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Introduction to the Supplement

Twenty Local Health Departments, 46 Million People

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Big City Health Departments: Leadership Perspectives highlights innovative strategies and programs of the health commissioners of the largest American cities. Led by Drs Jonathan Fielding of Los Angeles and Thomas Frieden of New York City, the commissioners formed the Big Cities Health Coalition (BCHC) in 2002 to reflect their needs as distinct from those of the many smaller jurisdictions across the country. Working together, these cities have used their combined resources and experience to formulate new strategies and solutions to address common challenges.

Originally based in New York City under the direction of Dr Frieden and then Dr Thomas Farley, it is now housed at the National Association of County and City Health Officials in Washington, DC, the association serving all 2800 local health departments (LHDs) across the country.[1] Since 2012, the coalition has been supported by the de Beaumont Foundation and the Robert Wood Johnson Foundation. A needs assessment was performed in 2013 to identify the greatest policy and technical and human capital needs across the member cities.

The 20 members of the BCHC serve approximately 46 million people, or about 15% of the current American population.[2] The cities currently included are Boston, New York, Philadelphia, Baltimore, Washington, Atlanta, Miami, Detroit, Cleveland, Chicago, Denver, Dallas, Houston, San Antonio, Phoenix, San Diego, Los Angeles, San Jose, San Francisco, and Seattle. These cities are defined by their large populations and population density as well as by an "urban core," with areas of concentrated poverty, health disparities, violence, and crime.

The abilities of these health departments reflect their size, their geography, and the range of interests of their jurisdictions. All are working in an environment shaped by significant budget reductions from the recession of 2008, with the simultaneous national need to reduce overall health care costs. All are trying to respond to the unique challenge and opportunity of the Patient Protection and Affordable Care Act (ACA) and to change our current national "health care" program to a "health" program emphasizing population health.

Population health has long been a concern of public health; the triple aims of a "health" program[3]—access, quality and cost savings—are the meat and potatoes of health departments, as is emergency preparedness and response. The more classic public health challenges, infectious disease, sanitation, food, and water safety, for example, continue.

The BCHC commissioners are increasingly called upon to develop a wide range of policies, as their cities are typically on the forefront of emerging challenges. These commissioners have been innovators with the talent, technical competence, and diversity of viewpoint to find innovative policies for population health. Moreover, the BCHC members have emerged as nimble and thoughtful policy makers in the current national political climate of state and federal gridlock, and can serve as examples to other local, state, and national leaders.[4-7]

In this supplement, Jonathan Fielding[8] provides an inspirational charge to all health department leaders. Subsequent articles provide specific recommendations on a wide range of topics that should serve all LHDs

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as they reconsider their organizational and community needs in light of the ACA. In some sense, all of these articles reflect on policy; however, more specific pieces on policy include those by Leider et al,[2] Choucair et al,[9] and Hearne et al.[10] Aragón and Garcia[11] focus on change management during these times of austerity and policy change.

Hearne et al[10] highlight the increased policy-level activity of BCHC member health departments at the local, state, and federal levels. For example, 11 BCHC commissioners signed a joint letter to Federal Drug Administration (FDA) Commissioner Margaret Hamburg urging the FDA to "follow our lead and use your full authority to apply all current tobacco regulations to e-cigarettes." BCHC leaders from Boston, Chicago, Los Angeles, and New York then held a congressional briefing earlier this year. Several BCHC member cities have proposed or enacted laws regulating the sale and advertising of e-cigarettes that are stricter than those proposed by the FDA.

BCHC member commissioners' interest in policy is reflected in their selection of "health in all policies" as a top priority in our recent survey. Wernham and Teutsch[12] detail this perspective and highlight "health in all policies" work in Boston, Seattle, and Washington. They also discuss health impact assessment as a tool for implementing a "health in all policies" approach. Through a funding opportunity made available by the de Beaumont Foundation, 3 cities—Chicago, Boston, and Phoenix (Maricopa County)—that identified "health in all policies" as a priority will begin to gain experience in health impact assessment in the upcoming year.

Articles on the ACA include Williams'[13] review of leveraging the ACA to improve health, England's[14] discussion of billing for services, and Schlenker and Huber's[15] consideration of Medicaid waivers. Leider et al[16] report on the anticipated effect of health care reform on LHDs' clinical and population-based services. Castrucci et al[17] and Choucair et al[9] emphasize the role of data, and Lumpkin[18] discusses the culture of health in big cities. Ferrer and Conley[19] firmly place public health in the realm of emergency preparedness, as stressed by Fielding.[8] Finally, Lloyd Novick,[20] the founding editor of this journal, provides a summary and places this issue in historical context.

The de Beaumont Foundation and our partner, the Robert Wood Johnson Foundation, have invested in the BCHC to support innovation within the member health departments and to promote their collective impact. These strategies and perspectives should serve all LHDs considering their organizational and community needs.

In closing, as the head of the de Beaumont Foundation, I would like to point out that we uniquely support governmental public health and we like "boots on the ground" projects. We believe that investment in the BCHC not only benefits the members themselves but also the entire public health system. Supporting innovation where it is most likely to occur and encouraging subsequent diffusion for uptake among a broader audience can be an effective strategy for systems change. We believe that this group of leaders is poised to make significant improvements in the overall health landscape in this country.

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