of systematically collecting, collating, and analyzing health-related information that can be communicated on a timely basis to guide action.[1] Sentinel surveillance is one form of surveillance that can serve as an early warning system in efforts to identify health threats that require rapid action.[2] Sentinel surveillance systems, such as the Centers for Disease Control and Prevention's US Outpatient Influenza-like Illness Surveillance Network,[3] provide the early red flag, the proverbial canary in the mine, that alerts public health to a threat requiring action. Can we do the same for the impacts of policy change on public health practice?

We already have examples of policy surveillance from federal and voluntary agencies that have developed policy surveillance systems for tobacco, alcohol, and school-based nutrition and physical education.[4] In an effort to separate fact from fear by identifying actual impacts of policy change, we have established a Sentinel Practitioner Surveillance System for Policy Change Impact. A diverse group of local and state-level public health officials were invited by *AJPH* Associate Editor Paul Erwin to participate in the sentinel surveillance system. Aspects of geography, population demographics and density, public health agency organizational structure and reach, and recent political context were the primary characteristics explored in considering whom to invite to participate. The makeup includes 12 public health practitioners, representing eight specific sites (three state health officers; five local health directors or officers): two states in the South, one state in the Northeast, two states in the Midwest, one state in the Mountain West, and two states in the West, as well as Tribal Health (Native American/Indian) and Territorial Health (Pacific Islands). They are a mixture of red, blue, and purple; urban and rural.

EXECUTIVE ORDER ON IMMIGRATION

The sentinel practitioner surveillance system was launched in January 2017. It is anticipated that on a monthly basis these practitioners will be actively surveyed regarding what they are actually experiencing in public health practice as a result of policy change, without any preconceived notions of whether policy changes may have positive or detrimental effects. Given the usual time lag in tracking policy change, we expected at least a few months to pass before identifying any actual impact. Then came President Trump's Executive Order on Immigration (officially, Executive Order on Protecting the Nation From Foreign Terrorist Entry Into the United States). Almost immediately there were anecdotal reports in the popular press regarding the impacts—health and otherwise—of the immigration ban.

In a first effort to separate fact from fear, the following question was sent to the sentinel practitioners: "Have you identified public health practice consequences of the Executive Order on Immigration? If so, what are they? If not, have concerns about potential impact prompted you/your agency to action?" What was striking in the responses was how quickly budgets were impacted. The Executive Order was issued on January 27, 2017; the question to sentinel practitioners was sent via e-mail on February 3, 2017; and by February 10, 2017, nine responses had been received. Although the responses included "I've queried my colleagues in [my area of representation] and I am not hearing any public health impacts as a result of the Immigration ban"; "I don't think we have been notified of any actual changes/impacts at this time"; and "No definite impact [here] yet that I know of. . . ."; three noted immediate budgetary impact:

1. A notice of $90 000 mid-year cut (from $410 000) in our refugee health program with the expected 30% decrease in refugees sent to our county. Other jurisdictions in [our state] have heard the same.
2. In [state], Local Public Health runs a Refugee program for health screenings, and referral to our medical community. . . . With the Executive Order we are now in a three-month "hold." We are not serving or screening any refugees which is impacting our staff that provide those services. With no income to support this population, and no income to pay these medical professionals that conduct the screenings, we are trying desperately to hold on to these staff and pay them from other resources for this time period.
3. We were notified of a 30% cut in our refugee health program. There are concerns about the amount of information that is stored within our data systems that reveal a client's immigration status though we do not directly ask that question.

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SEPARATING FACT FROM FEAR

Why establish this surveillance system now? President Trump has promised to make fundamental policy changes that are vitally important to the public's health, from repealing the Affordable Care Act, to environmental deregulation, to issues pertaining to women's health. Words and executive orders—Twitter or otherwise—have real consequences, both intended and unintended. What do we do with these responses from the practitioners? In an active sentinel surveillance system for an emerging infectious disease, the early identification of new events are meant to serve as alerts—information that suggests further searching for additional cases is warranted. They are not meant to be generalizable—we would not, by corollary, report that "25% of surveyed practitioners reported budget cuts in response to the Executive Order on Immigration." We are aware that the relatively small sample size of this surveillance system is a limitation and may present reporting bias. We will be careful in the types of questions we pose, their frequency, and our reporting of the responses. The role of *AJPH* is to inform, not act as a watchdog. What we will report on through this sentinel practitioner surveillance system is what a handful of committed public health professionals are experiencing first-hand—good or bad—as an early indication that the fact of change, not the fear of change, needs further light. This reporting will not substitute for peer-reviewed scholarly work published in *AJPH*; rather, by bringing issues to light, we hope to provide clues that can be further investigated by scholars or that can be useful for editors in examining or soliciting papers submitted to the *Journal*. AJPH

Paul C. Erwin, MD, DrPH,
for the Sentinel Public Health Practitioner Surveillance group

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Names of individual practitioners held by *AJPH* editors to ensure confidentiality.

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Areas of Concern for Public Health

The election of President Donald J. Trump was a seismic event in American political history, and the aftershocks are being felt throughout the country—in governments at all levels, in the private sector, and in families. Many despaired at this surprising outcome, and many rejoiced at the opportunity for significant change in our national politics and policies. Regardless of one's personal political affiliation or philosophy, there is a general sense of consternation related to uncertainty about some of the president's proposals.

It has reminded me of a favorite film, *High Anxiety* (1977), Mel Brooks's humorous parody of Alfred Hitchcock movies, in which Mr. Brooks plays a very anxious psychiatrist who manages to dodge a series of perilous events. Many Americans, and certainly public health professionals, now seem to be in a similar state of high anxiety and for good reason because of the possibility of budget cuts, decreased enrollment in Medicaid, weakening of environmental regulations, and diminished access to reproductive health services. Unlike the Mel Brooks movie, there is nothing funny about the potential for significant changes in policies that could have a deleterious impact on public health and undermine our nation's public health infrastructure.

AFFORDABLE CARE ACT REPEAL

One of President Trump's top priorities is to repeal the Affordable Care Act (ACA), which he emphasized by issuing an executive order on January 20, 2017, titled "Executive Order Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal." He made clear his Administration's commitment to repeal the law and in the meantime to delay further implementation.

However, he has found, along with his supporters in the Congress who favor repeal of the ACA, that replacing "Obamacare" will not be easy, and the timetable for doing so has been pushed back. Notwithstanding the difficulties of replacing, or "repairing" the ACA (as Senator Lamar Alexander recently characterized efforts in the Senate), there is reason to be concerned that the many public health provisions in this law that could also be repealed.

BUDGET CUTS

The ACA included authorization of the Prevention and Public Health Fund "to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public health care costs" (https://www.cdc.gov/funding/pphf). Of the $1 billion authorized annually for this, more than $892 million was to be transferred to the Centers for Disease Control and Prevention for activities to address heart disease, tobacco control, diabetes prevention, and other critical public health priorities. The ACA authorized $18.75 billion for the fund between fiscal years 2010 and 2022,

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