

The Basics

THE PUBLIC HEALTH SERVICE

HISTORY

The creation of the U.S. Public Health Service (PHS) dates to 1798 when Congress passed an act authorizing the provision of medical care to merchant seamen. The Marine Hospital Service, as it became known, was led by a supervising surgeon, a position later called the surgeon general. The first supervising surgeon created a uniformed service medical branch of the Marine Hospital Service, which was authorized as the Commissioned Corps in 1889. The Marine Hospital Service's responsibilities first expanded beyond providing direct care to merchant marines in the late 1800s when it was enlisted to help fight a yellow fever outbreak. Over time, its scope and responsibilities continued to change to reflect contemporary public health needs—from quarantine authority to immigrant medical inspection to conducting biomedical research, regulating vaccines, and fighting influenza and HIV/AIDS. Its name evolved from the Marine Hospital Service to the Public Health and Marine Hospital Service in 1902, and then to the current PHS in 1912.

The most recent modification to this act was signed into law on June 12, 2002, a 28th title created by the Public Health Security and Bioterrorism Preparedness and Response Act (P.L. 107-188).

The service was originally administered by the Treasury Department and was transferred to the Federal Security Agency by President Franklin D. Roosevelt. That agency became the Department of Health, Education, and Welfare (DHEW) in 1953. In 1968, management authority for the PHS was transferred from the surgeon general to the assistant secretary for health and scientific affairs, DHEW. Until then, the PHS had always been led by a commissioned officer. This reorganization changed the role of the surgeon general to that of an adviser and spokesperson on public health and opened PHS leadership positions to persons outside the Commissioned Corps. At the time of the reorganization, the Food and Drug Administration (FDA) and National Institutes of Health (NIH) were operational, and all other functions of today's PHS agencies were bundled in an agency called the Health Services and Mental Health Administration. In 1980, DHEW became the Department of Health and Human Services (DHHS). One final structural change occurred in 1995, when the PHS agencies began to report directly to the Secretary of DHHS, instead of the assistant secretary for health.¹

COMPONENTS OF THE PUBLIC HEALTH SERVICE

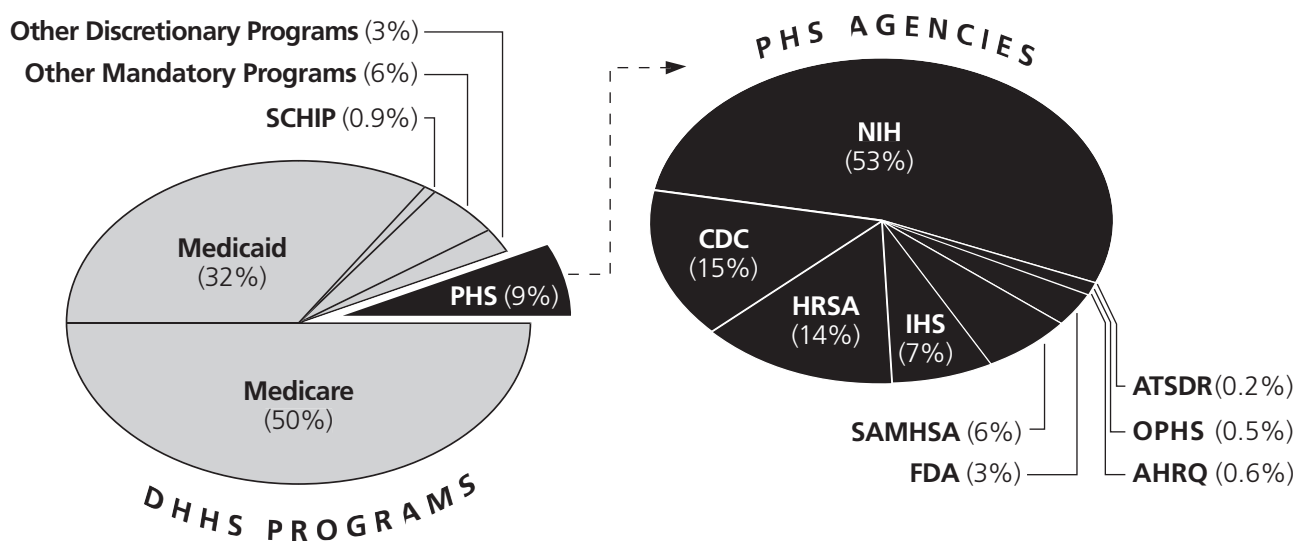
Today’s PHS consists of the Office of Public Health and Science (OPHS) (under the purview of the assistant secretary for health), which houses the Office of the Surgeon General and the Commissioned Corps, among other offices, as well as eight agencies that are listed here in descending order, according to their budgets:

- National Institutes of Health (NIH)
- Centers for Disease Control and Prevention (CDC)
- Health Resources and Services Administration (HRSA)
- Indian Health Service (IHS)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- Food and Drug Administration (FDA)
- Agency for Healthcare Research and Quality (AHRQ)
- Agency for Toxic Substances and Disease Registry (ATSDR)

THE DHHS AND PHS BUDGETS

In terms of the DHHS budget, the PHS is dwarfed by the Centers for Medicare & Medicaid Services whose programs—Medicare, Medicaid, and SCHIP (the State Children’s Health Insurance Program)—consume 83 percent of DHHS spending. In contrast, the PHS budget accounts

FIGURE 1
Fiscal Year 2005 Budgets for Programs of DHHS (left) and the PHS Agencies (right), in Percent



Source: DHHS FY 2006 Budget in Brief; available at www.hhs.gov/budget/FY2006BudgetinBrief.pdf.
 Totals do not add to 100 percent due to rounding of figures.

for 9 percent of the total DHHS budget.² The opposite is true in personnel terms. In FY 2005, PHS personnel constituted about 83 percent of all DHHS personnel compared with 7 percent for CMS.

The House and Senate Committees on Appropriations each have a Subcommittee on Labor, Health and Human Services, and Education that has jurisdiction over the appropriations for all of the PHS except for the FDA (which is governed by the Subcommittee on Agriculture, Rural Development, and Related Services), the IHS (Subcommittee on Interior, Environment, and Related Agencies), and ATSDR (Subcommittee on Interior, Environment, and Related Agencies). The budget figures in Table 1 reflect program-level budgets, meaning they include the base appropriation plus any user fees collected and any transfers of money between agencies and offices within DHHS. AHRQ has no base appropriation; its entire budget is generated through interagency transfers.

TABLE 1
PHS Component Budgets for
Fiscal Years 2003, 2004, and 2005 (in billions)

Agency	FY 2003	FY 2004	FY 2005
NIH	\$ 27.18	\$ 28.04	\$ 28.65
CDC	6.94	7.21	8.03
HRSA	7.02	7.19	7.37
IHS	3.54	3.71	3.77
SAMHSA	3.21	3.35	3.39
FDA	1.65	1.70	1.80
AHRQ	0.31	0.30	0.32
OPHS	0.17	0.21	0.26
ATSDR	0.08	0.07	0.08
TOTAL PHS	\$ 50.10	\$ 51.78	\$ 53.67
TOTAL DHHS*	\$505.45	\$542.01	\$583.96

*This figure is total DHHS outlays.

Source: Compiled from the President's budget documents for fiscal years 2004, 2005, and 2006; available at www.dhhs.gov/budget/docbudget.htm. These are program-level budgets which reflect agency and office base appropriations as well as any transfers or collections they received.

PHS COMPONENT DETAILS

The NIH is by far the largest of the PHS agencies in budgetary terms, and its 27 institutes and centers are the focal point for federal funding of biomedical research. Between FY 1998 and FY 2003, the agency benefited

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from a congressional and administration focus to double its budget from \$13.72 billion to \$27.18 billion. About 80 percent of its budget is distributed as research grants across the country (extramural) while the remainder is used to conduct research “in house” (intramural). The larger budget has brought increased scrutiny to the NIH, with Congress and the press raising concerns regarding potential conflicts of interest for NIH scientists who participate in private sector research activities while simultaneously administering extramural grants, as well as more general questions about the agency’s research priorities.

The **CDC** seeks to protect the public health and safety by controlling and preventing disease as well as promoting healthy behaviors. Its traditional focus on infectious disease has expanded over the years to include environmental and behavioral threats to health. The agency’s predecessor was established in Atlanta, Georgia, to fight malaria in the southern states during World War II, and the current organization continues to be headquartered there. In the wake of the anthrax exposures in 2001, the CDC gained prominence as a leader in the nation’s response to and preparation for bioterrorist events. The agency continues to work with states and communities to improve the public health system’s preparedness for future incidents. The agency began a major reorganization in 2005, which includes the consolidation of seven existing national centers into four new coordinating centers that focus on environmental health and injury prevention, health promotion, infectious diseases, and health information and services.

ATSDR was created by Congress in 1980 to implement the health-related activities of the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA) of 1980, commonly known as the Superfund Act. In that role, the agency assesses the health hazards of Superfund sites, works to prevent or reduce further exposure, and strives to expand the knowledge base about the health effects of exposure to toxic substances. The director of the Centers for Disease Control and Prevention serves as the administrator of ATSDR.

HRSA works to expand access to quality health care services with particular emphasis on low-income, uninsured, and vulnerable populations through five bureaus: the Maternal and Child Health Bureau, the Bureau of Primary Health Care, the Bureau of Health Professions, the HIV/AIDS Bureau, and the Healthcare Systems Bureau. The agency also houses the Federal Office of Rural Health Policy, which advises the DHHS Secretary on rural health policy issues. HRSA’s budget is dominated by the community health centers program and the Ryan White HIV/AIDS activities. Starting in 2001, HRSA began focusing on expanding the community health centers program over a five-year period. Despite increases to that program, HIV/AIDS activities continue to constitute the agency’s largest program, consuming \$2.07 billion of a total \$7.37 billion budget in FY 2005.

The **IHS** strives to provide comprehensive, culturally appropriate personal and public health services to American Indian and Alaska Native

people. The more than 560 federally recognized tribes across the country are sovereign nations and therefore maintain a government-to-government relationship with the United States, meaning that they interact directly with federal departments instead of working through any state or local government intermediary. The IHS uses just under half of its budget to directly administer its own health care system. The other half of the budget is transferred to tribal governments under the Indian Self-Determination and Education Assistance Act of 1975 so they can manage their own health care services.

SAMHSA's mission is to address the needs of people with or at risk for mental health and substance abuse problems. Most of the agency's funding is distributed as block grants to states through the Center for Mental Health Services, the Center for Substance Abuse Prevention, and the Center for Substance Abuse Treatment. As part of the government-wide New Freedom Initiative, President Bush established the New Freedom Commission on Mental Health to identify and address problems in the current mental health system. As a result of recommendations in the Commission's report, SAMHSA is working to transform the nation's mental health system through a new grant program to states. On the substance abuse treatment side, SAMHSA has created the Access to Recovery program, a state voucher program that gives consumers greater provider choice and seeks to improve the capacity of state and local governments to provide services. The agency is also promoting adoption of evidence-based practices in mental health services and substance abuse treatment and prevention.

The **FDA**, which is primarily a regulatory agency, conducts and coordinates research to ensure safety and efficacy and sets uniform standards for food, drugs, cosmetics, biological products, medical devices, and radiation-emitting products. The FDA collects substantial user fees from the companies whose products it evaluates (fees accounted for \$350 million out of the agency's \$1.8 billion budget in FY 2005), which has fueled debate about the potential for industry influence in FDA regulation. The agency's evolving role in the area of drug safety is frequently discussed as it relates to its ability to ensure the safety of prescription drugs imported from other countries and the safety of certain drugs once they have already been approved and gone to market. The FDA and the U.S. Department of Agriculture (USDA) share responsibility for regulating food. The FDA regulates all domestic and imported food, including shell eggs, but does not regulate meat and poultry. (The USDA regulates domestic and imported meat and poultry and processed egg products.) The DHHS and USDA jointly publish the *Dietary Guidelines for Americans* every five years.

AHRQ is the health services research complement to NIH's biomedical research. Created in 1989 as the Agency for Health Care Policy and Research (AHCPR), the Agency for Healthcare Research and Quality was renamed during its last reauthorization in 1999 to emphasize its focus on

research pertaining to health care quality. Its predecessor was the National Center for Health Services Research, created in 1968 as part of the Health Services and Mental Health Administration. The center was located in the Office of the Assistant Secretary for Health at DHHS from 1978 to 1989, when it became AHCPR. In the first years after its authorization as AHCPR, some provider organizations voiced concerns that the agency was overstepping its role by developing federal clinical guidelines and standards of practice. Since then, AHRQ has shifted its focus to building the evidence base for quality health care for patients, clinicians, administrators, and policymakers, as opposed to setting guidelines or standards.

The **OPHS** is home to the Office of the Surgeon General, the Office of Women's Health; the Office of Population Affairs, the Office of Minority Health, the Office of HIV/AIDS Policy, the Office of Disease Prevention and Health Promotion, the National Vaccine Program Office, the Office for Human Research Protections, the Office of Research Integrity, the President's Council on Physical Fitness and Sports, and the Regional Health Administrators. The 6,000-member Commissioned Corps is under the purview of the Office of the Surgeon General. It is a mobile group of health professionals prepared to respond to emergencies and also promote health in a variety of clinical and administrative positions. Commissioned Corps officers are largely employed by the PHS agencies described above.

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ENDNOTES

1. John L. Parascandola, in *A Historical Guide to the U.S. Government*, George Thomas Kurian, Ed. (New York: Oxford University Press, 1998), 487–493, available at http://lhncbc.nlm.nih.gov/apdb/phsHistory/resources/phs_hist/pub_phs01_text.html.
2. These percentages are derived from mandatory and discretionary program total outlays in relation to total DHHS outlays for FY 2005.



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