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United States Government Accountability Office
Washington, DC 20548

February 25, 2008

The Honorable Henry A. Waxman
Chairman
Committee on Oversight and Government Reform
House of Representatives

Subject: *Centers for Disease Control and Prevention: Changes in Obligations and Activities before and after Fiscal Year 2005 Budget Reorganization*

Dear Mr. Chairman:

The Centers for Disease Control and Prevention's (CDC) mission is to promote health and quality of life by preventing and controlling disease, injury, and disability. In fiscal year 2005, CDC, an agency within the Department of Health and Human Services (HHS), completed its first major organizational restructuring in more than 25 years, known as the Futures Initiative, as part of its efforts to prioritize its strategies, programs, resources, and needs.¹ In accordance with the conference report accompanying its 2005 appropriation, CDC also implemented a new internal budget reporting structure that specifically identifies funding obligated for leadership and management activities. However, questions have been raised concerning whether changing the budget reporting structure has made it difficult to compare obligations over time for leadership and management activities and for public health program activities.²

Prior to the fiscal year 2005 organizational restructuring, CDC consisted of an Office of the Director and national centers that housed CDC's public health programs, including programs to reduce or prevent infectious diseases, cancer, birth defects, injuries, and other health problems.³ CDC had two organizational levels that were primarily responsible for leadership and management:⁴ the CDC Office of the Director and the national center directors' offices. In fiscal year 2005, CDC added two national centers. CDC also added a new leadership and management organizational level, which consists of six coordinating centers designed to

¹See GAO, *Centers for Disease Control and Prevention: Agency Leadership Taking Steps to Improve Management and Planning, but Challenges Remain*, [GAO-04-219](#) (Washington, D.C.: Jan. 30, 2004).

²Obligations generally are commitments that create a legal liability of the government to pay for goods or services.

³We use the term national centers to refer to CDC's National Centers, such as the National Center for Immunization and Respiratory Diseases, as well as the National Institute for Occupational Safety and Health and the National Office of Public Health Genomics. For an overview of CDC's current organizational structure, see encl. I.

⁴We refer to the CDC Office of the Director, the coordinating centers, and the national center directors' offices collectively as CDC's leadership and management levels.

better integrate the work of the national centers.⁵ Four of the six coordinating centers each manage the work of two or more specific national centers, while the other two coordinating centers each manage agencywide issues related to global health and terrorism preparedness and emergency response. Adding coordinating centers to CDC’s structure was consistent with our 2004 recommendation that CDC oversee the national centers’ programmatic work at a level below that of the CDC Director.⁶ In addition to its leadership and management levels, CDC has one organizational level—consisting of the national center divisions, branches, and other units—that is primarily responsible for operating public health programs. In this report, we refer to this level as CDC’s division level. (See table 1.)

Table 1: CDC’s Organizational Levels

Prior to fiscal year 2005		Beginning in fiscal year 2005	
Leadership and management levels	<ul style="list-style-type: none"> CDC Office of the Director • Immediate Office of the Director^a • CDC-wide shared business services^b 	Leadership and management levels	<ul style="list-style-type: none"> CDC Office of the Director • Immediate Office of the Director^a • CDC-wide shared business services^b
	National center directors’ offices		Coordinating centers
			National center directors’ offices ^c
Division level	National center divisions, branches, and other units	Division level	National center divisions, branches, and other units ^c

Source: GAO analysis of information from CDC.

^aThe immediate Office of the Director consists of the offices that report to the CDC director.

^bShared business services are agencywide administrative services, such as rent, utilities, security, maintenance, contract and grants administration, financial management, information technology, human resources, telecommunications, and postage.

^cIn fiscal year 2005, CDC established two additional national centers.

Under CDC’s new budget reporting structure, the agency began allocating funding for staff and activities at its leadership and management levels under two new elements within CDC’s Disease Control, Research, and Training account, titled “Public Health Improvement and Leadership” and “Business Services Support.” Each of these elements is a Program, Project, or Activity (PPA).⁷ Under the previous structure in effect through fiscal year 2004, funds for CDC’s leadership and management levels, including shared business services⁸ in the CDC Office of the Director, were derived from a combination of CDC’s “Office of the Director”

⁵We use the term coordinating centers to refer to CDC’s four coordinating centers and two coordinating offices. For an overview of CDC’s current organizational structure, see encl. I.

⁶GAO-04-219.

⁷PPAs are elements within an agency’s budget or appropriations accounts intended to provide a meaningful representation of the operations financed by that account.

⁸Shared business services are agencywide administrative services, such as rent, utilities, security, maintenance, contract and grants administration, financial management, information technology, human resources, telecommunications, and postage.

PPA and indirect cost allocations⁹ against other CDC units, primarily from the division level. The “Office of the Director” PPA and the indirect cost allocations were eliminated as part of the budget reorganization.

You asked us to examine issues regarding changes in obligations for administrative activities—generally conducted in CDC’s leadership and management levels—and public health programs—generally conducted in CDC’s division level—before and after the organizational restructuring and budget reorganization. In response to your request, we examined the following questions:

1. How were obligations distributed between CDC’s division level and CDC’s leadership and management levels from fiscal years 2003 through 2006?
2. How have obligations and activities at CDC’s leadership and management levels—including shared business services in the CDC Office of the Director—changed from fiscal year 2003 through fiscal year 2006?
3. How have obligations and activities at CDC’s division level changed from fiscal years 2003 through 2006?

To address these questions about CDC’s implementation of its budget reorganization in fiscal year 2005, we obtained and analyzed obligations data at CDC’s leadership and management levels and at CDC’s division level from fiscal year 2003 through fiscal year 2006.¹⁰ Our work was limited to CDC’s discretionary budget, which constituted about 77 percent of CDC’s total budget in fiscal year 2006.¹¹ We reviewed documents, including those related to relevant legislation and CDC’s budget and obligations, and interviewed officials from CDC’s Financial Management Office and from CDC’s leadership and management levels to understand changes in obligations. Although administrative activities are generally conducted at leadership and management levels and public health programs are generally conducted at the division level, some administrative and public health activities are conducted at each CDC level. Therefore, we also examined the types of activities conducted at each level. In addition, to examine obligations at CDC’s national centers in greater detail, we selected five national centers and their related funding sources, based on changes in obligations from fiscal year

⁹CDC used two different types of indirect cost allocations. One type was for shared business services. The other type was used within CDC’s national centers for the operation of the national center directors’ offices. Methods for determining the amount of these allocations varied among national centers.

¹⁰We included the Agency for Toxic Substances and Disease Registry (ATSDR) in our analysis because CDC’s budget includes obligations for it. ATSDR is an agency of HHS; its administrative and management functions are consolidated with CDC’s National Center for Environmental Health. In addition, the director of the CDC is also the administrator of ATSDR.

¹¹CDC’s Vaccines for Children program, which is administered by the National Center for Immunization and Respiratory Diseases, is not a discretionary program and is not included in our analysis. It comprised most of the remaining 23 percent of CDC’s overall obligations in fiscal year 2006.

2003 through fiscal year 2006.¹² Specifically, we selected the two national centers' PPAs or their subcategories with the largest increases in obligations, the two with the largest decreases, and one with a small overall change. To better understand changes in obligations over time, we also adjusted CDC obligations data from fiscal year 2003 through fiscal year 2006 for inflation using the Gross Domestic Product (GDP) price index. We compared the adjusted obligations data to the unadjusted obligations data, particularly for the division level, because the effect of inflation was greater there than at the leadership and management levels. Throughout this report, we present unadjusted obligations data, unless otherwise noted. To assess the reliability of the obligations data provided by CDC, we (1) performed electronic testing for obvious errors in accuracy and completeness, (2) reviewed related documentation, including contractor reports concerning the data, and (3) worked closely with agency officials to reconcile questions about the data before conducting our analyses. We did not find any errors, and therefore we determined that the data were sufficiently reliable for the purposes of our report. Our review focused on how obligations and activities shifted among CDC's organizational levels over time and not whether these changes resulted in improved efficiency or effectiveness. We conducted our work from May 2007 to January 2008 in accordance with generally accepted government auditing standards. For more information on our scope and methodology, see enclosure III.

Results in Brief

The distribution of obligations between CDC's division level, which is primarily responsible for carrying out public health programs, and its leadership and management levels remained relatively stable from fiscal year 2003 through fiscal year 2006. Obligations at CDC's division level accounted for between 87 and 89 percent of CDC's obligations in each year, while obligations at CDC's leadership and management levels accounted for between 8 and 9 percent of CDC obligations. Obligations for buildings and facilities, which are not considered part of CDC's division level or CDC's leadership and management levels because they generally consist of onetime capital expenses, accounted for the remaining portion of CDC obligations. Overall, CDC's obligations increased from \$6.05 billion in fiscal year 2003 to \$6.14 billion in fiscal year 2006. Obligations at leadership and management levels fluctuated from about \$483 million in fiscal year 2003 to a high of about \$592 million in fiscal year 2004, before ending at \$516 million in fiscal year 2006, as obligations and activities such as shared business services were consolidated in the CDC Office of the Director. Obligations at CDC's division level remained between about \$5.4 billion and about \$5.6 billion, despite the movement of some activities to the division level from leadership and management levels and the movement of some administrative activities from the division level to the leadership and management levels. However, after adjusting for inflation, from fiscal year 2003 to fiscal year 2006, obligations declined at the division level to a greater extent than at the leadership and management levels.

¹²Obligations for the National Center for Human Immunodeficiency Virus (HIV) / Acquired Immune Deficiency Syndrome (AIDS), Viral Hepatitis, Sexually Transmitted Diseases (STD), and Tuberculosis (TB) Prevention are generally reported under the HIV/AIDS, STD, and TB Prevention PPA. Obligations for the National Center for Preparedness, Detection, and Control of Infectious Diseases are generally reported under the Infectious Disease Control PPA. Obligations for the National Center for Chronic Disease Prevention and Health Promotion are generally reported under the Chronic Disease Prevention and Health Promotion PPA. Obligations for the National Center on Birth Defects and Developmental Disabilities are generally reported under the Birth Defects, Developmental Disabilities, Disability and Health PPA. Obligations for the National Institute for Occupational Safety and Health are generally reported under the Occupational Safety and Health PPA. In fiscal years 2003 and 2004, all five of these components of CDC's budget were PPAs. Starting in fiscal year 2005, only Occupational Safety and Health remained a PPA, while the other components became subcategories of newly established PPAs. (For more information, see encl. II.)

We received written comments on a draft of this report from HHS. In its comments, HHS interpreted our findings to suggest that its 2005 organizational restructuring has had limited or no impact on funding available for public health program activities. However, because it is difficult to separate the effects of the organizational restructuring, inflation, or other factors on obligations for public health program activities, we did not draw this conclusion. We did note that, after adjusting for inflation, obligations at CDC's division level declined more than obligations at CDC's leadership and management levels from fiscal year 2003 to fiscal year 2006. HHS's written comments are reprinted in enclosure IV. HHS also provided technical comments, which we incorporated as appropriate.

Background

Under CDC's new structure, the agency's organization consists of the CDC Office of the Director, coordinating centers, and national centers. The coordinating centers include the Coordinating Office for Global Health, the Coordinating Office for Terrorism Preparedness and Emergency Response, the Coordinating Center for Environmental Health and Injury Prevention, the Coordinating Center for Health Information and Service, the Coordinating Center for Health Promotion, and the Coordinating Center for Infectious Diseases. Coordinating centers are intended to allow CDC's scientists to collaborate and innovate across organizational boundaries, improve efficiency, and improve the internal services that support and develop CDC staff. Four of these coordinating centers oversee the activities at multiple national centers. In addition to establishing coordinating centers, CDC added two new national centers, the National Center for Public Health Informatics and the National Center for Health Marketing. (Encl. I contains CDC's organizational chart.)

For fiscal year 2005, CDC restructured the 13 PPAs in its Disease Control, Research, and Training budget account into 10 PPAs to correspond with its new organizational structure and, in accordance with language in the Senate and conference reports accompanying its 2005 appropriation, to separate actual program costs from management and administrative costs.¹³ The new Public Health Improvement and Leadership PPA includes obligations for staff and activities at each of CDC's three leadership and management organizational levels.¹⁴ The new Business Services Support PPA includes obligations in the CDC Office of the Director on shared business services that benefit the entire agency. In addition, CDC consolidated the PPAs that it uses to track funding for its public health programs, creating new PPAs and subcategories to correspond with the newly created coordinating centers. (See encl. II for a list of PPAs and their subcategories before and after CDC's budget reorganization.)

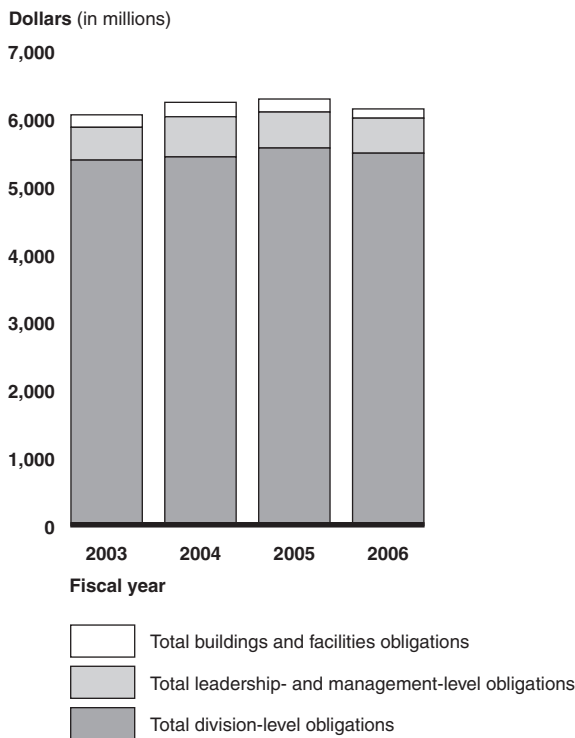
¹³S. Rep. No. 108-345, at 65 (2004); H. Rep. No. 108-792 at 1157 (Conf. Rep.).

¹⁴The Public Health Improvement and Leadership PPA has a subcategory called Leadership and Management, which includes funding for coordinating center and national center directors' offices.

The Distribution of Obligations between CDC's Division Level and Its Leadership and Management Levels Remained Relatively Stable

The distribution of obligations between CDC's division level, primarily responsible for operating CDC's public health programs, and its leadership and management levels remained relatively stable from fiscal year 2003 through fiscal year 2006. CDC's total obligations were about \$6.05 billion in fiscal year 2003, \$6.24 billion in fiscal year 2004, \$6.28 billion in fiscal year 2005, and \$6.14 billion in fiscal year 2006. Obligations at CDC's division level accounted for between 87 and 89 percent of CDC's total obligations in each year. Obligations at CDC's leadership and management levels accounted for between 8 and 9 percent of its total obligations in each year. The remaining 2 to 3 percent of CDC's obligations were for the purchase and construction of buildings and facilities, which are not considered part of CDC's division level or CDC's leadership and management levels because they generally consist of onetime capital expenses. Figure 1 indicates CDC's total obligations from fiscal year 2003 through fiscal year 2006, broken out according to obligations at the division level, obligations at leadership and management levels, and obligations for buildings and facilities.

Figure 1: CDC's Obligations by Level, Fiscal Year 2003 through Fiscal Year 2006



Source: GAO analysis of CDC data.

Note: CDC's division level consists of the national center divisions, branches, and other units. In fiscal year 2003 and fiscal year 2004, CDC's leadership and management levels consisted of the CDC Office of the Director and the national center directors' offices. As of fiscal year 2005, CDC's leadership and management levels also include the coordinating centers.

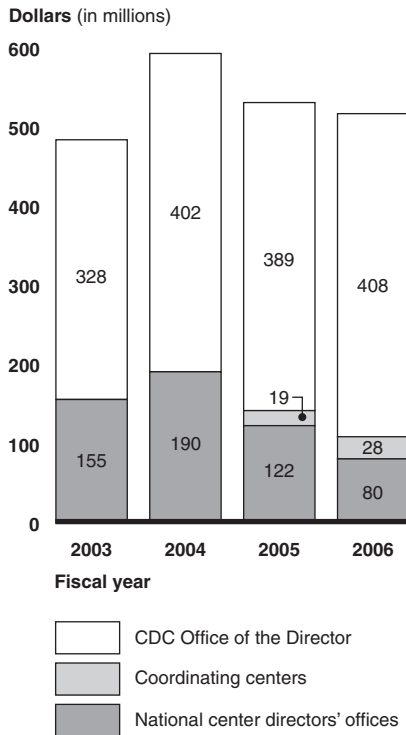
Obligations within CDC's Leadership and Management Levels Have Increased, and Obligations and Activities Have Been Consolidated in the CDC Office of the Director

Total obligations at CDC's leadership and management levels, which include the CDC Office of the Director, coordinating centers, and national center directors' offices, have fluctuated and increased overall, from \$483 million in fiscal year 2003 to \$516 million in fiscal year 2006. During this time, obligations and activities within the leadership and management levels were consolidated in the CDC Office of the Director. Obligations and activities at national center directors' offices have decreased, while obligations and activities at the CDC Office of the Director have increased as a result of the consolidation. Several activities previously performed in national center directors' offices were consolidated in the CDC Office of the Director, moved to the division level, or discontinued, thereby affecting obligations at these levels. Obligations for some public health program activities were part of the CDC Office of the Director from fiscal year 2003 through fiscal year 2006. In addition, obligations for shared business services within the CDC Office of the Director, which include the majority of obligations at CDC's leadership and management levels, have fluctuated and increased overall as new services, including information technology services, have been consolidated from other components throughout CDC.

Overall Obligations within CDC's Leadership and Management Levels Have Increased, and Obligations Have Been Consolidated in the CDC Office of the Director

Obligations at leadership and management levels from fiscal year 2003 through fiscal year 2006 have fluctuated but increased overall by about 6.9 percent. This increase is greater than the increase in CDC's total obligations, which rose by about 1.5 percent over the same period. It is also greater than the increase in obligations at CDC's division level, which rose by about 1.9 percent over the same period. Specifically, obligations at leadership and management levels increased from about \$483 million in fiscal year 2003 to about \$592 million in fiscal year 2004, but then decreased to about \$530 million in fiscal year 2005 and about \$516 million in fiscal year 2006. Figure 2 shows the obligations at CDC's three leadership and management levels from fiscal year 2003 through fiscal year 2006.

Figure 2: CDC Obligations at Leadership and Management Levels, Fiscal Years 2003 through 2006



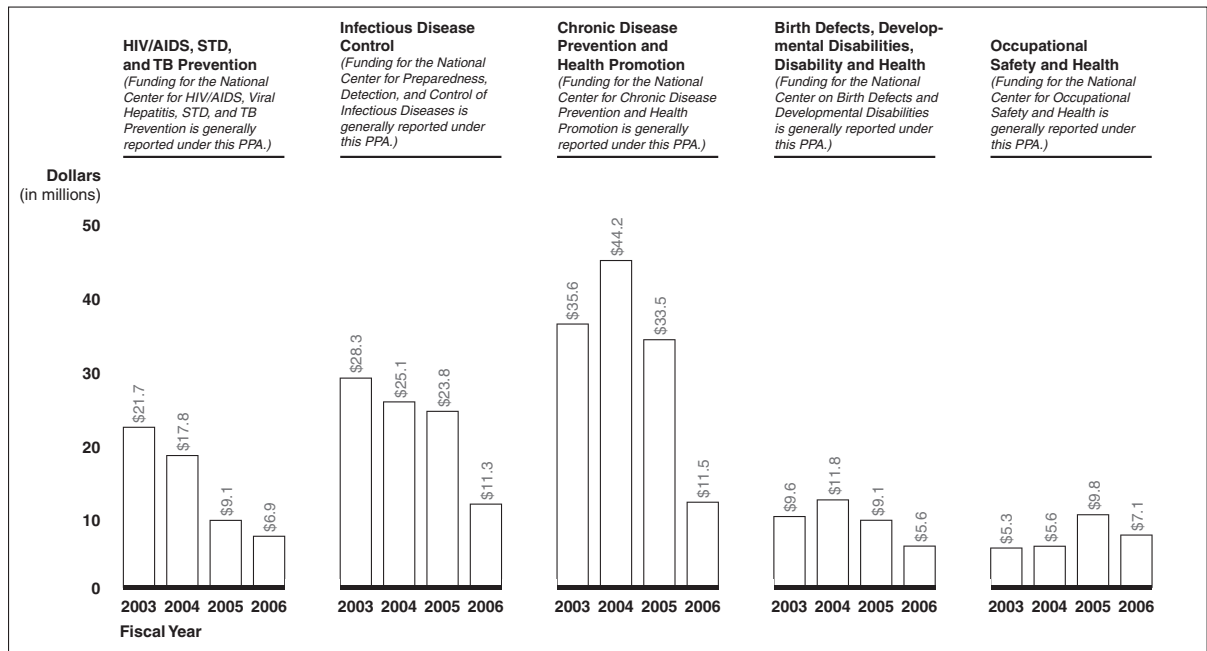
Source: GAO analysis of CDC data.

Note: CDC's coordinating centers were established in fiscal year 2005.

As shown in figure 2, obligations within CDC's leadership and management levels increased at the CDC Office of the Director and at coordinating centers but decreased at national center directors' offices. The portion of CDC's total leadership- and management-level obligations in the CDC Office of the Director increased from 68 percent in fiscal year 2003 to 79 percent in fiscal year 2006. This percentage increase corresponded to an increase in CDC Office of the Director obligations from \$328 million in fiscal year 2003 to \$408 million in fiscal year 2006. The portion of CDC's total leadership- and management-level obligations that was part of CDC national center directors' offices decreased from 32 percent in fiscal year 2003 to 15 percent in fiscal year 2006. This decrease corresponded with a decline in obligations at national center directors' offices from \$155 million in fiscal year 2003 to \$80 million in fiscal year 2006. The portion of leadership and management level obligations in coordinating centers, which were established in fiscal year 2005, was 4 percent or \$19 million in fiscal year 2005 and 5 percent or \$28 million in fiscal year 2006.

Obligations at national center directors' offices decreased for four of the five PPAs that we examined in detail. (See fig. 3.) The decreases in these four PPAs ranged from about 42 percent or \$4 million for Birth Defects, Developmental Disabilities, Disability and Health to about 68 percent or \$24 million for Chronic Disease Prevention and Health Promotion from fiscal year 2003 through fiscal year 2006.

Figure 3: Leadership- and Management-Level Obligations at National Center Directors' Offices for Selected PPAs, Fiscal Years 2003 through 2006



Source: GAO analysis of CDC data.

Note: With the exception of Occupational Safety and Health, these PPAs became subcategories of newly established broader PPAs in fiscal year 2005 due to the reorganization of CDC's budget. See enclosure II for the full list of changes to CDC's PPAs.

Several Activities Previously Performed in National Center Directors' Offices Have Moved or Been Discontinued

Some administrative activities and public health program functions previously performed in national center directors' offices have been consolidated in the CDC Office of the Director, moved to the division level, or discontinued. CDC officials told us that it was common for public health program functions to be placed in national center directors' offices in fiscal year 2003 and fiscal year 2004 because these offices had funding available to them that could be utilized for program functions. It has become less common for program functions to be placed in national center directors' offices as funding levels for national center directors' offices have declined, leading to program functions being moved or discontinued. CDC officials provided the following examples of these changes in activities.

Consolidated in the CDC Office of the Director—CDC officials indicated that some administrative activities that were previously performed in national center directors' offices were consolidated into the CDC Office of the Director. For example, budget analysts had been distributed throughout CDC, including the national center directors' offices. CDC consolidated its budget analysts in the CDC Office of the Director as part of the Financial Management Office in fiscal year 2005, contributing to an increase in financial management obligations at the CDC Office of the Director level from about \$17 million in fiscal year 2004 to about \$34 million in fiscal year 2005.

Moved from National Center Directors' Offices—CDC officials in five national centers also provided examples of public health program functions that were moved from national center directors' offices to the division level in fiscal year 2005 and fiscal year 2006, including the following:

- Antimicrobial Resistance Program functions, previously housed in the director's office of the National Center for Infectious Diseases, were moved to the Division of Healthcare Quality Promotion in fiscal years 2005 and 2006. Obligations for these program functions totaled \$7.7 million in fiscal year 2004 and decreased to \$3.1 million in fiscal year 2006.
- Functions of the Emerging Infections Office/Program, which were previously located in the director's office of the National Center for Infectious Diseases, were moved to the Division of Emerging Infections and Surveillance Services in fiscal years 2005 and 2006. Obligations for these program functions totaled \$33 million in fiscal year 2004 and decreased to \$22 million in fiscal year 2006.
- The National AIDS Clearing House, which was previously located in the director's office of the National Center for HIV, STD, and TB Prevention,¹⁵ was moved to the National Center for Health Marketing in fiscal year 2005. Obligations for this program function totaled \$9.5 million in fiscal year 2004 and remained at the same level for fiscal year 2006.

Discontinued Activities That Had Been in National Center Directors' Offices—

Other activities were discontinued from national center directors' offices. For example, the alcohol activity grant and global health evaluation projects were located in the director's office of the National Center for Chronic Disease Prevention and Health Promotion. In fiscal year 2004, obligations for these programs totaled \$100,000 and \$205,000, respectively. These activities were discontinued in fiscal year 2006. CDC officials stated that CDC does not keep data on the total amount of obligations for public health programs in national center directors' offices. However, the amount of obligations for grants—one type of program obligations—in national center directors' offices decreased from about \$28.8 million in fiscal year 2004 to \$1.1 million in fiscal year 2006. CDC officials told us that most of this decrease was due to programs being moved to divisions or discontinued, but that some program-related activities were moved to the CDC Office of the Director. An additional \$700,000 in obligations for grants occurred at the coordinating centers in fiscal year 2006, and obligations for grants at the CDC Office of the Director increased from about \$1.2 million in fiscal year 2004 to about \$3.8 million in fiscal year 2006. As a result, the net decrease in obligations for grants at CDC's leadership and management levels was about 81 percent from fiscal years 2004 to 2006.

Some Additional Obligations for Public Health Program Activities Were Part of the CDC Office of the Director in Fiscal Years 2005 and 2006

In addition to obligations for grants, some other public health program obligations became part of the CDC Office of the Director in fiscal years 2005 and 2006. About \$2.2 million of the director's discretionary fund was used to finance public health programs concerning influenza and obesity in fiscal year 2005, and about \$3.3 million was used to finance public health programs concerning infant mortality and other issues in fiscal year 2006. Furthermore, \$19.6 million in fiscal year 2005 and \$18.5 million in fiscal year 2006 from the Office of

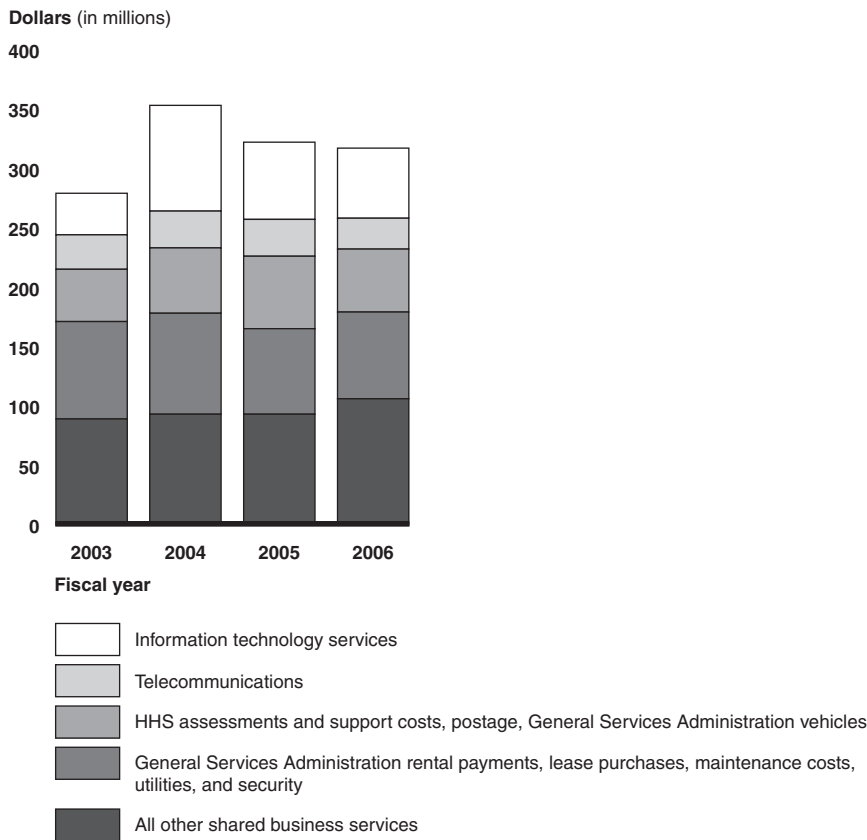
¹⁵The National Center for HIV, STD, and TB Prevention was renamed the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention in March 2007 to reflect the addition of CDC's Viral Hepatitis program.

Workforce and Career Development, part of the CDC Office of the Director, were used for workforce and career development activities within CDC's public health programs. These amounts constitute a relatively small percentage of overall obligations for the CDC Office of the Director, which were \$389 million in fiscal year 2005 and \$408 million in 2006.

Obligations for Shared Business Services within the CDC Office of the Director Have Fluctuated and Increased Overall as New Services Have Been Consolidated

Obligations for shared business services within the CDC Office of the Director—which included between 58 and 62 percent of the obligations at CDC's leadership and management levels—have fluctuated and increased overall as new services, particularly information technology services, have been moved from other components within CDC and consolidated in that office. From fiscal year 2003 through fiscal year 2006, obligations on shared business services have fluctuated from about \$278 million, or 4.6 percent of CDC's total obligations in fiscal year 2003, to about \$353 million, or 5.7 percent of CDC's total obligations in fiscal year 2004. Obligations for shared business services peaked in fiscal year 2004 and have since declined to about \$318 million in fiscal year 2006. (See fig. 4.)

Figure 4: Obligations on Shared Business Services in the CDC Office of the Director, Fiscal Year 2003 through Fiscal Year 2006



Source: GAO analysis of CDC data.

Shared business services were centrally located as part of the CDC Office of the Director in each year from fiscal year 2003 through fiscal year 2006 even though the method for funding them changed in fiscal year 2005. Beginning in that year, CDC started using its newly created Business Services Support PPA to allocate funding for these services.¹⁶ Although shared business services have been part of the CDC Office of the Director in each year, the types of services and the amount of obligations for shared business services have changed over time, in part due to functions moving between the CDC Office of the Director and the national centers. As shown in figure 4, the largest fluctuations in obligations on shared business services from fiscal years 2003 through 2006 were for CDC’s information technology services. However, the CDC information technology offices included within CDC’s shared business services have changed from year to year, and CDC officials told us that changes in services provided by these offices were largely responsible for the fluctuations in obligations. The information technology offices that were part of shared business services during this period were the Information Resource Management Office (IRMO), the Information Technology Service Office (ITSO), the Office of the Chief Information Officer (OCIO), and the Management Information Systems Office (MISO). See table 2 for the offices that CDC included in its shared business services in each fiscal year and how the corresponding obligations have fluctuated.

Table 2: Information Technology Offices Included in CDC’s Shared Business Services and Corresponding Obligation Levels, Fiscal Year 2003 through Fiscal Year 2006

	Fiscal year 2003	Fiscal year 2004	Fiscal year 2005	Fiscal year 2006
Information technology offices included in CDC’s shared business services	<ul style="list-style-type: none"> Information Resource Management Office (IRMO) 	<ul style="list-style-type: none"> IRMO Information Technology Service Office (ITSO) Office of the Chief Information Officer (OCIO) 	<ul style="list-style-type: none"> ITSO OCIO Management Information Systems Office (MISO) 	<ul style="list-style-type: none"> ITSO OCIO MISO
CDC obligations for these offices	\$34.5 million	\$89.3 million	\$65.1 million	\$59.1 million

Source: GAO analysis of CDC data.

Note: In fiscal year 2005, IRMO was eliminated. Its functions were moved into ITSO, OCIO, MISO, and the National Center for Public Health Informatics.

Information technology personnel were moved from other components within CDC and consolidated into the newly created ITSO in fiscal year 2004, contributing to the increase in obligations in CDC’s information technology offices from about \$35 million in fiscal year 2003 to about \$89 million in fiscal year 2004. Although IRMO was CDC’s primary centralized information technology organization in fiscal year 2003, the majority of information technology obligations, approximately \$57 million, were outside of the CDC Office of the Director in the division level and directors’ offices of national centers. In fiscal year 2004 when ITSO was formed within the CDC Office of the Director, these decentralized

¹⁶A portion of obligations for shared business services in fiscal year 2005 was accounted for by one of CDC’s national centers, the National Institute for Occupational Safety and Health (NIOSH). These obligations were not part of CDC’s Business Services Support PPA. Beginning in fiscal year 2006, a corresponding amount of obligations was included in the Business Services Support PPA. In addition, in fiscal year 2006, NIOSH also accounted for a smaller, additional amount of obligations for CDC’s shared business services. We included these additional amounts in our calculation of business services support obligations in fiscal years 2005 and 2006.

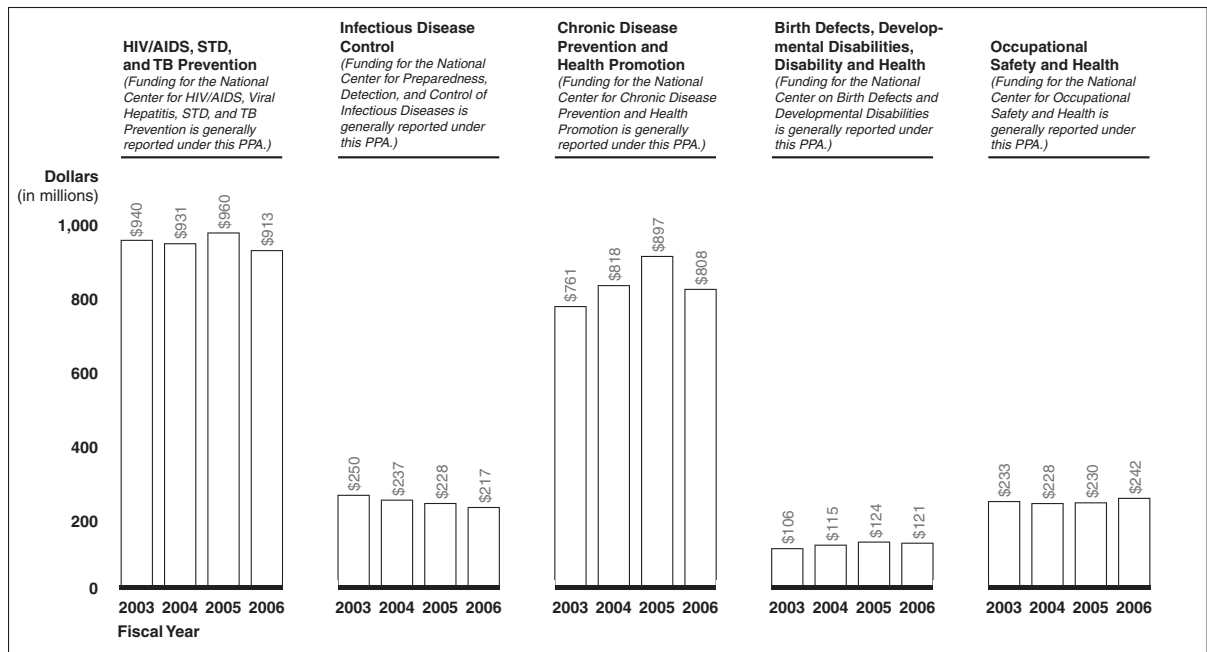
information technology obligations were consolidated to form ITSO and several related functions within IRMO. IRMO was eliminated for fiscal year 2005 and its functions were moved into ITSO, OCIO, and MISO. About an additional \$21 million was moved out of the CDC Office of the Director to the National Center for Public Health Informatics, contributing to the decrease in shared business services information technology obligations from about \$89 million in fiscal year 2004 to about \$65 million in fiscal year 2005.

Obligations at CDC’s Division Level Remained Generally Stable from Fiscal Year 2003 through Fiscal Year 2006 but Have Declined When Adjusted for Inflation

Obligations at CDC’s division level, which includes most CDC public health programs, remained generally stable from fiscal year 2003 through fiscal year 2006. Division level obligations increased by 1.9 percent from fiscal year 2003 through fiscal year 2006, from about \$5.4 billion to about \$5.5 billion. This increase is similar to the increase in CDC’s total obligations, which rose 1.5 percent over the same period. However, after adjusting for inflation, from fiscal year 2003 through fiscal year 2006, obligations declined.

Without adjusting for inflation, obligations at the division level for the PPAs we selected have remained generally stable. Division level obligations declined for two of the selected PPAs and increased slightly for three of the selected PPAs. (See fig. 5.)

Figure 5: CDC Division-Level Obligations for Selected PPAs, Fiscal Years 2003 through 2006



Source: GAO analysis of CDC data.

Note: With the exception of Occupational Safety and Health, these PPAs became subcategories of newly established broader PPAs in fiscal year 2005 due to the reorganization of CDC’s budget. See enclosure II for the full list of changes to CDC’s PPAs.

The shifting of obligations and activities between CDC’s leadership and management levels and CDC’s division level had varying effects at CDC’s division level. Program functions that were moved to divisions from national center directors’ offices, such as Antimicrobial Resistance Program functions in fiscal years 2005 and 2006, expanded the responsibilities of the division level. Officials from a CDC national center director’s office told us that these new

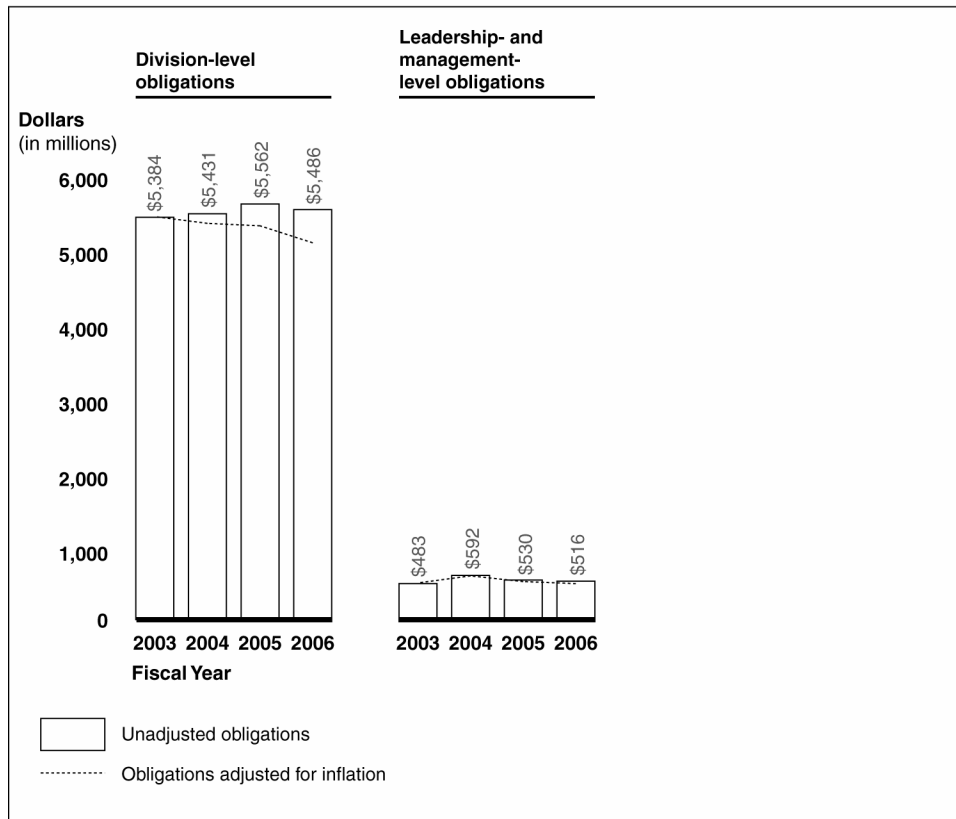
program functions often had to be absorbed by the divisions without any overall increase in obligations. Alternatively, divisions no longer had to fund administrative activities and personnel that were consolidated into CDC's leadership and management levels, such as budget analysts or information technology personnel who were moved to the CDC Office of the Director in fiscal year 2005.

After adjusting for inflation, division-level obligations declined from fiscal year 2003 to fiscal year 2006.¹⁷ Obligations at CDC's leadership and management levels also declined during this period after adjusting for inflation, but the decline was smaller than at the division level. (See fig. 6.) To have kept pace with inflation, obligations at CDC's division level would have had to increase by almost 9 percent from fiscal year 2003 to fiscal year 2006, but they increased less than 2 percent. Figure 6 shows how obligations at CDC's division level and leadership and management levels compare with the respective inflation-adjusted obligation amounts.¹⁸ The fact that obligations declined after adjusting for inflation is not unique to CDC; obligations at many other federal agencies also did not keep pace with inflation during this period.

¹⁷See encl. III for more information about our methodology, including our use of the Gross Domestic Product (GDP) price index to adjust for inflation.

¹⁸See also *Centers for Disease Control and Prevention Professional Judgment for Fiscal Year 2008*, April 20, 2007, for CDC's analysis of the effects of inflation. In this statement, CDC noted that the loss of purchasing power due to inflation has led to the erosion of core funding for non-terrorism-related research and noninfluenza, non-emerging infectious disease science.

Figure 6: Comparative Unadjusted and Adjusted Obligations at CDC Leadership and Management Levels and Division Level, Fiscal Year 2003 through Fiscal Year 2006



Source: GAO analysis of CDC data.

Note: CDC's division level consists of the national center divisions, branches, and other units. In fiscal year 2003 and fiscal year 2004, CDC's leadership and management levels consisted of the CDC Office of the Director and the national center directors' offices. As of fiscal year 2005, CDC's leadership and management levels also include the coordinating centers.

Agency Comments and Our Evaluation

We received written comments on a draft of this report from HHS. In its comments, HHS provided information on CDC's mission, goals, and the rationale for its current organizational structure. In regard to this report, HHS interpreted our findings to suggest that its 2005 organizational restructuring has had limited or no impact on funding available for public health program activities. However, because it is difficult to separate the effects of the organizational restructuring, inflation, or other factors on obligations for public health program activities, we did not draw this conclusion. We did note that, after adjusting for inflation, obligations at CDC's division level declined more than obligations at CDC's leadership and management levels from fiscal year 2003 to fiscal year 2006. HHS's written comments are reprinted in enclosure IV. HHS also provided technical comments, which we incorporated as appropriate.

As we agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution of this report until 30 days after the date of this letter. At that time, we will send copies to the Secretary of Health and Human Services and other

interested parties. We will also make copies available to others on request. In addition, the report will be available at no charge on GAO's Web site at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or bascettac@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Key contributors to this report were Sheila Avruch, Assistant Director; Linda Kohn, Assistant Director; Timothy Cunningham; Roseanne Price; William Simerl; and Michael Zose.

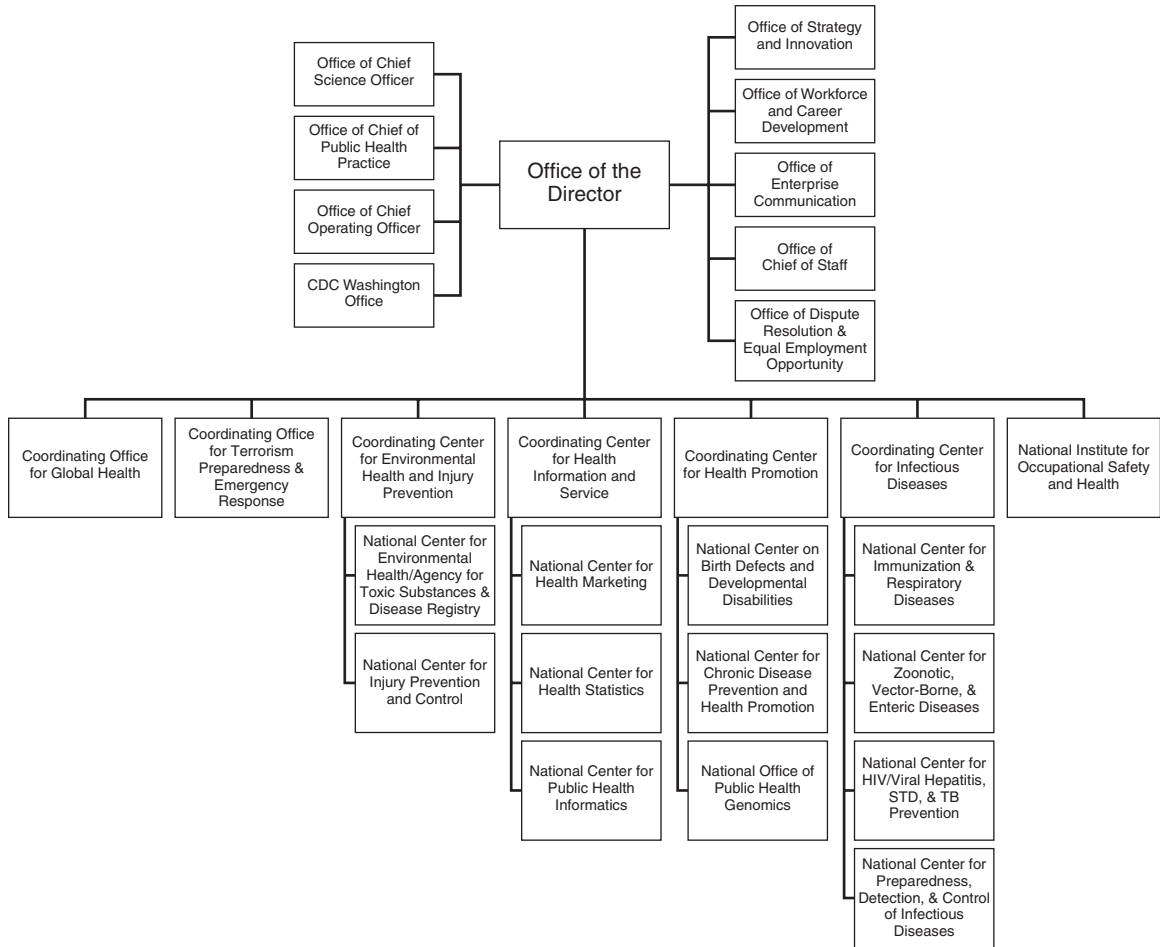
Sincerely yours,

A handwritten signature in black ink that reads "Cynthia Bascetta". The signature is written in a cursive style with a large initial "C".

Cynthia Bascetta
Director, Health Care

Enclosures – 4

**Centers for Disease Control and Prevention (CDC) Organizational Chart
(effective March 22, 2007)**



Source: GAO analysis of CDC data.

Note: The national centers in this chart include both their respective directors' office and their divisions, branches, and other units, which we refer to collectively as CDC's division level in this report. We use the term national center to refer to the 11 national centers listed above, the National Office of Public Health Genomics, and the National Institute for Occupational Safety and Health. This organizational chart reflects some changes that CDC made to its structure after the fiscal year 2005 organizational restructuring.

Enclosure II

Programs, Projects, or Activities for the Centers for Disease Control and Prevention's (CDC) Disease Control, Research, and Training Account

Programs, Projects, or Activities (PPA) are elements within an agency's budget or appropriations accounts intended to provide a meaningful representation of the operations financed by those accounts.¹ This enclosure lists the PPAs for the CDC's Disease Control, Research, and Training account.

CDC restructured the PPAs within the Disease Control, Research, and Training account for fiscal year 2005 to correspond with its new organizational structure and to separate funding for programs from funding for management and administrative services. For fiscal year 2004, Disease Control, Research, and Training included the following 13 PPAs:

- Birth Defects, Developmental Disabilities, Disability and Health
- Chronic Disease Prevention and Health Promotion
- Environmental Health
- Epidemic Services and Response
- Human Immunodeficiency Virus (HIV) / Acquired Immune Deficiency Syndrome (AIDS), Sexually Transmitted Diseases (STD) and Tuberculosis (TB) Prevention
- Immunization
- Infectious Disease Control
- Injury Prevention and Control
- Occupational Safety and Health
- Preventive Health and Health Service Block Grant
- Public Health Improvement
- Building and Facilities
- Office of the Director

For fiscal year 2005, Disease Control, Research, and Training included the following 10 PPAs:

- Infectious Diseases
- Health Promotion
- Health Information and Service
- Environmental Health and Injury
- Occupational Safety and Health
- Global Health
- Public Health Improvement and Leadership
- Preventive Health and Health Service Block Grant
- Buildings and Facilities
- Business Services Support

¹For annually appropriated accounts, the Office of Management and Budget (OMB) and agencies identify PPAs by reference to congressional committee reports and agency budget justifications. For permanent appropriations, OMB and agencies identify PPAs by the program and financing schedules that the President provides in the "Detailed Budget Estimates" in the budget submission for the relevant fiscal year. Program activity structures are intended to provide a meaningful representation of the operations financed by a specific budget account—usually by project, activity, or organization. See GAO, *A Glossary of Terms Used in the Federal Budget Process*, [GAO-05-734SP](#) (Washington, D.C.: September 2005), at 80.

Scope and Methodology

To examine (1) the distribution of obligations between the Centers for Disease Control and Prevention's (CDC) division level and CDC's leadership and management levels, (2) obligations and activities at CDC's leadership and management levels, including shared business services within the CDC Office of the Director, and (3) obligations and activities at CDC's division level, we obtained and reviewed obligations data at CDC's leadership and management levels and at CDC's division level from fiscal year 2003 through fiscal year 2006.¹ Although administrative activities are generally conducted at leadership and management levels and public health programs are generally conducted at the division level, some administrative and public health activities are conducted at each CDC level. Therefore, we also examined the types of activities conducted at each level. Our work was limited to CDC's discretionary obligations, which comprise about 77 percent of CDC's overall obligations in fiscal year 2006. We also reviewed documents, including those related to relevant appropriations legislation and CDC's budget and obligations, and interviewed officials from CDC's Financial Management Office and from CDC's leadership and management levels. We did not review CDC's Vaccines for Children program, which is not a discretionary program and comprised most of the remaining 23 percent of CDC's overall obligations in that year.

We compared obligations at CDC's division level and at CDC's leadership and management levels, which include the CDC Office of the Director, coordinating centers, and national centers directors' offices, from fiscal year 2003 through fiscal year 2006.² For this comparison, we included the following items that constitute obligations at the CDC Office of the Director level: (1) obligations from CDC's Programs, Projects, or Activities (PPA) dedicated to the Office of the Director and the offices included in it; (2) obligations from indirect cost allocations³ against CDC components for shared business services in the CDC Office of the Director in fiscal year 2003 and fiscal year 2004; (3) obligations dedicated to leadership and management that CDC attributed to the Office of the Director in fiscal year 2005 and fiscal year 2006; and (4) obligations from indirect cost allocations against the National Institute for Occupational Safety and Health (NIOSH) by the CDC Office of the Director in fiscal year 2005 and fiscal year 2006. For the coordinating centers, we included obligations dedicated to leadership and management that CDC attributed to the coordinating centers in fiscal year 2005 and fiscal year 2006. For the national center directors' offices, we included (1) obligations from indirect cost allocations for the division level by national centers for the national center directors' offices in fiscal year 2003 and fiscal year 2004, (2) obligations dedicated to leadership and management that CDC attributed to national center directors' offices in fiscal year 2005 and fiscal year 2006, and (3) the portion of the NIOSH appropriation obligated at the NIOSH director's office. For the division level, which is primarily responsible for operating public health programs, we included obligations at divisions and other units within national centers. CDC officials reviewed our analysis and confirmed that the way we had grouped the obligations was appropriate. We did not consider

¹Obligations generally are commitments that create a legal liability of the government to pay for goods or services.

²Our review focused on how obligations and activities shifted among CDC's organizational levels over time and not whether these changes resulted in improved efficiency or effectiveness.

³CDC used two different types of indirect cost allocations. One type was for shared business services, which are services such as rent, utilities, security, and administrative infrastructure that benefit all CDC components. The other type was used within CDC's national centers for the operation of the national center directors' offices. Methods for determining the amount of these allocations varied among national centers.

Enclosure III

buildings and facilities obligations to be a part of obligations at CDC's division level or at CDC's leadership and management levels because in each year they generally consist of onetime capital expenses. Other building-related expenses, such as maintenance or rent, are included as part of obligations at CDC's leadership and management levels in the shared business services category.

To specifically address changes in shared business services in the CDC Office of the Director—part of CDC's leadership and management levels—we obtained and reviewed CDC data on obligations for shared business services from fiscal years 2003 through 2006. We also determined the obligations for subcategories in shared business services, interviewed CDC officials, and reviewed documentation provided by them to determine how changes in CDC's PPAs have affected obligations levels for shared business services over time.

Funding for each of CDC's national centers is generally reported under one of CDC's PPAs or subcategories within CDC's budget. We selected five of these national centers and their related PPAs or subcategories for additional analysis based on changes in obligations from fiscal year 2003 through fiscal year 2006. We selected the two national centers' PPAs or subcategories with the largest increases in obligations, the two with the largest decreases, and one with a small overall change. The PPAs or their subcategories with the largest increase in obligations are Chronic Disease Prevention and Health Promotion, under which funding for the National Center for Chronic Disease Prevention and Health Promotion is generally reported; and Birth Defects, Developmental Disabilities, Disability and Health, under which funding for the National Center on Birth Defects and Developmental Disabilities is generally reported. The PPAs or their subcategories with the largest decrease in obligations are HIV/AIDS, STD, and TB Prevention, under which funding for the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention is generally reported; and Infectious Disease Control, under which funding for the National Center for Preparedness, Detection, and Control of Infectious Diseases is generally reported. The PPA with a small overall change in obligations is Occupational Safety and Health, under which funding for NIOSH is generally reported. In fiscal years 2003 and 2004, all five of these components of CDC's budget were PPAs. Starting in fiscal year 2005, only Occupational Safety and Health remained a PPA, while the other components became subcategories of newly established PPAs. For each of the selected national centers, we reviewed obligations data from their PPAs or subcategories and interviewed the corresponding national center and coordinating center leadership and management officials.

As part of our analysis of CDC obligations data, we adjusted CDC obligations data from fiscal year 2003 through fiscal year 2006 for inflation using the Gross Domestic Product (GDP) price index and compared it to the unadjusted obligations data. While CDC officials told us that they preferred to use the Bureau of Economic Analysis's Biomedical Research and Development Price Index (BRDPI) to measure inflation, which generally results in a larger adjustment than the GDP price index, we chose the more conservative GDP price index over the BRDPI. Both indexes show that obligations have declined after making the adjustment. Given that the choice of index does not affect our findings, we chose the more conservative index.

We compared the adjusted obligations data to the unadjusted obligations data, particularly for the division level, because the effects of inflation were greater there than at the leadership and management levels. Throughout this report, we present unadjusted obligations data, unless otherwise noted. To assess the reliability of the obligations data provided by CDC, we (1) performed electronic testing for obvious errors in accuracy and completeness,

Enclosure III

(2) reviewed related documentation, including contractor reports concerning the data, and (3) worked closely with agency officials to reconcile questions about the data before conducting our analyses. We did not find any errors, and therefore we determined that the data were sufficiently reliable for our purposes, although we did not independently verify it.

We conducted our work from May 2007 to January 2008 in accordance with generally accepted government auditing standards.

Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Assistant Secretary
for Legislation

Washington, D.C. 20201

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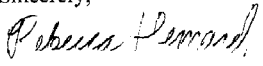
Ms. Cynthia A. Bascetta
Director, Health Care
U.S. Government Accountability Office
Washington, DC 20548

Dear Ms. Bascetta:

Enclosed are the Department's comments on the U.S. Government Accountability Office's (GAO) draft report entitled, "Centers for Disease Control and Prevention: Changes in Obligations and Activities before and After Fiscal Year 2005 Budget Reorganization."

The Department appreciates the opportunity to review and comment on this draft before its publication.

Sincerely,


Vincent Ventimiglia
Assistant Secretary for Legislation

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE U.S. GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: CENTERS FOR DISEASE CONTROL AND PREVENTION: CHANGES IN OBLIGATIONS AND ACTIVITIES BEFORE AND AFTER FISCAL YEAR 2005 BUDGET REORGANIZATION (GAO 08-328R)

Centers for Disease Control and Prevention (CDC) remains at the forefront of public health efforts to prevent and control infectious and chronic diseases, injuries, workplace hazards, disabilities, environmental and other health threats resulting from natural or man-made disasters. CDC is globally recognized for conducting research and investigations and for its action-oriented approach, applying research and findings to improve people's lives, and responding to health emergencies. CDC is a science-driven agency, but the singular mindset that the scientific approach can sometimes engender, coupled with the Agency's past organizational structure, has limited the Agency's ability to be fully integrated in its activities across organizational units.

Beyond implementing the recommendations of the GAO report, **Centers for Disease Control and Prevention: Agency Leadership Taking Steps to Improve Management and Planning, but Challenges Remain, GAO-04-219** (Washington, D.C.: January 30, 2004), CDC's goal has been to enhance the role of leadership through a horizontal scientific and management approach, rather than the more vertical, categorical approach that the previous organizational structure perpetuated. CDC is committed to achieving true improvements in people's lives by accelerating health impact and reducing health disparities. CDC created a set of four overarching Health Protection Goals to make the best use of CDC resources to achieve health impact, give priority to activities that have the greatest health impact and reduce health disparities, align CDC's annual budget to these priorities, and demonstrate accountability for the funding that Congress gives CDC.

These goals are:

- **Healthy People in Every Stage of Life:** CDC's primary mission is to reduce health risks, at all stages of life, through the most efficient and effective means possible.
- **Healthy People in Healthy Places:** CDC is working hard to ensure the places we live, work, and play have safe, healthy environments.
- **People Prepared for Emerging Health Threats:** CDC's preparedness activities-spanning the spectrum from mental health to environmental health-will help in safeguarding lives and responding to threats.
- **Healthy People in a Healthy World:** CDC spearheads efforts to improve global health through medical technology, international coalitions, government interventions, and basic behavior changes.

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE U.S. GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: CENTERS FOR DISEASE CONTROL AND PREVENTION: CHANGES IN OBLIGATIONS AND ACTIVITIES BEFORE AND AFTER FISCAL YEAR 2005 BUDGET REORGANIZATION (GAO 08-328R)

CDC believes these goals can best be achieved through the organizational structure created in 2005. The major focus of the Coordinating Centers and Offices created through the restructuring is to identify opportunities for integration among the centers or divisions in their cluster. Today's environment is characterized by a series of internal and external forces driving the Agency to find new and improved ways to direct its resource investments in ways that maximize health impact and provide necessary disaster relief. These forces require CDC to continually assess how health results are measured. As good stewards of the public's health and the public's funds, CDC uses the Coordinating Center and Offices to maximize its resources by identifying those programs that demonstrate clear and measurable results for the dollars invested.

We are pleased to see that this GAO report shows that the 2005 restructuring has had limited or no impact on funding available for programmatic activities.

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