



BUILDING A SOLID FOUNDATION FOR HEALTH:

A Report on Public Health System Development

**Minnesota Department of Health
January 2003**



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Protecting, maintaining and improving the health of all Minnesotans

Dear Colleague:

We are pleased to share with you *Building a Solid Foundation for Health: A Report on Public Health System Development*. The report was prepared to comply with Minnesota Statutes Chapter 62Q.33, which requires a biennial report on public health system development.

We hope you will find this report to be a clear and informative description of issues facing the public health system in Minnesota. The report outlines several issues that must be addressed in order to have an effective and efficient public health infrastructure to ensure the health of Minnesota residents.

Today's public health system is operating in a rapidly changing environment. Meeting the challenges presented by those changes and the need to leverage better services to communities is both daunting and exciting. Working together, we can meet these challenges and ensure that Minnesota has a strong public health foundation for the twenty-first century. If you have any questions, please contact Debra Burns of my staff at (651) 296-8209.

Sincerely,

A handwritten signature in blue ink, reading "Dianne M. Mandernach", is positioned below the word "Sincerely,".

Dianne M. Mandernach
Commissioner
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As requested by Minnesota Statute 3.197:

This report cost approximately \$3,000 to prepare, including staff time, printing and mailing expenses.

Upon request, this material will be made available in an alternative format such as large print,

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

A REPORT ON PUBLIC HEALTH SYSTEM DEVELOPMENT

I. Introduction

II. Public Health in Minnesota

A. Government's Responsibility for Public Health

B. Effective Partnerships with Others

III. Strategic Issues for Minnesota's Public Health System

A. Ensuring that Essential Public Health Services are Available Statewide

B. A Focus on Ensuring Public Health Emergency Preparedness

C. Addressing a Shortage of Public Health Workers

D. Expanding Partnerships with Tribal Governments

E. Streamlining Administrative Requirements and Funding

F. Articulating the Value of Prevention

IV. Conclusion

EXECUTIVE SUMMARY

INTRODUCTION

This report was prepared to comply with Minnesota Statutes Chapter 62Q.33, which requires the Commissioner of Health to submit a biennial report to the Legislature on public health system development. It incorporates the discussion and recommendations of advisory groups to the Commissioner of Health during 2001 and 2002, such as the State Community Health Services Advisory Committee (SCHSAC)¹ and the Minnesota Health Improvement Partnership (MHIP).² It also reflects many conversations with local public health staff, and dialogue with community groups.

PUBLIC HEALTH IN MINNESOTA

The government has a fundamental responsibility to protect the health of the public. As stated by the United States Supreme Court:

The preservation of the public health is one of the duties devolving upon the state as a sovereign power and cannot be successfully controverted or delegated. In fact, among all the objects to be secured by government laws, none is more important than the preservation of the public health.³

While the term “public health” may bring to mind public health care programs, governmental responsibilities for public health involve a much broader set of duties. In fact, the primary role of the public health system is to keep people well so they do not need medical care.

State and local government public health agencies:

- Prevent epidemics and the spread of communicable diseases.
- Protect against environmental hazards in our water and soil.
- Prevent injury and violence.
- Encourage healthful behaviors that can reduce other health costs.
- Respond to disasters.
- Provide essential services to at-risk populations who are not served by the medical care system.

¹ The State Community Health Advisory Committee is advisory to the Commissioner of Health on issues relating to local public health. Its 51 members represent each of the Community Health Boards in the state.

² The Minnesota Health Improvement Partnership was established in 1996 to advise the Commissioner of Health on system development issues that cross the boundaries of public, private and non-profit sectors, with a broad-based membership from each of those sectors.

³ Schulte v. Fitch, N.W. 717, 1925

Minnesota's public health system relies on state and local governments playing complementary roles. Public health services are locally delivered, within a system of state guidelines and coordination. Local governments deliver public health services in their communities as part of a network of Community Health Boards (the governing body for local health departments) that covers the entire state. The Minnesota Department of Health (MDH) provides technical expertise and services that are most efficiently provided at the state level, along with coordinated planning and statewide guidelines.

For example, in response to a Presidential initiative requiring smallpox vaccination of public health and health care response teams in each state, the state-local system enabled plans for regional clinics to be made in less than three weeks. This example also illustrates the complementary roles of MDH and local health departments. The MDH role involves developing the overall plan; providing scientific expertise, planning support and statewide coordination to local efforts; distributing vaccine and other supplies provided by the federal government; and coordinating with other state agencies. Local health departments implement the state guidelines for administration of vaccine, training, security, monitoring and treatment of adverse events at a regional and local level. The state-local system of public health will mobilize 1,500 volunteers to vaccinate 10,000 public health and other health care providers in a 30-day period.

Similarly, during disease outbreaks the Commissioner of Health depends on the response capacity of local health departments to identify and contain the spread of disease with assistance and technical expertise from the MDH.

Efforts to strengthen Minnesota's public health system have two main focal points. First, the governmental public health system must strengthen its ability to carry out core governmental public health functions and ensure that residents in all parts of the state have access to essential public health services. State and local government share efforts to strengthen the public health system, working through the State Community Health Services Advisory Committee (SCHSAC), a 51-member committee representing all community health boards in Minnesota.

While governments are vested with specific health protection and promotion responsibilities, many other organizations play important roles in assuring the public's health, as do individuals. The second major public health system development activity in recent years has been to build and expand partnerships with organizations and agencies outside of the governmental public health system that play a role in improving the public's health. Much of that work has been done in collaboration with the Minnesota Health Improvement Partnership (MHIP) and is part of Minnesota's Turning Point Project funded by the Robert Wood Johnson Foundation.

The expected outcomes of these combined efforts are:

- A strong infrastructure of governmental public health at the state and local levels.
- An effective and coordinated network of public health partnerships.
- Improved services and health outcomes for all Minnesotans with particular attention to those experiencing health disparities.

STRATEGIC ISSUES FOR THE PUBLIC HEALTH SYSTEM

In addition to identifying and addressing health problems, it is also necessary to identify and respond to issues that affect the ability of the public health system to function effectively and efficiently. This biennial report focuses on the identification of system development needs. Several strategic issues are described in this report, along with ways that they can be addressed. The issues include ensuring that core public health functions are available around the state; focusing efforts on public health emergency preparedness; addressing shortages of public health workers; strengthening relationships with Tribal Governments; streamlining administrative requirements and grants; and articulating the value of prevention.

Ensuring that Essential Services are Available Statewide

Minnesota has historically had a relatively strong public health system when compared with other states. Several characteristics of the public health system have fostered effective public health practice:

- The early development of broad-based statutory authority for public health.
- Considerable local financial commitment to public health.
- The evolution of a comprehensive community assessment and planning process.
- A long-standing history of state and local government working in partnership to achieve public health goals.

Local public health services are based on an assessment of local needs, with a minimum of state mandates. Because of the local control and significant local investment of resources, the type and level of public health services provided by Community Health Boards varies throughout the state. This flexibility has been one of the system's greatest strengths, because it assures that services are in line with community needs and desires. However, this flexibility also means that there is no set of basic public health services that people can expect to have in their community. In the current environment where governmental services are expected to contract, it will be critical to identify a core set of basic public health services and ensure that they are available throughout the state.

Focusing Efforts on Preparedness to Respond to Health Threats

As new health threats appear and former diseases reappear in new populations, as terrorists threaten to use biological weapons, and as governments struggle with limited resources, concern has grown about the ability of state and local public health agencies to respond quickly and effectively to large-scale emergencies and multiple outbreaks.

The list of threats to the public's health is growing. Drug-resistant bacterial infections, rising rates of tuberculosis and other infectious diseases in foreign-born populations, growth in the potential for food-borne illnesses, and bioterrorism all present new challenges. Public health agencies also are called upon to respond to public health needs created by disasters such as floods, tornadoes and spills of hazardous materials. Many local public health agencies are working hard to meet day-to-

day needs while preparing to cope with large-scale public health initiatives such as smallpox vaccination.

Efforts under way to improve public health readiness must be continued. Despite budget issues the public health system must continue to work to: formalize and strengthen partnerships with many groups, including emergency responders; improve coordination of emergency response, in particular to reach high-risk populations; strengthen capacity to detect emerging health hazards and develop and introduce technologies to address them; and improve on systems for rapid notification and response with state, local, and federal partners.

Addressing a Shortage of Public Health Workers

Public health workforce shortages exist throughout Minnesota and are particularly acute in greater Minnesota. Probably the most visible shortage at present is in the nursing workforce in greater Minnesota, where local public health agencies compete with area hospitals for available registered nurses, yet are not able to match the salaries provided by hospitals.

Several projects are underway to address public health workforce shortages. The MDH has a federal grant intended to increase the supply of adequately prepared public health nurses by enhancing the value of student clinical experiences at those health departments. The Minnesota Public Health Association held a workforce summit during 2002, and plans a follow up during 2003. Additionally, the MDH has obtained a small foundation grant to examine ways to interest high school students, particularly students of color, in public health careers. Despite these beginning efforts, a number of gaps have been identified that, if met, would aid with workforce development efforts including: public health promotional materials to attract high school and undergrads into public health as a career choice; an inventory of recruitment materials and activities underway in Minnesota and nationally; information about Minnesota's public health workforce such as number of current workers, preparation for the field, work environments, salary and other factors related to recruitment and retention; and a roster of current public health professionals who are available to make presentations about careers in public health.

Expanding Partnerships With Tribal Governments

American Indians living on reservations have a unique political and legal status. Each American Indian tribe is a separate legal entity and each is a sovereign nation. Although local public health departments and the MDH have been effective partners in protecting and promoting health for over 25 years, the state-local model of 1976 does not acknowledge or address the governance role of tribal governments in public health. An Executive Order was issued in 2002 which requires state agencies to recognize the unique legal relationships between the State of Minnesota and Indian tribes, and whenever feasible, consult with governments of the affected Indian tribe or tribes when developing or implementing policies that will directly affect Indian tribes and their members. The impact of this directive on the state-local Community Health Services (CHS) partnership has not yet been explored. A reflective examination of the goals and structure of the state-local partnership is needed to consider the practical application of a broader "partnership of governments" approach specified in the executive order.

Streamlining Administrative Requirements and Funding

Funding from the MDH to Community Health Boards (CHBs) has become increasingly categorical over the last decade. The number of small, competitive grants has increased while broad, formula-based grants have decreased. A significant result of fragmented public health funding is that an increasing amount of time is spent on administration of programs rather than on actual program activities. Each grant program has its own application, program development and reporting requirements, which complicate grant management for CHBs.

The CHS annual reporting system, created more than 10 years ago, currently collects data about activities and expenditures of CHBs as outlined in Minnesota Rule 4736.0090. This system has the potential to serve as a foundation for more coordinated data collection, but in its current form is inadequate, both in content and technologically. In order to be useful as a basic method of accountability for the CHS system it must be updated to focus on current public health activities and expenditures. It could then evolve to integrate the collection of outcome measures related to local CHS plans.

Articulating the Effectiveness of Prevention

Public health, with its emphasis on prevention, is one of the best investments government can make because of the focus on preventing problems before they become human or economic losses. Of the 30 years in life expectancy gained during the 20th century, 25 can be attributed to public health efforts such as vaccinations, safer work places, control of infectious diseases, safer food and water, decreased heart disease and stroke because of changes in diet and exercise, healthier mothers and babies.

Although many factors affect health, health behaviors play a significant role. An MDH study last year estimated that \$500 million per year is spent on health care in Minnesota as a result of physical inactivity alone; however, the vast majority of health care expenditures are for health care services with very little for health behaviors. The public health system plays a key role in prevention, as do many other organizations. A national business group called the Partnership for Prevention documents a number of positive outcomes resulting from business investments in prevention, including improved productivity, and lower healthcare costs.⁴

Despite the documented benefits of investment in prevention, those results have not been widely shared or understood. There is a need to develop a clear, concise rationale for investment in prevention that is based on evidence yet understandable to a general audience. A beginning step would be to examine existing studies (e.g., the Guide to Community Preventive Services, Centers for Disease Control and Prevention's Ounce of Prevention; Healthy Workforce 2010) that have considered investments versus outcomes in public health, in order to craft statements on the benefits of investment in prevention.

⁴ Healthy Workforce 2010. Partnership for Prevention. Fall 2001. Washington, D.C.

A REPORT ON

PUBLIC HEALTH

SYSTEM DEVELOPMENT

I. INTRODUCTION

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In addition to describing Minnesota's public health infrastructure, this report takes a close look at several important issues facing the public health system. These issues have been identified as strategic opportunities for the public health system and its partners to take action to maintain a strong public health system, which will result in meaningful improvements in the public's health.

II. PUBLIC HEALTH IN MINNESOTA

The public health system in Minnesota consists of a strong state and local government system at its core, complemented by partnerships with the many organizations and entities that play a role in improving health. These components are described in more detail below.

A. Government's Responsibility for Public Health

Protecting the public's health is so basic, and the consequences of *not* protecting the public's health are so serious, that both the state and federal constitution contain provisions to ensure this protection. The Supreme Court has repeatedly found that protection of the public's health is a duty that falls on government: "The preservation of the public health is one of the duties devolving upon the state as a sovereign power and cannot be successfully controverted or delegated. In fact, among all the objects to be secured by government laws, none is more important than the preservation of the public health."³

State and local government public health agencies improve the lives of Minnesota citizens by:

- Preventing epidemics and the spread of communicable diseases.
- Protecting us against environmental hazards in our water and soil.
- Preventing injury and violence.
- Encouraging healthful behaviors that reduce other health costs.

¹ The State Community Health Advisory Committee is advisory to the Commissioner of Health on issues relating to local public health. Its 51 members represent each of the Community Health Boards in the state.

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³ Schulte V. Fitch, N.W. 717, 1925.

- Responding to disasters.
- Providing essential services to at-risk populations who are not served by the medical care system.

Governmental public health agencies ensure safe drinking water, safe food, clean air, adequate immunizations, and provide necessary support to young families, the disabled, and the elderly. Moreover, as government entities, public health agencies also have unique responsibilities and an established structure for collecting and analyzing data on births, deaths, and the health status of the population, including monitoring of disease and injury. Much as we expect to have police to watch out for our public safety, public health workers have a responsibility to watch out for the health of our communities. These responsibilities are often called the “essential public health services”.

To fulfill their duties, government public health agencies have been granted specific authorities for the enforcement of health and sanitary codes relating to housing, water, health care facilities, food, and plumbing; to enforce disease control laws in a variety of situations; and to enforce minimum standards in the delivery of health care services. The responsibility of government for the health and well being of the public applies by definition to all citizens, not just a select few. This approach to public health is referred to as “population-based”. Population-based strategies emphasize health promotion and prevention of health problems and may be directed at individuals, communities, or systems, depending upon how the problem may best be addressed.

In order for government to carry out its public health responsibilities, an effective system must be in place at both the state and local levels. This system is commonly referred to as the public health infrastructure. Difficult though it might be to visualize, the public health infrastructure is integral to the day-to-day functioning of a community. It is like roads, bridges, water systems, and other types of essential government services and structure, which citizens may take for granted, but expect to exist. It requires that the necessary legal authorities, trained public health workforce, equipment and other resources are present in sufficient amounts to address public health issues that arise in a community or state.

Minnesota’s State and Local Government Partnership

Minnesota is unique among states for having a public health system that is a partnership of shared responsibility between state and local governments. This system allows state and local government to coordinate resources to effectively and efficiently address public health needs.

The Commissioner of Health is responsible for “developing and maintaining an organized system of programs and services for protecting, maintaining and improving the health of the citizens”.⁴ Minnesota Department of Health (MDH) program areas include disease prevention and control, family health, chronic disease and health promotion, community health, environmental health, public health laboratory services, health care policy, and regulation.

⁴ Minnesota Statutes Chapter 144.05, subd.1.

The Local Public Health Act lays out the vision for the strong local public health system that exists in Minnesota today.⁵ This law calls on local government to “develop an integrated system of community health services” by extending public health services into the community.

Community Health Boards (CHBs) are established and supported by local government and made possible by state funding provided through the state community health services (CHS) subsidy.⁶ To be eligible for the CHS subsidy, each of the 51 CHBs develops a four-year community health plan to address locally determined public health problems. By law, the CHS plans must address the six program areas of disease prevention and control; emergency medical services; environmental health; family health; health promotion; and home health care.

This state and local public health system recognizes the differing needs of communities around the state, provides the flexibility to address specific needs. It allows sharing of technical expertise, data and resources between state and local government and promotes direct and timely communication between state and local agencies. The CHS system has resulted in an effective state and local partnership that does not rely on mandates for cooperation, but upon shared goals and a strong desire to work together to improve the lives of all Minnesotans.

B. Effective Partnerships with Others

Creating a healthy society is a responsibility that is shared by all residents. While governments are vested with specific health protection and promotion responsibilities, no one person, family, business, organization or government agency has the resources to bring about the changes needed for a healthy public.

Many organizations have a role in improving the public’s health. To focus broad community attention and inspire action toward addressing health problems, public health agencies at the national, state, and local levels work with their communities to create shared goals to guide health improvement efforts. At the local level, each CHB conducts a community assessment and develops a Community Health Services Plan every four years. At the state level, the *Healthy Minnesotans Public Health Improvement Goals* were published in 1998 as a statewide agenda for health. The *Healthy Minnesotans* goals represent a statewide call to action, and also a reminder that we all share the benefits of and the responsibility for a healthy society.

In 1996, the Commissioner of Health convened a broad-based group, the Minnesota Health Improvement Partnership (MHIP), representing many of the types of organizations that play a role in improving the public’s health. One of the major responsibilities of this group was to work with MDH in developing the *Healthy Minnesotans* goals. Since then, MHIP has focused on specific areas within the goals for further development and work. During the 1990s, a particular emphasis was placed on developing relationships with managed care organizations.

⁵ Minnesota Statutes Chapter 145A.

⁶ A CHB is a county or group of counties, or city eligible to receive the CHS subsidy. In this document, the terms CHB and “local public health department or agency” may be used interchangeably.

Legislation that passed in 1994 created new and more formalized opportunities for dialogue between public health agencies and the private system of health care through the development of collaboration plans. The Collaboration Plan's purpose is to describe the actions that the Health Maintenance Organizations or Community Integrated Service Networks have taken and those it intends to take to contribute to achieving public health goals for its service areas. Recently, representatives from MDH, local public health, and health plans discussed ways that this legislation could be strengthened and streamlined and proposed changes that were enacted by the Legislature in 2001. The next set of Collaboration Plans are to be developed on the same timeline as the CHS plans, and provide an opportunity to undertake joint planning and to meet locally and regionally identified needs, with a small number of statewide priorities drawn from the CHS plans. The *Healthy Minnesotans Public Health Improvement Goals and Strategies for Public Health* provide a broad framework for those efforts.

Strengthening Minnesota's Public Health System

Although Minnesota currently has a well-established public health system, many issues remain to be addressed. Efforts to strengthen Minnesota's public health system have two main focal points. First, the governmental public health system must ensure that it can carry out core governmental public health functions and fulfill its responsibilities under state law. This includes responding to increased demands on the system due to demographic changes and new health threats. State and local government share efforts to strengthen the public health system, which occurs in great part through the State Community Health Services Advisory Committee (SCHSAC), a 51-member committee representing all community health boards in Minnesota.

The second major emphasis involves broadening the public health focus beyond government to explicitly include the many other organizations that work to improve the public's health. Much of that work in recent years has been done in collaboration with the Minnesota Health Improvement Partnership and is part of Minnesota's Turning Point Project, which is funded by the Robert Wood Johnson Foundation.

Over time, the expected outcomes of these combined efforts to strengthen public health in Minnesota are:

- A strong infrastructure of governmental public health.
- Expanded network of partnerships with non-governmental organizations.
- Improved services and health outcomes for Minnesotans particularly those experiencing health disparities.

III. STRATEGIC ISSUES FOR THE PUBLIC HEALTH SYSTEM

In order to assure that the public health needs of Minnesotans are met, it is necessary to assess and address problems that are affecting the public's health. State and local assessment and planning efforts regularly identify and document health problems, health threats, and trends in health status. At the state level, this is done through the *Healthy Minnesotans Public Health Improvement Goals*.

At the local level, it is done through the assessment and planning process that community health boards conduct every four years. The identification of health threats is done on an ongoing basis, through a surveillance system which relies on the cooperation of health care providers and many other partners; as well as informal mechanisms.

It is also necessary to identify and address systems issues which affect the ability of the state and local public health system to fulfill its' responsibilities for public health. This report focuses on the identification of system development needs. Several important issues need a particular focus during the upcoming biennium, to ensure a public health system that can meet the needs of Minnesota residents. These issues include ensuring that essential public health services are available around the state, focusing on public health emergency preparedness; addressing shortages of public health workers; strengthening partnerships with tribal governments; streamlining administrative requirements and grants; and articulating the value of prevention.

A. Ensuring that Essential Public Health Services are Available Statewide

Minnesota has historically had a strong public health system. Several characteristics of the public health system have fostered effective public health practice:

- The early development of broad-based statutory authority for public health.
- Considerable local financial commitment to public health.
- The evolution of a comprehensive community assessment and planning process.
- A long-standing history of state and local government working in partnership to achieve public health goals.

Local public health services are based on an assessment of local needs, with a minimum of state mandates. Because of the local control and significant local investment of resources, the type and level of public health services provided by CHBs varies throughout the state. This flexibility to address community needs is one of the system's greatest strengths; it is also a potential vulnerability to the extent that there is not a core set of public health services that Minnesota residents can be assured of receiving regardless of where in the state they live. In the current environment of budget crisis and contraction of governmental services, it will be critical to identify a basic core of essential public health services, and ensure that they are in place for all Minnesotans.

In Minnesota, local government's responsibilities and authorities are broadly defined in the Local Public Health Act (MS145A), and further established in the related rule. Guidelines developed by MDH in cooperation with local public health boards and staff provide further clarification of common expectations. Primary examples include:

- CHS Planning and Reporting Manual
- Guide for Promoting Health in Minnesota
- CHS Administration Handbook
- Environmental Exposures Handbook for Public Health Nurses
- Disease Prevention and Control Common Activities Document

- A Guide for Controlling Public Health Nuisances

Planned public health activities are set forth in each agency's CHS plan and further detailed in individual grant applications. Consultation, training, and technical assistance provided by MDH can help agencies achieve these expectations. Although state statute contains provisions to withhold the CHS subsidy if an agency does not comply with the requirements of the law, there are no sanctions imposed if an agency does not meet the activities set forth in its plan. Moreover, although the law contains requirements of local government for basic health protection, the success of the CHS system depends largely on the voluntary commitment of local government to public health.

There has been periodic consideration of whether a more uniform set of expectations, either voluntary or mandatory should be established statewide. The Common Activities for Disease Prevention and Control approved by SCHSAC in 1998 serves as a potential prototype. However, commitment to local flexibility in Minnesota remains strong, which has created a tension between desire for local control and desire for a standardized level of quality.

Also in 1998, two work groups of the SCHSAC addressed the issue of improved performance. The SCHSAC Governance Work Group concluded that, in order for government to fulfill its responsibilities, a solid foundation, or infrastructure was needed at both the state and local levels. The work group recommended more work be done to identify indicators of organizational capacity to support this infrastructure. Another SCHSAC work group reviewed national efforts to accredit local health departments. This group concluded that accreditation was not the best way to improve performance in Minnesota at this time. However, they recommended that the MDH and CHBs work together to develop and implement voluntary performance measures.

The context for public health services has shifted dramatically in recent months. With a \$4 billion shortfall in the state budget, state funding to local governments is expected to steeply decline. While funds for essential public health services have always been tight, budget pressures over the next biennium are expected to put the local public health system in jeopardy, as available funding must be stretched to meet the competing needs at all levels of government. These budget problems may result in an inability of local governments in some parts of the state to provide even the most basic set of public health services to fulfill their role in the state and local public health system.

There appears to be a growing consensus that it is time to establish community expectations for a basic set of public health services - so that every resident in Minnesota, regardless of where they live has access to essential public health services and protections. Many options exist for how such an effort could be structured. For example, they could be tiered to ensure that they are obtainable for smaller local health departments with limited infrastructure and organizational capacity. They could be done on a voluntary basis, or phased in over a period of years; they could be modeled after the common activities of disease prevention and control; they could be tied to funding or tied to regular technical assistance from the state; while some activities may need to be available on a daily basis in some areas, they may be needed only on a periodic basis in other areas; some consideration of regional collaboration to provide a set of services may be considered. During the upcoming biennium, it is expected that the SCHSAC will need to wrestle with these and other questions about the intent, scope and structure of a set of essential public health services.

B. A Focus on Ensuring Public Health Emergency Preparedness

The public health system is increasingly being asked to anticipate and address new and emerging health issues. The threat of bioterrorism has emerged as a key issue for public health preparedness; however is not the only emerging issue that requires a strong public health response. New or antibiotic resistant infectious disease threats, and the re-emergence of familiar diseases that were once thought to be effectively controlled, are among these issues. For example, food borne diseases, while not new, are increasingly being recognized as an important public health problem.

Clandestine drug labs that manufacture methamphetamine have created health, environmental, and law enforcement problems of crisis proportions in other states. Toxins in school buildings have posed health threats in children. The public health system is asked to find ways to address health implications of a wide variety of potential crises and emergencies - including natural disasters, environmental releases of toxic substances, major disease outbreaks and acts of terrorism. And as our state's population continues to diversify, we are increasingly being asked to assess and respond to health issues that face our newest citizens.

Key Issues

In no other area of public health is it more crucial to have a strong infrastructure - a skilled and prepared workforce, effective information systems, and ability to mobilize community organizations. This foundation – the public health infrastructure – must be strengthened to respond to emerging health threats at both the state and local levels. Strengthening the infrastructure involves several components:

- Forming new partnerships and improving collaboration between/among state and local organizations.
- Detecting and monitoring emerging issues.
- Increasing capacity to respond to emerging health threats.
- Strengthening intervention capacity.

Partnerships and Improved Collaboration. Readiness to respond to emerging health threats requires a complex collaboration of federal, state and local government and also private organizations. At the state level, MDH has been working with many primary partners to assure a system is in place for any public health threat. At a regional and local level, local public health agencies have been developing detailed plans to assure readiness in case of a bioterrorism attack. The current planning around smallpox is has increased awareness of the need for coordinated planning and communication, and has provided opportunities to formalize relationships and coordination.

Detecting and Monitoring of Emerging Issues. For the public health system to effectively detect and monitor emerging health threats, it must have sufficient capacity in several key areas. First, it must have the capacity to collect and analyze data on specific health behaviors, diseases, drug resistance, health effects, or exposures in the population. Second, it must have sufficient laboratory capacity to conduct surveillance for detection and identification of infectious agents, hazardous chemicals and radioactive substances. Finally, it must have sufficient epidemiological and toxicological expertise to interpret data on disease, disability and exposure to biological

organisms and chemical agents in order to develop effective prevention and control programs. Federal funding for public health preparedness/bioterrorism has provided resources for some of that work.

Emerging Threat Response Capacity Issues. Emerging threat response capacity refers to the ability to effectively *respond* to threats to the public's health once they are detected. Inherent in this capacity is staffing capacity for planning, coordination, management and response; and data management and communication infrastructure to support a rapid exchange of information with partners.

Issues Related to Emergency Public Health Intervention Capacity. Emergency public health *intervention* capacity refers to the legal authorities needed to take the extraordinary steps that might be needed to protect the public's health during a terrorism event, large scale disease outbreak or other public health threat; as well as the ongoing training, planning, exercises, and evaluation of response systems to assure the systems are continually modified to reflect changes in resources, expertise and threats.

Many efforts have taken place or are underway to address these issues. Several years ago, state and local government worked together to identify roles and activities needed to address infectious diseases. A 1997 work group of the SCHSAC developed a framework of activities for disease prevention and control common to all local health departments and MDH. While not all local health departments are able to perform all activities, all CHBs have begun to work with MDH to determine their current capacity and set benchmarks for improvement. Second, the SCHSAC also worked with MDH and emergency management at the state and local levels to develop a handbook to assist local health departments to prepare for public health emergencies. Following the completion of this work, a state-local work group developed a template for developing a disaster and emergency response plan. Prior to the terrorist attack on September 11, 2002, all local health departments had some type of plan in place, most often as an annex to the county disaster plan. Third, efforts to improve communication with many organizations have expanded due to development of a Health Alert Network. This network, funded by a grant from the CDC, provides for Internet access to all local health departments. This network is used to communicate about public health disasters and other health threats.

Finally, federal funds were provided in 2002 for public health preparedness planning. While comprehensive planning efforts have been sidetracked by the need to focus on smallpox planning, this real-time exercise in developing plans for vaccination of public health and health care provider teams is making a valuable contribution to public health preparedness. Despite the many activities of recent years, public health preparedness will continue to be a significant issue for the public health system in the upcoming biennium.

C. Addressing a Shortage of Public Health Workers

Public health workforce shortages exist throughout Minnesota and are particularly acute in greater Minnesota. It is estimated that the public health field will need to grow 40 percent to meet future needs.⁵ Despite a lack of concrete numbers on Minnesota's public health workforce as a whole, we know that one third of the MDH workforce will be eligible to retire by 2010. By 2013, 39 percent of the MDH employees will be eligible for retirement; of these 65 percent will be managers and 50 percent will be supervisors.

Probably the most visible shortage at present is in the nursing workforce. Local health departments are seeking practitioners with the skills necessary to provide the essential services of public health, but the supply of adequately prepared nurses is dramatically dwindling. There are more job openings than nursing graduates in this state. Schools of nursing in Minnesota produce around 1,900 registered nurses (RNs) per year, but Minnesota currently has 2,900 job openings for RNs.⁶ These circumstances result in grave concerns for recruitment of qualified nurses, especially younger nurses, for public health practice. In a survey of all county and city public health agencies conducted in December, 1999 (81 percent return rate), the MDH found that 65 percent of responding agencies indicated difficulty recruiting. A major factor was starting salaries. In most markets in Minnesota, local health departments compete with area hospitals for available RNs. In 1999 the median starting salary at local health departments was \$14.49 (range = \$10.03 - \$19.22). The median starting wage in Minnesota hospitals represented by the Minnesota Nurses Association at that same time was \$16.75 (range = \$14.26 to \$18.20).

There is also a need to increase the diversity of professionals in the field of public health. A more diverse and culturally competent work force that reflects the racial and ethnic diversity of Minnesota residents is urgently needed in the health sector to overcome existing non-financial barriers to public health and health care services (e.g., language and communication barriers, mistrust or fear of health care and government institutions, and limited knowledge about how to navigate large agencies and systems.⁷ The effort to attract and retain a diverse work force is a process that requires organizations to establish and adhere to practices to recruit, retain, and promote personnel who reflect the cultural and ethnic diversity of the communities served.

Several projects are underway to address public health workforce shortages. The MDH has a federal grant to intended to increase the supply of adequately prepared public health nurses by linking schools of nursing with practicing public health nurses at local health departments, to enhance the value of student clinical experiences at those health departments. The MDH has also obtained a small amount of foundation funding to examine ways to interest high school students, particularly students of color, in public health careers. The Minnesota Public Health Association is leading efforts to plan events during Public Health Week in April that include communications about public health careers.

⁵ Local Public Health Association Public Health Workforce Report.

⁶ Office of Rural Health and Primary Care. February, 2001. Registered nurse workforce profile. Minnesota Department of Health. St. Paul, MN.

⁷ Georgetown University Child Development Center, National Center for Cultural Competence. Rationale for cultural competence in primary health care. <http://www.ucdc.georgetown.edu/nccc6.html>

Recent conversations regarding workforce issues in the public health community have identified other gaps, which would assist public health recruitment efforts if they are met. First, a current comprehensive inventory of recruitment materials and activities already underway both in Minnesota and nationally is needed. The inventory would provide important information needed to identify where recruitment opportunities might be being missed, estimate the resources needed to do a better job, and give the public health community a picture of what is being done beyond an individual's own organization or discipline.

Specific information about Minnesota's public health workforce is also needed. In future years, this could possibly be done in conjunction with the CHS agencies' annual reports due to MDH each April 15. Information about numbers of workers as well as information regarding preparation for the field, work environments, salary and compensation, and other factors related to both recruitment and retention would be extremely helpful to guide workforce development efforts.

Finally, a public health speaker's bureau is needed to make presentations available to high schools and colleges across the state to talk about careers in public health. Pre-packaged PowerPoint presentations with "talking points" would assist speaker's bureau participants, who could adapt them to the particular audience. Also needed are discussions between public health disciplines with specific recruitment/retention issues, such as the current unavailability of undergraduate degrees in some fields (like epidemiology) or undergraduate curricula that produces graduates without the background necessary to work in a particular area of public health (like some environmental sciences programs) with institutions preparing the entry-level practitioner. This is currently being done in the field of public health nursing through the federal nursing grant referenced earlier. The possibility of extending this kind of partnership between practice and academia in other disciplines should be explored.

D. Expanding Partnerships with Tribal Governments

American Indians living on reservations have a unique political and legal status. Each American Indian tribe is a separate legal entity and each is a sovereign nation. Although local public health departments and the MDH have been effective partners in protecting and promoting health for over 25 years, the state-local model of 1976 does not acknowledge or address the governance role of tribal governments in public health. While examples of effective working relationships exist between state and county public health programs and tribal governments, they are not universal. Given the significant health disparities that exist in Minnesota's American Indian population, developing effective public health partnerships with tribal governments is a critical public health issue for the future.⁸

Legal Framework⁹

Tribal governments are sovereign nations that exist within the boundaries of a separate nation, the United States. As sovereign nations, tribes have the power to:

⁸ This will not, however, address the distinct and important issues faced by the urban American Indian population in Minnesota.

⁹ The information in this section is taken from the Minnesota Indian Affairs Council web site, <http://www.indians.state.mn.us/>

- Determine a form of government.
- Determine tribal membership.
- Establish a police force.
- Administer justice.
- Exclude people from the reservation.

The right to form a government is an important power of tribes. This power comes from the tribal members and includes the right to choose officials and methods of governing. Many tribes have written constitutions and three branches of government. Tribal governments in Minnesota are called by various names such as tribal council, reservation business committee, or business council. Officials are either elected to serve two-year or four-year terms of office by eligible voting tribal members. A description of the tribal government for each of the 11 tribes in Minnesota is at the Minnesota Indian Affairs Council website www.indians.state.mn.us.

The relationship between the United States and American Indian tribal nations is defined by treaties and the United States government's trust responsibility. "Treaties formalize a nation-to-nation relationship between the federal government and the tribes. In treaties, Indians relinquished certain rights in exchange for promises from the federal government. Trust responsibility is the government's obligation to honor the trust inherent to these promises and to represent the best interests of the tribes and their members."

Key Issues

In 2002 state agencies were issued an Executive Order, which included the following directive:

- Agencies of the State of Minnesota and persons employed by state agencies shall recognize the unique legal relationship between the State of Minnesota and Indian tribes, respect the fundamental principles that establish and maintain this relationship and accord tribal governments the same recognition and respect accorded to other governments.
- When undertaking to formulate and implement policies that directly affect Indian tribes and their members, the State and its agencies must recognize the unique government-to-government relationship between the State and Indian tribes and whenever feasible consult with the governments of the affected Indian tribe or tribes regarding a State action or proposed action anticipated to directly affect an Indian tribe. (Executive Order 02-01, October 17, 2002)

The impact of this directive on the traditional state-local CHS partnership has not yet been fully explored. A reflective examination of the goals and structure of Minnesota's statewide public health system is needed to consider the practical application of a broader "partnership of governments" approach specified in the executive order to the structure and function of the SCHSAC and in the policies, guidelines, and other products of the committee. During 2002, the MDH Tribal liaison will discuss concrete next steps with the SCHSAC Executive Committee.

E. Streamlining Administrative Requirements and Funding

Funding from the MDH to CHBs has become increasingly categorical over the last decade. The number of small, competitive grants has increased while broad, formula-based grants have decreased. As described in the 2000 SCHSAC report *Streamlining Grant Funding for Minnesota's Public Health System*, the percent of categorical grant dollars provided to local CHBs from the MDH has remained fairly stable at ten percent of total expenditures. However, over the last decade, the number of grants that comprise that ten percent has increased significantly. Thus categorical grant funding as a proportion of total local public health expenditures has remained steady, but the amount of work related to applying for and administering these grants has increased, and funding is less stable overall. The result of this shift is that local governments have less flexibility to meet locally identified needs. The CHS subsidy – the only truly flexible source of funding available from the state to CHBs – has remained a relatively small percentage of overall grant funding. The CHS subsidy made up only eight percent of total CHS expenditures in 2000, down from ten percent in 1999.

A significant result of fragmented public health funding is that an increasing amount of time is spent on administration of programs rather than on actual program activities. Each grant program has its own application, program development and reporting requirements, which complicates grant management for CHBs.

The fragmented funding structure lends itself to the development of a wide variety of grant program requirements. These requirements come from numerous sources, including federal or state legislation, federal or state agency interpretation of legislation, federal and state grant management policies and local agency policies. When each grant must be managed in a slightly different way due to these varying requirements, the amount of time spent on administrative duties becomes time-consuming and unnecessarily burdensome.

The CHS annual reporting system, created more than 10 years ago, currently collects data about activities and expenditures of CHBs as outlined in Minnesota Rule 4736.0090. This system has the potential to serve as a foundation for more coordinated data collection, but in its current form is inadequate, both in content and technologically. The system has the potential to serve as a basic method of accountability for the CHS system, but it must first be updated to focus on current public health activities and expenditures. It could then evolve to integrate the collection of outcome measures related to local CHS plans.

The current environment, with an increasing emphasis on accountability, will likely bring this issue to the forefront. Like business, government at all levels is moving toward quality improvement and greater accountability. The federal government, in conjunction with several public health organizations, has developed several performance measurement tools to identify benchmarks for effective performance. One example is the national Maternal Child Health performance measures. The Centers for Disease Prevention and Control has recently completed a set of indicators of performance for local health departments that may be used as a tool to address performance in each of the essential public health services. This is seen as the possible precursor for a national

accreditation program. The National Association of County Health Officials is also working on the issue of local health department accreditation.

Local public health staff and county commissioners are critically aware of the need to upgrade information systems. Many of them have expressed repeated concerns about the financial drain of creating, upgrading, and supporting information systems at a time when resources are also stressed. At the same time, both the MDH and CHBs recognize the need to better coordinate data and share information both within the MDH and between state and local government, and to streamline the grant application reporting process.

F. Articulating the Value of Prevention

Public health, with its emphasis on prevention, is one of the best investments government can make because of the focus on preventing problems before they become human or economic losses. Of the 30 years in life expectancy gained during the 20th century, 25 can be attributed to public health efforts such as vaccinations, safer work places, control of infectious diseases, safer food and water, decreased heart disease and stroke because of changes in diet and exercise, and healthier mothers and babies.

As a recent example of a public health prevention success, Haemophilus influenzae type B was a major cause of meningitis with 200 sick children each year in Minnesota and an average of four deaths. Through education and coordination with health care providers, childcare providers and parents to have children immunized, the number of cases of this disease is essentially zero, resulting in savings to the health care system.

Although many factors affect health, health behaviors play a significant role. An MDH study last year estimated that \$500 million per year is spent on health care in Minnesota as a result of physical inactivity alone; however, the vast majority of health care expenditures are for health care services with very little for health behaviors. It is estimated that only four percent of health care expenditures at the national level are devoted to health behaviors, with the vast majority spent on health care.¹⁰ Although Minnesota-specific data are not available, it is likely that Minnesota follows the national picture.

Although the public health system plays a key role in prevention, so do many other organizations. According to the Partnership for Prevention, savings from small decreases in absenteeism alone can more than offset the cost of a health promotion program. In a report titled *Healthy Workforce 2010*, the Partnership for Prevention documents a number of positive outcomes resulting from business investments in prevention, including improved productivity, lower healthcare costs, and improvements in corporate image. In a 1998 analysis of five absenteeism studies, average program savings of almost \$5 for every dollar spent were identified.¹¹

¹⁰ Centers for Disease Control and Prevention, University of California at San Francisco, Institute for the Future, Minnesota Health Improvement Partnership report: A Call to Action.

¹¹ Healthy Workforce 2010. Partnership for Prevention. Fall 2001. Washington, D.C.

Despite the documented benefits of investment in prevention, those results have not been widely shared or understood. There is a need to develop clear, concise arguments for investment in prevention that are understandable to a general audience. A beginning step would be to examine existing studies (e.g., the Guide to Community Preventive Services, CDC's Ounce of Prevention; Healthy Workforce 2010) that have considered investments versus outcomes in public health, in order to craft statements on the benefits of investment in prevention.

IV. CONCLUSION

In previous years a plan of action has been included as part of the Public Health System Development Report. However, at present there are too many unknown factors to lay out a clear plan. Instead, staff will work with SCHSAC and others in upcoming months to determine specific activities to address the issues described in this report.



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