

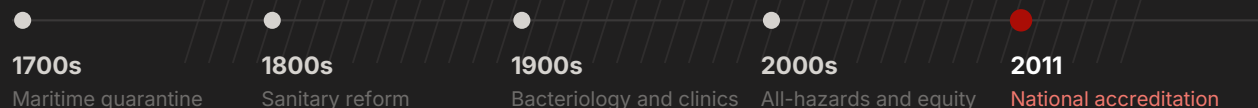
WHITE PAPER NO. 1 · POLICY ANALYSIS · HEALTH SYSTEMS GOVERNANCE & PUBLIC HEALTH LAW

Resolving the Disarray

How Constitutional Federalism and Reactive History Created Public Health Inequity, and How National Accreditation Resolves It

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AccrediQI Academy · October 2026



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About this white paper

This policy analysis traces how the reactive history of American public health and the constitutional design of federalism produced wide variation in public health protection, and how national accreditation offers a remedy that respects state sovereignty. It is White Paper No. 1 in the AccrediQI Academy White Paper Series and provides the context for White Papers No. 2 and No. 3 on the Accreditation Coordinator workforce.

Suggested citation

Mando, J. (2026). *Resolving the disarray: How constitutional federalism and reactive history created public health inequity, and how national accreditation resolves it* (White Paper No. 1). AccrediQI Academy. <https://accrediqi.com>

Keywords

public health accreditation; PHAB; federalism; Tenth Amendment; police power; fiscal federalism; categorical grants; 10 Essential Public Health Services; Foundational Capabilities; quality improvement

SUMMARY

Abstract

For more than a generation, governmental public health in the United States has grappled with deep geographic disparities in service delivery, institutional capacity, and population health outcomes. When the Institute of Medicine (IOM) declared in 1988 that public health was "in disarray," it identified two structural root causes: the absence of consensus on the core mission of public health, and organizational fragmentation across levels of government.

This article traces the historical and constitutional architecture of that disarray. It examines how public health evolved through reactive, episodic responses to crisis, from eighteenth-century maritime quarantine to twenty-first-century environmental and biological threats, producing a fragmented, piecemeal scope of practice. It then analyzes how constitutional federalism and the Tenth Amendment institutionalized vertical and lateral fragmentation, producing structural divergence across centralized, decentralized, and mixed governance models, while fiscal federalism, through categorical and block grants, reinforced programmatic silos.

Finally, it shows how voluntary national accreditation administered by the Public Health Accreditation Board (PHAB), built on the 10 Essential Public Health Services and the National Public Health Performance Standards, resolves this historic paradox. By establishing nationally recognized standards and Foundational Capabilities without infringing on state police powers, accreditation reconciles local autonomy with consistent quality assurance and continuous quality improvement.

THE ARGUMENT AT A GLANCE**Part I · History**

Public health grew by reacting to crises, so its scope differs from place to place.

Part II · Federalism

The Constitution leaves health powers to the states, so structures and funding diverge.

Part III · Standards

The Core Functions and 10 Essential Services defined scope but could not assure quality.

Part IV · Accreditation

PHAB sets a national baseline of capability while preserving state sovereignty.

INTRODUCTION

Introduction: The Enduring Paradox of Public Health "Disarray"

In 1988, the IOM published what remains the most influential assessment of American governmental public health, *The Future of Public Health*. The committee's diagnosis was unsparing:

"This nation has largely lost sight of its public health goals and has allowed the system of public health activities to fall into disarray."

Institute of Medicine (1988, p. 19)

At the center of this disarray was a structural failure: wide, unjustifiable variation in the scope, capacity, and quality of public health protection depending on where a person lived. One county might offer strong chronic disease surveillance, comprehensive maternal and child health clinics, and rigorous environmental enforcement, while a neighboring municipality or state lacked even basic sanitary oversight or communicable disease tracking.

The IOM attributed this inequality to two foundational weaknesses (IOM, 1988, p. 107):

Root cause	What it meant in practice
No consensus on the mission	The scope of public health was defined ad hoc by local politics, selective crises, and fiscal convenience.
Organizational fragmentation	Relationships among local, state, and federal government were fractured, and internal programs were insulated from one another.

In the decades since, researchers, state health officers, and federal leaders recognized that resolving this disarray required more than incremental grant investment. It required a structural mechanism able to reconcile two seemingly incompatible imperatives: respecting the constitutional sovereignty of states while guaranteeing a baseline of public health protection for every American. That mechanism is the national voluntary accreditation program governed by PHAB.

To see why accreditation is such an important institutional breakthrough, we must examine the two engines that historically generated variation in American public health: the reactive trajectory of its history, and the constitutional mechanics of federalism.

PART I · HISTORY

I The Reactive Evolution of the Public Health Mission

The lack of consensus about an essential baseline of public health services is not an accident of administrative neglect. It is the direct consequence of how governmental public health evolved in the United States: not through deliberate, forward-looking design, but through episodic responses to acute crises.

Figure 1. Four eras in the reactive expansion of the public health mission

18TH CENTURY Maritime containment	19TH CENTURY Sanitary awakening	20TH CENTURY Bacteriological revolution	21ST CENTURY All-hazards and equity
Quarantine and isolation in port cities	Water, sewage, refuse, and vital statistics	Laboratories, immunization, and clinics	Preparedness, climate, equity, and informatics

Each era added new functions on top of the last, unevenly and in response to crisis rather than design.

1. Maritime containment in the eighteenth century

In the colonial and early national eras, governmental public health was conceived almost entirely as an emergency border defense. Spurred by outbreaks of yellow fever, cholera, and smallpox carried by maritime trade and immigration, colonial and early municipal assemblies enacted ad hoc quarantine and isolation mandates (Hanlon & Pickett, 1984; IOM, 1988). Early boards of health were temporary committees in port cities such as Boston, New York, Philadelphia, and Charleston, charged with inspecting ships and isolating infected travelers. Inland settlements and rural communities faced different exposures and developed no comparable infrastructure. From the republic's beginning, public health was defined geographically and episodically.

2. Urbanization and the nineteenth-century sanitary awakening

Industrialization brought unprecedented urban crowding and squalor. Contaminated wells, uncollected refuse, and absent sewage disposal produced endemic typhus, tuberculosis, and infant diarrhea. Prompted by landmark sanitary investigations, most notably Edwin Chadwick's 1842 report in Great Britain and Lemuel Shattuck's 1850 *Report of the Sanitary Commission of Massachusetts*, public health shifted from episodic quarantine to environmental and municipal sanitation (Shattuck, 1850; Winslow, 1923).

Jurisdictions created permanent local boards of health to oversee refuse management, clean water, drainage, and the systematic collection of vital statistics. Implementation remained highly uneven: affluent, progressive cities invested in water filtration and sanitary inspection, while rural districts and poorer regions retained little governmental presence.

3. The bacteriological revolution and clinical expansion in the twentieth century

Germ theory, pasteurization, Koch's postulates, and immunology redefined the public health portfolio in the late nineteenth and early twentieth centuries. Quarantine and general sanitation were supplemented, and often overshadowed, by laboratory science, immunization campaigns, contact tracing, and personal clinical care (Starr, 1982; Winslow, 1923).

State and local agencies established diagnostic laboratories, tuberculosis sanatoria, maternal and child health clinics, and venereal disease dispensaries. As the century progressed, the line between population-based prevention and individual medical care blurred. Some health departments became safety-net providers for the poor; others limited themselves to regulatory inspection and vital records.

4. The twenty-first-century horizon: all-hazards, climate, and informatics

The 2001 anthrax attacks and subsequent federal legislation institutionalized public health emergency preparedness, demanding bioterrorism and disaster readiness (Kapur & Smith, 2011). Rising chronic disease, structural racism, climate change, and the COVID-19 pandemic further pushed agencies to integrate climate resilience, health equity, and modern informatics into their work (CDC, 2015; DeSalvo et al., 2016).

The cumulative consequence: wide variation in scope

Because each new layer of function was added incrementally, during moments of acute vulnerability, public health infrastructure developed unevenly across the country:

"All of the states in the United States are involved in some manner in sanitation, laboratory investigation, collecting vital statistics, regulation of the environment, epidemiology, administering vaccines, maternal and child health, mental health, and care of the poor. How local systems conduct these programs differs greatly from area to area."

Institute of Medicine (1988, p. 71)

Without an authoritative definition of what a health department fundamentally owes its community, local political convenience determined whether an agency provided comprehensive, population-level health promotion or simply inspected septic tanks.

PART II · FEDERALISM

II Constitutional Federalism and Structural Fragmentation

If reactive history explains why the scope of public health became fragmented, constitutional federalism explains why that fragmentation became permanently embedded in governmental structures.

1. The Tenth Amendment and state police powers

The U.S. Constitution makes no direct reference to health or public health. Under the Tenth Amendment, powers not delegated to the federal government are reserved to the states or to the people. The primary legal authority to protect the public's health, safety, and welfare, the police power, therefore rests with the states (Gostin & Wiley, 2016; Parmet, 2007).

This allocation provides valuable flexibility, allowing states and localities to tailor their responses to local cultural and ecological conditions (Gerston, 2007; Lister, 2005). It also produces two structural side effects:

Vertical disconnect

The federal government has no direct constitutional power to command state or local health departments to carry out specific mandates or follow standardized operating protocols (Turnock & Atchison, 2002).

Lateral disconnect

Each state legislature decides independently how, or whether, it delegates public health authority to counties, municipalities, or regional districts.

2. Three models of public health governance

Exercising that sovereign authority over two centuries, states built very different arrangements for local public health delivery. As Wasserman et al. (2006) and ASTHO (2020) describe, governmental public health operates under three dominant models:

Table 1. The three dominant models of state and local public health governance

Model	How it works	Example
Centralized	Local health units are operational arms of the state health agency, which directs staff, budgets, and policy.	Florida: all 67 county health departments are extensions of the state agency
Decentralized	Local health departments are units of local government, governed by local boards of health or elected officials.	Massachusetts: hundreds of municipal boards of health govern independent towns
Shared or mixed	Authority is divided between state and local government, or varies within a state by jurisdiction.	States where some localities run their own departments while the state serves others

Note. Governance categories follow Wasserman et al. (2006) and ASTHO (2020).

This divergence gave rise to the familiar saying, "If you've seen one health department, you've seen one health department" (Turnock, 2015, p. 114). A local health department in Massachusetts bears little institutional resemblance to a county health department in Florida.

3. The unintended stovepipes of fiscal federalism

Unable to exercise direct command-and-control under the Tenth Amendment, the federal government relied on the power of the purse to steer state and local practice toward national goals (Dilger, 2015; IOM, 1988). Beginning with Title V of the Social Security Act of 1935 and the Partnership for Health Act of 1966, and expanding through later CDC and HRSA investment, federal dollars flowed through two primary mechanisms:

Table 2. The two mechanisms of fiscal federalism and their side effects

	Categorical grants	Block grants
Design	Restricted funds earmarked for narrowly defined purposes, such as childhood lead poisoning, Ryan White HIV/AIDS care, or Title X family planning (Fowler, 1993; Kenadjian, 1966)	Broad funds, such as the Preventive Health and Health Services Block Grant, that states allocate across priority areas (Dilger, 2015)
Strength	Rapidly scales specific clinical or surveillance capabilities	Lets agency leaders invest flexibly across programs
Side effect	Programmatic stovepipes: rules against commingling funds wall programs off from one another and leave agency-wide leadership, informatics, and governance under-resourced (Conlan, 1984; IOM, 2003)	Divergence between jurisdictions: each state sets its own priorities, so baseline services in neighboring states drift further apart

Conlan (1984) described the result as "maladies of program fragmentation and inadequate coordination" (p. 250). An agency's immunization team could be legally and operationally

separated from its chronic disease staff. Federal grants thus reached diminishing structural returns: they rewarded compliance with discrete, vertical program requirements while failing to build a consistent, resilient public health infrastructure.

PART III · STANDARDS

III The Evolution of Standards: Defining Scope Versus Assuring Quality

By the early 1990s, public health leaders recognized that neither categorical grants nor crisis funding could overcome the system's disarray. The field needed a shared framework.

1. Defining the scope: the Core Functions and the 10 Essential Public Health Services

The IOM (1988) first distilled governmental public health into three Core Functions:

Assessment

Systematic collection, analysis, and sharing of community health data

Policy development

Formulating evidence-informed policy that serves the public interest

Assurance

Ensuring that priority personal and community-wide services are available and delivered

In 1994, the Public Health Functions Steering Committee, which included federal agencies, ASTHO, NACCHO, and academic leaders, translated these functions into the 10 Essential Public Health Services, revised in 2020 with equity at the center (CDC, 2020; McCullough & Fenton, 2011). For the first time, there was national consensus on the scope of services a governmental public health system was expected to deliver.

2. The quality gap and the National Public Health Performance Standards

A problem remained. The 10 Essential Services defined *what* public health did, but offered no measures of *how well* it did it (Luo, 2013). Adoption was voluntary, and without concrete thresholds, an agency could claim to "monitor health status" by publishing an outdated census report once a decade.

To close this gap, CDC and national partners developed the National Public Health Performance Standards between 1998 and 2002 (Milhon, 2011). The standards provided instruments for state and local public health systems to assess their performance against the 10 Essential Services. They generated valuable self-assessment data but lacked external accountability, independent peer validation, and meaningful incentives. They described what communities could reasonably expect, but lacked the leverage to ensure agencies built the capacity to deliver it.

Table 3. How successive frameworks addressed the disarray

Framework	Defines scope	Measures performance	External validation
IOM Core Functions (1988)	Yes	No	No
10 Essential Public Health Services (1994; 2020)	Yes	No	No
National Public Health Performance Standards (1998–2002)	Yes	Self-assessment	No
PHAB national accreditation (2011–present)	Yes	Yes	Yes, peer-reviewed

PART IV · ACCREDITATION

IV National Accreditation as the Structural Solution

The long effort to overcome the constraints of federalism without sacrificing local autonomy culminated in the founding of the Public Health Accreditation Board in 2007 and the launch of national voluntary accreditation in 2011. PHAB's standards were updated in Version 2022 and again in the Refreshed Standards & Measures (2026) (PHAB, 2022, 2026).

Accreditation succeeds where traditional federal regulation cannot. It is a voluntary, peer-reviewed, standards-based framework that works across federal, state, and local boundaries.

Figure 2. From disarray to accreditation: key milestones

1988 IOM declares public health "in disarray"	1994 10 Essential Public Health Services	1998 Performance Standards developed (to 2002)	2007 PHAB founded	2011 National accreditation launched	2020 Essential Services revised around equity	2026 Refreshed Standards & Measures
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1. Standardizing Foundational Capabilities across different governance models

PHAB standards do not prescribe how a health department must be organized. A decentralized board of health in Ohio and a centralized state district office in South Carolina can both achieve accreditation. Rather than regulating structure, PHAB standardizes Foundational Capabilities, the operational capacities every community needs, including:

- Public health surveillance, laboratory investigation, and epidemiological analysis
- Community health assessment (CHA) and community health improvement planning (CHIP)

- Health communication, emergency preparedness, and environmental hazard response
- Evidence-based policy development, accountability, and ethical governance

By shifting the benchmark from organizational form to functional capability, accreditation helps ensure that residents receive a reliable baseline of protection whether their agency is centralized, decentralized, or mixed.

2. Dismantling programmatic stovepipes

Accreditation deliberately works against the categorical silos created by decades of federal grantmaking. An agency cannot demonstrate excellence through a single strong lead-poisoning program while its infectious disease and administrative operations struggle. Measures addressing workforce development, performance management and quality improvement, and leadership and governance require coordination across the whole agency:

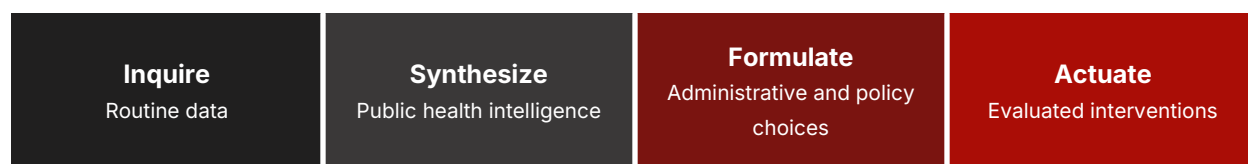
- Clinical teams share data with epidemiologists.
- Environmental health inspection findings inform the community health improvement plan.
- Quality improvement projects run across administrative, environmental, and clinical units alike.

Accreditation asks the health department to operate as an integrated system rather than a holding company for separate federal grants.

3. Institutionalizing the Trajectory of Practice and continuous quality improvement

Accreditation also moves governmental public health from a reactive posture toward that of a learning organization. Its performance management and quality improvement requirements reflect what AccrediQI Academy calls the **Trajectory of Practice**: the continuous translation of routine data into evidence-based action.

Figure 3. The Trajectory of Practice



By requiring accredited agencies to maintain performance management systems that track routine operational measures and launch structured quality improvement projects when performance lags, accreditation builds daily accountability into the institution itself.

CONCLUSION

Conclusion: Bridging the Constitutional Divide Through Practice Excellence

The history of governmental public health in the United States has been a continuous tension between the need for nationwide health protection and the centrifugal forces of constitutional federalism. For more than two centuries, the reactive growth of public health functions and the legal dispersion of police powers produced a fractured, unpredictable landscape, leaving millions of Americans exposed to preventable inequities because of their ZIP code.

Federal grants, the IOM Core Functions, and the 10 Essential Public Health Services made major contributions to diagnosing this fragmentation and defining the intended boundaries of practice. None, however, had the structural capacity to close the gap between aspirational scope and verified quality.

National accreditation through PHAB offers a resolution. By establishing a rigorous, evidence-based, peer-reviewed standard of practice that applies across diverse governance structures, accreditation preserves state sovereignty while promoting nationwide consistency. It helps transform health departments from isolated, compliance-driven bureaucracies into accountable, high-performing engines of community health. In doing so, accreditation advances the unfinished promise the Institute of Medicine articulated in 1988: moving public health out of disarray and toward an enduring, equitable architecture of excellence.

NEXT IN THIS SERIES

The Trajectory of Practice: how routine public health work becomes accreditation-ready evidence.

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Resolving the Disarray

Accreditation reconciles what American federalism kept apart: local autonomy and a national baseline of public health protection for every community.

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