ARIZONA HEALTH FUTURES

FALL 2002

Building a Public Health Movement in Arizona

2020s – The U.S. conquers fat. Millions lose weight and regain energy and vitality as states pass fat taxes and levy fines on overweight people. Arizona leads the nation.

INSIDE:

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St. Luke's Health Initiatives
A Catalyst for Community Health

GREAT MOMENTS IN PUBLIC HEALTH

1910s
The U.S. establishes strict laws governing the pasteurization of milk and purification of drinking water. Sanitation improves, infant mortality rates decline. *Arizona follows the nation.*

1950s
Millions pop a sugar cube in their mouth and are immunized against polio. The crippling disease retreats worldwide. *Arizona follows the nation.*

1980s
States establish strict seatbelt laws. Thousands of traffic fatalities are avoided. *Arizona follows the nation.*

1990s
States get aggressive with big tobacco companies, using anti-smoking campaigns and tobacco taxes. Smoking rates decline dramatically. *Arizona leads the nation.*

2020s
The U.S. conquers fat. Millions lose weight and regain energy and vitality as states pass fat taxes and levy fines on overweight people. *Arizona leads the nation.*

Building a Public Health Movement in Arizona

What Price Good Health?

2020 is a fantasy. It will never happen, right? Certainly not in Arizona, land of the Lexus cowboys, where libertarians roam free, children ride in the back of open pickups, people supersize their meals and lack of physical activity is well above the national average (34% compared to 27% nationally in 2000).

And yet Arizonans voted to curb the personal liberty to smoke in certain public places in Mesa, Tempe, Tucson and other communities. More tobacco taxes are on the ballot; can more taxes on alcohol, gaming and fatty foods be far behind?

Maybe not. But it raises a central issue: What price are we willing to pay for "good health?"

More to the point, what price are we willing to charge *others* for their bad health habits? What degree of personal freedom are we willing to curtail for public health, public safety and the increased threats of bioterrorism and environmental disasters?

If those are hard questions to answer, consider these: Who, or what, is the *public* in public health? What is the role of local communities in setting public health policy and standards? Who is actually responsible for public health work? Are localities simply pawns under the heavy regulatory thumb of states? Are states, in turn, suffocating under the weight and bureaucratic rule of the federal government?

Is public health top-down or bottom-up? Who pays, who decides? Where do we get the greatest return on our public health investment?

A Ghost Sector

The events surrounding September 11 galvanized public opinion around issues of public safety and threats from outside forces. But while biodefense is a wake-up call for strengthening public health surveillance, warning and communication systems, the risk is that in our preoccupation with the trees of immediate and perceived threats to our safety and health, we lose sight of the forest of public health needs and issues that will determine, to a great extent, our quality of life in the foreseeable future.

The fact of the matter is that public health, for all the recent attention, is little understood, and even less appreciated, by most Americans. In many ways it's a ghost sector: invisible, although the traces of its work are everywhere. Why this is so – and what we can do about it in Arizona – is the central subject of this *Arizona Health Futures* Issue Brief.

We discuss what public health is and isn't, and how it's structured and financed in Arizona. We analyze how public health trends and issues play out in our state, and where we might make progress in addressing them. Finally, we lay out the central issues and strategies to build a public health movement in Arizona through stronger public-private partnerships, education and advocacy.

No More Whining

Sources for this report include a review of the relevant research on public health and interviews with over 30 key informants at the county, state and national levels. One constant theme we heard over and over again was that people are "sick and tired of whining" – complaining

about how bad things are in Arizona, why we seem to be bottom feeders in so many health and human service indicators, how the legislature can't seem to get anything right, etc.

Whining is often a "bonding" activity. It feels good, it provides an emotional release in the face of seemingly insurmountable obstacles. Some people are paid quite a bit of money to whine, in fact.

But enough is enough. Whining gets us nowhere. Major public health issues of safety, access to health care, lifestyle choices and disparities between population groups face Arizona and the rest of the nation. This report starts from a different place: Come together as a community through public-private partnerships across ideological, racial and cultural fault lines. Build a culture of hope, optimism and energy. Public health is really everyone's responsibility, and that's where we need to start.

No more whining. We can build a public health movement in Arizona.

Did You Know?*

- Life expectancy for Arizonans is 71 years, compared to the national average of 76 years. For Native Americans in Arizona, life expectancy is 55 years – 16 years sooner than the Arizona average.
- African Americans are 1.4 times more likely to die from heart disease than all Arizonans.
- The age-adjusted mortality rate for individuals dying from diabetes in Arizona increased from 15.6 per 100,000 in 1990 to 19 in 2000. Native Americans have a rate four times that of the average; Hispanic and African American populations are twice the average.
- The number of people who died from motor-vehicle related injuries in Arizona has remained relatively constant over the past ten years – and that's in spite of a dramatic increase in population during the same period. The age-adjusted mortality rates has dropped from 23.6 to 17.5 per 100,000.
- In 2000, there were 1640 cases of vaccine preventable diseases in Arizona – down from 12,404 in 1990.
- About 43 percent of Arizona children have untreated tooth decay, compared to a U.S. average of 31 percent.
- Fewer Arizonans smoke cigarettes than the national average (18.6 percent compared to 23.2 percent), but more Arizonans report having no physical activity in the past month than the national average (34 percent compared to 27 percent).
- About 16 percent of Arizona citizens lack health insurance, compared to 12 percent nationwide.

These are just a few of the many reasons we need to build a public health movement in Arizona. We should celebrate our successes, and plan to have more of them in the future.

* Compiled from Arizona Health Status and Vital Statistics 2000 (ADHS); Reforming the Health Care System: State Profiles 2001 (AARP); and Open Wide: The Future of Oral Health Care in Arizona (SLHI, 2002).

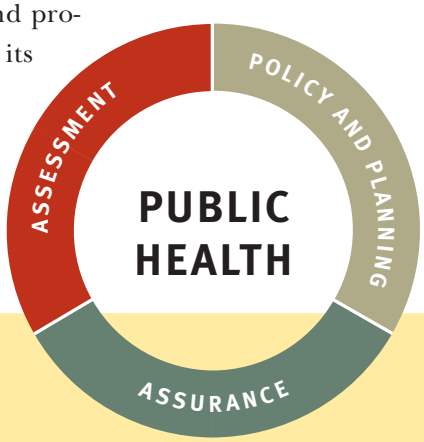
What is *Public Health?*

"Public health is about keeping people healthy, while health care is about making people better after they have already gotten sick."

Sue Gerard, Arizona State Senator

Eyes glaze over at defining something as apparently amorphous as public health. Yet a working definition of public health – and its core functions – is the starting point for understanding its critical importance in our society.

In its 1988 report, The Future of Public Health, the Institute of Medicine (IOM) defined public health as "...an organized community effort aimed at the prevention of disease and promotion of health." From this definition flows its central mission: to "fulfill society's interest in assuring conditions in which people can be healthy."



Essential Public Health Functions and Services*

- ***Assess and Monitor*** the health of communities and populations at risk to identify health problems and priorities.
  1. Monitor health status to identify community health problems.
  2. Diagnose and investigate health problems and health hazards in the community.
  3. Inform, educate and empower people about health issues.

- ***Formulate Public Policies***, in collaboration with community and government leaders, designed to solve identified health problems and priorities.
  4. Mobilize community partnerships to identify and solve health problems.
  5. Develop policies and plans that support individual and community health efforts.

- ***Assure*** that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention services, and that the community of policymakers and ordinary citizens is part of the public health decision-making process.
  6. Enforce laws and regulations that protect health and ensure safety.
  7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
  8. Assure a competent public health and personal health care workforce.
  9. Evaluate effectiveness, accessibility and quality of personal and population-based health services.
  10. Research for new insights and innovative solutions to health problems.

* Institute of Medicine, The Future of Public Health, National Academy of Sciences, 1988.
Public Health Functions Steering Committee, 1994 (multiple organizations).

Essential Elements to Protect and Improve Healthy Communities *

CONDUCT COMMUNITY DIAGNOSIS collect, manage and analyze health-related data to inform decisions	PREVENT AND CONTROL EPIDEMICS investigate and contain diseases and injuries	PROVIDE A SAFE AND HEALTHY ENVIRONMENT maintain clean and safe air, water, food and facilities
MEASURE PERFORMANCE, EFFECTIVENESS AND OUTCOMES OF HEALTH SERVICES monitor health care providers and the health care system	PROMOTE HEALTHY LIFESTYLES provide health education to individuals and communities	LABORATORY TESTING identify disease agents
PROVIDE TARGETED OUTREACH AND FORM PARTNERSHIPS assure access to services for all vulnerable populations assure culturally appropriate care	PROVIDE PERSONAL HEALTH CARE SERVICES treat illnesses, injury and disabling conditions, from primary and preventive care to specialty and tertiary treatment	MOBILIZE THE COMMUNITY FOR ACTION provide leadership and initiate collaboration

* Source: The Bottom Line, Profitable Partnerships for Healthy Communities, NACCHO, 1999.

"Health care is vital to all of us some of the time, but public health is vital to all of us all of the time."

C. Everett Koop, M.D., former U.S. Surgeon General

Public Health Highlights

Public health has had some stunning successes over the past 100 years. The federal Centers for Disease Control (CDC) marked the end of the 20th century by identifying ten great public health achievements. Each reflects prevention activities that significantly reduced the number of deaths, illnesses and disabilities. According to CDC, public health achievements contributed 25 of the 30 years of life added to the average lifespan of people in the U.S. over the 20th Century period. The CDC list is certainly not exhaustive of public health's achievements, but it reflects the breadth and depth of its impact.

Ten Great Public Health Achievements

United States 1900-1999

- Vaccination
- Control of infectious diseases
- Safer and healthier foods
- Decline in deaths from coronary heart disease and stroke
- Motor-vehicle safety
- Safer workplaces
- Healthier mothers and babies
- Family planning
- Fluoridation of drinking water
- Recognition of tobacco use as a health hazard

Source: CDC, MMWR Weekly, April 2, 1999.

Note: These are not listed in any order of priority.

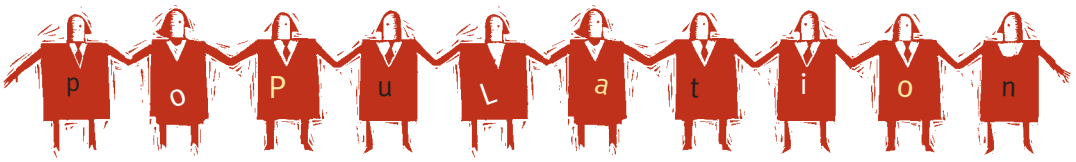
What's *Public* *About* Public Health?

Have You Ever Met a Population?

The primary focus of public health is on "populations," while the primary focus of the health care system is on individuals. Or at least this is the way the distinction is usually framed.

But have you ever met a population? Taken one out to lunch?

The fact that public health is *public* is one of the reasons it is often unnoticed, unappreciated, underfunded and, until recently, taken for granted. In America we spend upwards of 98 percent of a $1.3 trillion outlay for health care on individuals, with a paltry one-two percent on what is nominally defined as public health services.



Why? Ask most people, and they'll tell you that health care is a *public* good, yet we provide it in this country as a *private* good, i.e., as part of private commerce. This is consistent with our values of individualism, civil liberties, equality (of process, not outcome) and economic rationality that assumes self-interest and competition (*Elazar, D. 1966. American federalism: A view from the states*).

Unlike most other industrialized countries, where health care is seen as part of the responsibility of society and a public good, health care in the U.S. is primarily perceived as a matter of private resources and purchases.

Public health achievements contributed 25 of the 30 years of life added to the average lifespan of people in the U.S. over the 20th Century period.

Centers for Disease Control (CDC)

Key Word: Perceived

The key word here is "perceived." American culture is so saturated with the language and ideology of individualism, private interests and "free" markets that it masks an extensive and vital public infrastructure that establishes many of the conditions that make the free exchange of private goods and services possible in the first place.

For example, when tax breaks for employer-based health insurance are factored in, about 60 percent of health care in the United States is financed by *public* dollars (*Health Affairs, July/August, 2002*). The safety of the water we drink and the food we eat is courtesy of decades of *public* health investments. Immunizations, food sterilization, work place safety, traffic safety, air quality, the monitoring of infectious diseases like the recent West Nile Virus – it's all *public* health.

But as the accompanying chart shows, when you ask Americans what they think public health is, almost half (47%) think it has something to do with medical treatment for the poor and uninsured.

By inference, they see the public as a collection of *individuals*, and public health, by extension, as a collection of individual encounters. The idea that a "population" is built on characteristics in *common* is superseded by a world view that stresses the *differences* between individuals.

Out of Sight, Out of Mind

One of the lessons Americans learned from the events surrounding September 11, 2001 was that there is this thing called the public health "system." It's all about safety, prevention and health, and we need to start paying attention to it and provide the resources it needs to do its job.

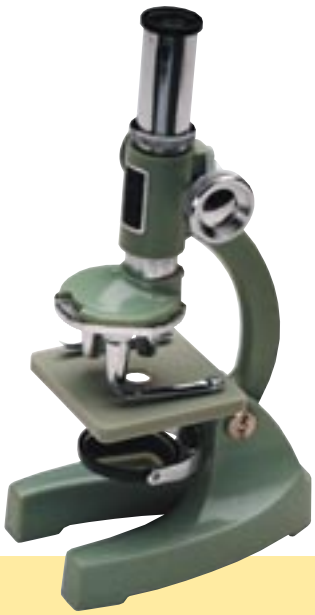
But then, it's common to take no notice of things when they're going well. We don't think much about clean water and safe food, or breathing the air in mega-skyscrapers. The public health infrastructure that makes this possible is largely invisible to us, a ghost sector amid the more immediately visible – and loud – sectors of acute health care, commerce and the media. On this "out of sight, out of mind" theory, public attention and resources wane; public health becomes to some extent the victim of its own success.

Those success stories – and there are many – were responses to environmental, social and cultural conditions of the moment. The prevalence of infectious diseases throughout the first half of the 20th Century, for example, elicited a set of public health responses (assessment, intervention, prevention, workforce training, etc.) specifically tailored to address them.

But times change. New public health issues loom large, as September 11 so vividly illustrated. The question to explore further is whether our public health infrastructure – and the public health 'culture' – is prepared to change with the times, with a particular focus on the situation in Arizona.

In America we spend upwards of $1.3 trillion on health care, of which 98 percent is on health care for individuals, with a paltry one-two percent on what is nominally defined as public health services.

When you hear the term "public health," which of the following comes to mind?



A government-provided health care system for all and health care for the poor	**47%**
Policies and programs that maintain healthy living conditions	**27%**
Protecting the population from disease	**16%**
Not sure	**10%**

Source: A poll funded by Pew Charitable Trust and conducted by the Mellman Group and Public Opinion Strategies, 1999.

What's *Changed?*

The Emerging Focus on Personal Health*

"21st Century public health is about personal health."

James Allen, M.D., Director of Chronic Illness and Tobacco Prevention, Maricopa County Department of Public Health

DETERMINANTS OF DISEASE

Behavioral Lifestyle	**48%**
Genetic Constitution	**25%**
Environment	**16%**
Lack of Access to Medical Care	**11%**

Source: American Public Health Association, 1999.

In a nation that tends to define the public good in personal terms, it's no stretch to predict the future of public health as increasingly focused on personal health and behavioral issues.

But being increasingly focused on personal health is not the same thing as being exclusively focused on it. New strains of infectious diseases, environmental imbalances, threats of bioterrorism, war, natural disasters – all these and more will tax the resources of public health monitoring, preparedness, prevention and response. In Arizona and other western states, the future use and quality of scarce water alone may become a public health issue, as it already is in certain communities. The same is true of a number of important border health issues such as air quality and the inspection of food and other products crossing the border.

With that caveat noted, a public health focus on personal behavior and lifestyle in the future is a foregone conclusion when so much of that behavior has been demonstrably linked to disease and bad health outcomes. Public health's attention to tobacco and smoking over the past several decades, and its turn to issues like nutrition and obesity, exercise and the management of chronic diseases is only the opening salvo in a predicted long and tenacious assault on changing personal behavior.

With this assault will come the accompanying mine fields: issues of personal liberty and privacy, the interests of private business and economic development and – a fortress in its own right – an entrenched acute care health system and supporting industries that depend on bad behavior for their livelihood.

Prevention doesn't necessarily grease the bottom line in an acute care setting. Physicians counsel patients to lose weight and exercise, but so far their waiting rooms are overflowing with people who find this easier said than done.

Then, too, public funding for prevention is discretionary, while medical care is primarily driven by entitlements. That fact alone explains why many critical elements of public health aren't adequately funded.

Nevertheless, demographic, economic and cultural trends will drive public health's focus on changing personal behavior:

- **AN AGING SOCIETY.** SLHI's *The Coming of Age* report documents a rapidly aging population in Arizona, where people aged 60 and older will comprise almost 25% of the population in 2025. Of those, about 380,000 will be 80 years of age or older, roughly the size of the current population of Mesa. Many of them will have chronic and debilitating diseases such as hypertension, diabetes, arthritis, heart disease and mood disorders. Much of this will be preventable and controllable, and public health will focus its attention on prevention and education.

- **DEMOGRAPHIC AND CULTURAL SHIFTS.** In addition to an aging population, Arizona and the rest of the nation will see increasing numbers of minorities, who often exhibit a disproportionate share of the burdens of chronic disease and lack of

* Past SLHI reports and issue briefs on aging, health care costs and related topics cover trends briefly mentioned here, and are available at **www.slhi.org**. Arizona's *Turning Point: Collaborating for a New Century in Public Health* project, also published *Arizona 2010: A Scenario* (1998), which discusses trends impacting the future of public health.

access to health care. Arizona will most likely see continued population growth, but it will be uneven, with some counties growing rapidly and others declining in population, heralding all sorts of public health needs (transportation, workforce, health facilities, etc.). More people, more traffic, more environmental pollutants, changing family arrangements and requirements (single parent families, isolated elders, differences in educational levels, day care, etc.) – all this and more will fuel a public health focus on the locus of individual behavior and health outcomes.

ECONOMICS. Factor in demographic trends with the economics of Medicaid, Medicare and consumer addiction to expensive acute care in a quick and convenient "Circle K" setting, and you get a health care economic forecast that is dismal at best. One example from Arizona's AHCCCS system (Medicaid): approximately 35,000 elderly long-term care patients (about 4 percent of the total AHCCCS population), who need support services in addition to medical care, account for 27 percent of the total AHCCCS budget – about $950,000 out of a $3.5 billion budget. Add more elderly people and the agendas of competing public goods – education, transportation, social welfare – and you see why public health might want to turn its attention to personal behavior and lifestyle changes that result in better health at a lower societal cost.

The trends are in place, but will a public health agenda that focuses on changing individual behavior, expectations and lifestyle prove to be successful in the face of powerful forces that promote excessive and unhealthy consumption?

It will be an uphill battle. But it will be an impossible goal without reconfiguring public health in local community settings, and engaging new political, professional and civic organizations in a common public education and advocacy agenda.

"Double, double,
toil and trouble;
Fire burn and
cauldron bubble."

A Recipe for Disaster?

Public Health Stew

MIX THE FOLLOWING INGREDIENTS:

- 3 parts declining public revenues
- 3 parts unhealthy lifestyles
- 3 parts rising health care costs
- 1 part unfunded mandates
- 2 parts increasing senior population
- 4 parts special interest agendas
- 2 parts increasing chronic diseases
- 10 parts rules and regulations

SEASON TO TASTE WITH:

- tax policy
- unrestrained markets
- individual liberty
- competing ideologies
- social justice
- big media
- consumerism
- education disparities

Heat to boiling point in a political cauldron (ten years or so). Serve scalding hot to a public satiated with expensive health care on someone else's tab. If the public still has a pulse following a meal of public health stew, see if they're willing to talk about changing health policy.

Beyond *Sound Bytes*
Arizona's Public Health System

There is no single model of how states accomplish public health objectives.

Mass media tend to reduce all complex issues to sound bytes. The events surrounding September 11 provided sound bytes for public health, and for the moment at least part of the "ghost sector" is front and center in the national consciousness.

But there is no zippy way of describing the often impenetrable web of responsibilities, regulations, financial schemes and organizational structures spanning federal, state and local jurisdictions of public health. There is no single model of how states accomplish public health objectives, and much of what invariably occurs under the rubric of public health plays out in the nexus of both formal and informal systems and relationships that defy easy description.

Nevertheless, it is possible to make some general observations across states, and to describe where Arizona fits along a continuum of organizational and functional structures.

*General Organizational Structure**

SUPERAGENCY

Public health functions are the responsibility of a single comprehensive health department – an "umbrella" agency. The state of Washington is an illustrative example. This can be further broken down into:

Collaborative Approach

Public health functions are the responsibility of multiple divisions under the control of a larger superagency. Virginia is an example.

Embedded Approach

A single public health division is embedded within the larger health department. Within this division are embedded most of the core public health functions such as epidemiology, community and family health, emergency medical services, etc. North Carolina is one example.

FREE-STANDING SYSTEMS

Public health functions are the responsibility of a freestanding public health agency that is not under the direct control of a larger health agency, and that answers directly to the governor. Alabama is one example; so, too, is Arizona.

The essential difference between superagency and free-standing systems is that in the former, public health is one of several responsibilities of the agency, while it is the sole responsibility of the latter.

* These divisions and distribution of responsibilities are taken from *Turning Point: State Public Health Law Assessment Report*, published by the Turning Point National Program Office, U. of Washington, April, 2002.

Where's Arizona?

Most observers would characterize Arizona's public health system as a free-standing organizational structure with decentralized responsibilities, i.e., public health functions are the responsibility of counties, cities and towns. But how a system is formally organized, and how it actually *functions*, are not necessarily the same thing.

Movement, Not Sector

For purposes of this analysis, we limit the organizational and financial focus to a fairly confined set of relationships that, over time, has come to be commonly referred to as the "public health sector." In Arizona, that is primarily the Department of Health Services (ADHS), the 15 county health departments and their related appendages.

But while we *start* here, we don't want to *end* here. A description of Arizona's public health system from 30,000 feet is instructive not so much for what it includes, but what it *excludes* – and that's a number of critical community partners and relationships that can help move public health from a necessary but restrictive focus on assessment and regulation to a leadership role in public education and advocacy.

In the future, we foresee less attention to the dimensions of the public health sector, and more attention to a public health movement.

Distribution of Public Health Responsibilities*

CENTRALIZED (TOP-DOWN) APPROACH

The state public health agency either provides directly, or regulates the level and extent of, public health services at the local county or city levels (Florida, Virginia, others).

DECENTRALIZED (BOTTOM-UP) APPROACH

The authority and direct responsibility for many public health functions lie at the local county or city level (Colorado, Wisconsin, others).

HYBRID APPROACH

The responsibility for public health functions are shared between state and local governments (Illinois, Texas, others).

* These divisions and distribution of responsibilities are taken from *Turning Point: State Public Health Law Assessment Report*, published by the Turning Point National Program Office, U. of Washington, April, 2002.

In the future, we foresee less attention to the dimensions of the public health sector, and more attention to a public health movement.

Show Me *the Money*

Public Health Finances and Functions *in Arizona*

If we follow the flow of public health monies and functions in and out of ADHS and county health departments, we can begin to discern the system's strengths and weaknesses, and lay the groundwork for exploring opportunities for positive change.

We start with a quick overview of ADHS public health service expenditures. The caveat here is that public health services do not comprise all of public health functions, some of which may be found in other divisions of ADHS and other public agencies. There is also the matter of public health expenditures on tribal nations in Arizona, which have a direct and sovereign relationship with the federal government. We plan to look at Native American health issues in a future *Arizona Health Futures* issue brief.

State Funds

State funds are appropriated in two ways: One is for general and program operating costs that pay for staff and related expenses. The other – "assistance to others" – funds specific program services as determined by the legislature and implemented through contracts with county health departments and community organizations. The funds themselves come from the state's general fund or from designated sources, such as tobacco taxes and the tobacco settlement program.

Federal Funds

ADHS receives federal funds for public health services primarily from two agencies: Health Resources and Services Administration (HRSA) and Centers for Disease Control (CDC). These funds are a combination of categorical grants (directed at a designated area or

Arizona Department of Health Services
Public Health Service Expenditures FY 2000-01

	State Funds	Federal Funds	Other Funds	Grand Total
Asst. Dir./Health Systems Development/ Health Statistics/TEPP*	$67,406,264	$1,892,826	$237,140	$69,536,230
Emergency Medical Services	$ 5,083,520	$ 3,385	$0	$ 5,086,905
Epidemiology, Disease Control	$ 7,921,010	$17,640,452	$659,977	$ 26,221,439
Community/Family Health Services	$22,151,314	$116,229,188	$27,073,590	$165,454,092
State Laboratory	$3,050,897	$791,650	$2,417,530	$6,260,077
Total	$105,613,005	$136,557,501	$30,388,237	$272,558,743

Source: ADHS.

* The great majority of funds in this category come from tobacco taxes. See SLHI's *When the Smoke Clears* report for a closer look at how tobacco tax funds are used.

activity), block grants (for general purposes that may involve a number of areas, with further determination by the state), cooperative agreements and competitive grants. Similar to state funds, some of the federal dollars are used for operating and program costs within ADHS itself, but the great majority are placed in contracts with county health departments and other community-based providers.

Other Funds

The "other" category consists primarily of funds received through intergovernmental agreements with other state agencies, designated licensing fees, grants and donations.

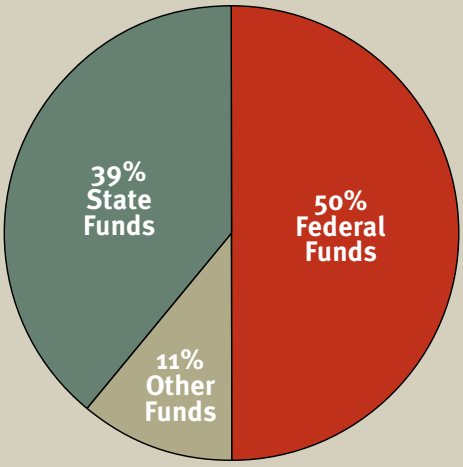
In 2000-2001, almost 72% of ADHS's public health expenditures were contracted out for services to others.

Is Arizona's Public Health System Top-Down or Bottom-Up?

In one sense it's both. Public health services are delivered at the local level by county health departments and by a variety of nonprofit and human service organizations. This is bottom-up. But there is a particular relationship between the state (ADHS) and local health departments that is well grounded in both tradition and law. This is top-down. With regard to the counties, ADHS is responsible for:

- promoting the development, maintenance, efficiency and effectiveness of local health departments
- providing technical consultation and assistance
- providing financial assistance
- recommending the qualification of all personnel

Where the Money Comes From



Source: ADHS

These responsibilities are implemented through contracts with county health departments, which receive direct and per capita grants from funds appropriated by the legislature to support core public health functions at the local level. The grants, which currently range from $38,000 to $138,000, are limited to counties with populations less than 500,000 – effectively excluding Maricopa and Pima counties (this was a result of 2002 legislation). Although Arizona's population and public health needs have increased exponentially since the direct and per capita grants were first implemented in the early 1970s, funding levels have remained static or even declined.

Grants to the county are hardly the end of it. Counties enter into contracts with ADHS for a variety of services, ranging from immunizations and communicable disease surveillance to child health programs. ADHS also establishes delegation agreements with county health departments for activities that are by statute the responsibility of the state, but are more appropriately implemented at the local level. These include health inspections of public pools, restaurants, septic systems, etc. While the counties do not receive funding from the state for these functions, a number of them generate the necessary revenue through fees.

Healthy Arizona 2010

In 1979 the federal Health and Human Services Department published *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*. This kicked off a national campaign that filtered down to the states with *Healthy People 2000* and *Healthy People 2010*.

Arizona's current response is Healthy Arizona 2010. It's based on 12 key health areas:

PHYSICAL ACTIVITY
NUTRITION
TOBACCO USE
SUBSTANCE ABUSE
RESPONSIBLE SEXUAL BEHAVIOR
MENTAL HEALTH
INJURY AND VIOLENCE PREVENTION
ENVIRONMENTAL HEALTH
IMMUNIZATION AND INFECTIOUS DISEASES
ACCESS TO CARE
MATERNAL/INFANT HEALTH
ORAL HEALTH

ADHS recently published its first Healthy Arizona 2010 report card, which covers the period ending in 2000 (available at www.HealthyAZ2010.org). Along with a representative advisory committee and a number of community partners, they are engaged in activities with the goal of reaching specific 2010 objectives in each area.

Everyone applauds the vision and intent. But *Healthy Arizona 2010* is not without some concerns:

MONEY. ADHS doesn't have the financial resources to effectively develop public education and advocacy around prevention issues. That means they have to rely on forming community partnerships and seeking outside support. For example, SLHI provided a grant to ADHS to develop a communications strategy in physical activity that led to a community partnership with KTVK-TV (Channel 3). A great deal more of this should be going on.

FOCUS. Some believe the program is spread too thinly across too many areas. Better to focus on two or three areas, they say, and channel energy and resources accordingly.

SKILLS. There is a general perception that ADHS – and state agencies generally – are good at administration, assessment, regulation and evaluation, and not as good in employing new techniques in communication, social marketing and advocacy. When state agencies actually have some real money to use and form partnerships with private firms, however, the results can be impressive, as we saw with Arizona's successful media campaign in smoking prevention.

LINKS TO THE MEDICAL COMMUNITY. *Healthy Arizona 2010* has insufficient links with local physicians and others in the medical community who deal with health issues on a daily basis. This is a concern for public health generally, as we discuss in the "When Cultures Collide" section of this report.

Categorical $$
Restrictive Silos *or* Creative Opportunities?

Categorical funds always bring out a diversity of passionate opinions among public health officials and advocates.

On the One Hand

Many believe that categorical funds are restrictive remnants of "silo" thinking and hamper local health efforts by failing to establish links to broader dimensions of community health and a culture of cooperation and change. In the words of one observer, "public health departments need to work across all lines – voluntary, faith and private businesses. How do we do this without running afoul of tight restrictions on where we can spend the money?"

In the same vein, another observer points out that categorical funds often limit options for care, citing that "there are few public health nurses working these days because there is no money earmarked to hire them." These people find categorical funding to be an ironic anachronism in an age that talks the game of collaboration and partnerships across sectors and issues and then provides funding restricted to specific needs, configurations and uses.

Categorical funds are public funds restricted for a particular purpose (maternal and child health, HIV/AIDS, etc.)

On the Other Hand

Others point out that challenging categorical funds is like railing against the tide: Congress likes funding things this way, and they're not going to go away. Further, those who want to get increased funding for public health programs and services are much more likely to be successful with categorical funds than unrestricted block grants. These observers believe many of the restrictions are so-called "smoke and mirrors" imposed by the bureaucracy, which are often overcome with a little creativity, challenging and coaxing.

Some county and state officials think that, in the end, people can work across lines and restrictions if they want. In the words of one veteran of the health care wars, "we had to fight the agencies all the way, but now we are beginning to work across lines with [the health of] kids as the focus, and not the money flow."

Our Take

Anybody who's been in the grant game for any length of time knows how to "spin" the restrictions. In effect, one learns how to chop up an unrestricted operating budget into a series of "special projects" that fit some funder's restrictive program guidelines. The same thing is true in the federal and state public health arena. As these skills vary among county public health officials, so do success rates in getting grants.

At what point does the end of "working with kids" or any other public health goal justify means that can border on subterfuge, inadvertent misrepresentation or even outright lying? Often the core issues surrounding categorical funding are not in the final analysis technical and legal, but ethical and moral.

The *Counties** *All* Public Health *is Local*

All public health, like politics, is ultimately local. States can assess, regulate, license and evaluate public health functions and programs, but at the end of the day people at the local level have to make it work.

In Arizona, local county health departments are responsible for providing "essential public health services." State law requires that county Boards of Supervisors establish a county department of health or a public health services district to develop these services with the use of any combination of federal, state or local funds. Each county has a Board of Health that serves as an advisor to the director of the health department and the County Board of Supervisors regarding health policies, rules and regulations. As the attached chart indicates, county health departments receive funding from the county general fund, cities, grants and contracts (ADHS, federal agencies, foundations, etc.) and service fees (restaurant or pool inspection, animal control, personal health care, etc.).

ARIZONA COUNTY PUBLIC HEALTH EXPENDITURES, 1998-99*

$91,962,076 TOTAL

Federal	37%
Counties	25%
State	19%
Fees	12%
State/Federal Combined	3%
Cities	2%
Other	2%

* County financial data, list of provided public health services and related information are extracted from *Arizona Counties Public Health Funding Report*, prepared for the Arizona Counties' Health Officers Association by Catharine M. Riley, 1999. Available at **www.maricopa.gov/public_health/epi/**.

County Costs and Services

What can we tell about public health services and costs at the county level on a comparative basis? The answer: not as much as one might think.

County Public Health Department per Capita Expenditures and Service Ranking

COUNTY (Population 2000)	PER CAPITA EXPENDITURES 1999	NUMBER OF PROGRAMS
Greenlee (8,547)	$64.26	30
Cochise (117,755)	$60.87	40
Coconino (116,320)	$59.82	60
Gila (51,335)	$42.88	40
La Paz (19,715)	$33.79	30
Yavapai (167,517)	$33.56	51
Mohave (155,032)	$31.62	40
Pinal (179,727)	$30.06	50
Yuma (160,026)	$26.55	44
Santa Cruz (38,381)	$24.58	34
Pima (843,746)	$22.10	38
Graham (33,489)	$20.09	25
Navajo (97,470)	$14.64	45
Apache (69,423)	$14.61	34
Maricopa (3,072,149)	$12.10	34

Services

Certainly the data show a wide variation in expenditures for public health services, as well as the number of services provided. There are some 70 different services provided under the 13 general categories listed in the accompanying illustration, and while virtually all 15 counties offer some services (link people to services, childhood immunizations, investigation of communicable diseases, etc.), there is no discernable pattern in the variation of other provided services.

Costs

Differences in per capita funding levels are equally variable. On the one hand, one would assume per capita costs would be lower in counties with larger populations, as they would be spread out across more people. That's the case with Greenlee – the county with the smallest population and the highest per capita cost – and Maricopa – the county with the largest population and the smallest per capita cost.

But even this pattern doesn't necessarily hold. Gila County, with a population almost three times the size of La Paz County, has a higher per capita cost, although with more public health services provided. Similar examples can be found as well.

Funding Sources

Then there's the murky matter of funding sources. To use just one example, Maricopa County reports 52 percent in federal funds for public health and 13 percent from county funds; Pima reports 20 percent federal and 41 percent county. As it turns out, looking at "average" costs across the counties on a source and per capita basis is neither particularly helpful nor revealing.

COUNTY PUBLIC HEALTH SERVICES

- Children's Services
- Environmental Health
- Adult Immunizations Services
- Health Planning and Leadership
- Maternal Health Services
- Jail Services
- Communicable Disease Control
- Primary Care
- Nutrition Services
- AHCCCS
- Homecare Services
- Community Health Education
- Miscellaneous

A Public Bargain*

How do public health investments compare to total health care investments in the U.S. and Arizona? Here are a few relevant ratios:

Total U.S. Health Care Expenditures, 2001
$1.3 trillion

98% Individual Health Care

2% Public Health

Total Arizona Health Care Expenditures, 2001
$17 billion

97.7% Individual Health Care

2.3% Public Health ($400 mil.)

Total AHCCCS Expenditures, 2001
$2.4 billion

AZ Public Health Expenditures – 16.6% of AHCCCS

AHCCCS Projected Budget, 2003
$3.5 billion

AZ Public Health Expenditures – 12% of AHCCCS (Projected)

Conclusions

- The AHCCCS program – which currently covers about 15 percent of the population, receives six times the funding allocated to public health in Arizona, which impacts the entire population.
- Arizona's Long Term Care Program (ALTCS) covers about 35,000 low-income frail elderly and disabled persons, who consume approximately $950 million out of a $3.5 billion budget – twice the financial resources allocated to public health services and programs.
- Ergo, the demonstrated accomplishments and benefits of public health programs and services are a bargain in an environment dominated by expensive individual health services. For example, every $1 invested in the fluoridation of water yields $38 savings in dental treatment costs (CDC). Other examples abound.

*Figures/projections are extracted from AHCCCS, ADHS and federal reports.

Our *Conclusions*

Arizona ought to undertake a thorough assessment of whether essential public health services are being provided to each citizen at reasonably the same level; establish consensus performance standards and develop a plan to address obvious gaps.

Based on interviews with key informants and further review of the history and structure of public health programs at the county level, we conclude the following:

- **PUBLIC HEALTH OUTCOMES CANNOT BE TIED TO PUBLIC HEALTH SERVICES AND DOLLARS ALONE AT THE COUNTY LEVEL.** The differences between populations (race, income, urban/rural) reflect variable levels of need and types of public health services to address them. There are also major differences in areas like primary and acute care infrastructure, transportation, housing and business development that directly impact public health outcomes but are well outside the traditional public health funding structure.
- **COUNTIES MAY NOT NECESSARILY BE THE BEST WAY TO EITHER VIEW, OR TO DELIVER, PUBLIC HEALTH SERVICES.** Infectious diseases, water and air, and people themselves know no borders. Some public health programs and services might be better initiated through regional consortiums, health districts or other organizational mechanisms that cross county, tribal, state and national borders. Others may be best implemented through local and regional partnerships that aren't necessarily tied to county departments of health, but depend on personal relationships and the willingness of people and communities to work together in ways not always prescribed by law.
- **THERE ARE FEW COMMON STANDARDS FOR REPORTING PUBLIC HEALTH NEEDS, SERVICES AND FUNDING SOURCES ACROSS THE COUNTIES.** How one county defines and reports a public health need and service is not necessarily the same as another county reports it. The skill sets, experience and qualifications of persons in public health positions who provide such reports are uneven, according to many informants.
- **INFORMATION SYSTEMS AND COMMUNICATIONS TECHNOLOGY ARE UNEVEN ACROSS ARIZONA COUNTIES.** In the rush to get the state up to speed with a real time electronic surveillance and reporting system, we forget that some parts of the state don't even have reliable phone service. The ability of public health workers to use the new technology is also uneven and, in some cases, non-existent.
- **FUNDING DOESN'T NECESSARILY FOLLOW NEED.** Large categorical grants can come down to the state with one set of general restrictions, and then often move farther down to the counties with restrictions stipulated by the state itself. These may be directly tied to the needs of one county, but not another, depending on population differences, other funding sources, etc. Public health programs often "chase" the dollars, rather than vice versa; counties that are "creative" in tying real needs to categorical funding sources tend to receive more total funding than counties who lack these skills (see sidebar on categorical funds). The great majority of funding for public health at the county level is tied to grants and contracts, leaving few resources for core workforce training and basic infrastructure.

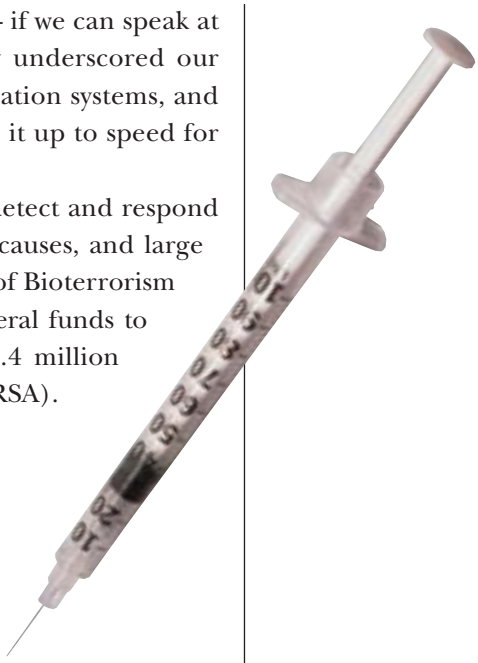
If anything is clear after looking at the variability of public health services and funding at the county level, it's that Arizona ought to undertake a thorough assessment of whether essential public health services are being provided to each citizen at reasonably the same level; establish consensus performance standards and develop a plan to address obvious gaps.

Of course, this will require leadership.

Bioterrorism Preparedness and Response*
The Public Health Issue Du Jour

One of the positive outcomes of the events surrounding September 11 – if we can speak at all about that tragic series of events in a positive light – is that they underscored our nation's inadequate public health surveillance, warning and communication systems, and galvanized the public and political will to do something about bringing it up to speed for the 21st Century.

Arizona is among the front running states in developing a plan to detect and respond to large-scale disease outbreaks, whether from bioterrorism or natural causes, and large scale disasters. The state received a grant in 2000 to establish the Office of Bioterrorism Preparedness and Response, and it recently was awarded significant federal funds to develop and implement a state public health preparedness plan ($16.4 million from the CDC) and a Hospital Preparedness Plan ($2.2 million from HRSA).



Five Key Areas

The proposed system is designed around five key areas:

- Disease surveillance and epidemiological tracking
- Planning and preparedness
- Laboratory services
- Communications
- Education and training

Essentially, the system is designed to move from a slow, sporadic and often ineffective reporting process utilizing phone and "snail mail" to one using sophisticated real-time electronic surveillance and reporting systems, including web-based disease and lab reporting. Electronic disease surveillance networks are being refined and expanded with county health departments, infectious disease physicians, infection control professionals and wildlife and veterinary medicine professionals. A pre-hospital syndrome surveillance system is also under development that will monitor information from emergency medical services and hospital emergency departments.

Other pieces of the new system:

- Improving the capacity of hospitals and other providers of emergency services.
- An electronic reporting system that allows real-time reporting from clinics, physician offices and hospitals.
- Upgrading state and county laboratories and establish protocols to improve their capacity and performance.
- Statewide educational and training programs for those on the front lines who will have to respond immediately to a disaster, disease outbreak or terrorist attack.
- Conferences and training sessions for public health and health care providers, law enforcement, volunteer organizations and others who will be involved in preparedness and response at some level.

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* Information supplied by ADHS.

It is important to use the renewed energy, commitment and federal dollars in the wake of September 11 to infuse positive change in all aspects of Arizona's public health system.

Leverage for Change

The influx of federal dollars to improve Arizona's public health infrastructure is important not only because of its immediate application to bioterrorism and major disasters, but also because of the leverage it provides for improvements in all aspects of the state's public health work. Closer links with local physicians, seamless communication and coordination between emergency rooms and trauma centers, more trained epidemiologists and public health nurses, real-time training programs over the web, links with other data systems and institutions like schools and universities – these are a few of the possibilities for leveraging the new reporting, surveillance and response system.

Without exception, all key informants we interviewed for this issue brief commented on how important it was to use the renewed energy, commitment and federal dollars in the wake of September 11 to infuse positive change in *all* aspects of Arizona's public health system, and to begin to forge partnerships across a broad range of public and private groups to address chronic diseases, health disparities between populations, public safety, access to health care for all citizens and other important issues.

Arizona's new bioterrorism and preparedness system is a start. The challenge is in making sure it doesn't stop with a narrow definition of public health.

Communication: It's more than bits and bytes

ADHS gets high marks from both national and state leaders on the quality of its bioterrorism plan and its promptness and efficiency in getting it out of the box and on the ground.

At the same time, key informants in county health departments, hospitals and other dimensions of the public health and medical communities report some frustration at not being either fully informed or involved in the development of the state's bioterrorism plan, as well as in public health issues generally. In the words of several observers, it's like, "We're the state and you're the counties. Get over it."

No doubt ADHS and other state agencies sometimes feel that way about the federal government. It underscores the central fact that building real partnerships and engaging in true cooperative planning and action ultimately comes down to real time relationships between real time people in real-time settings. It's messy, often emotional and requires active listening and dialogue to bridge both the real and imagined differences between people and groups.

The Powers That Be

Who could possibly be against a public health agenda? Don't we all want clean air and water, healthy lifestyles, prevention that reduces health risks and lowers costs, effective management of chronic diseases, no health disparities between populations?

Yes, but when our livelihood or immediate self-interest is potentially threatened, our passion for long term public health goals is cooled by short term needs and desires. All of us, at one time or another, can be counted among the powers that thwart a shared public health agenda. Here is a slightly irreverent list:

- **THE ACUTE CARE INDUSTRY.** Many people have sunk a lot of money into acute care facilities, training and equipment, and depend on you to be sick and seek immediate treatment, preferably treatment with high margins. Prevention may pay for you, but not necessarily for your cardiac surgeon.

- **HEALTH PLANS.** Health plans want you to adopt a healthy lifestyle and stay out of the hospital, but they don't want to pay for prevention activities if you're just going to enroll in another health plan six months from now. Then the competition reaps the benefits at their expense.

- **DEVELOPERS.** Healthy communities require healthy infrastructure, clean air and water. If they get a tax break, fine. If not, you take your chances or pay for it yourself.

- **THE FAST FOOD INDUSTRY.** Supersized meals = supersized people and supersized profits. We buy stocks in these companies for a "healthy" retirement.

- **THE TOBACCO INDUSTRY**. We know all about them.

- **THE ENTERTAINMENT INDUSTRY.** Seen anybody in the movies lately who doesn't smoke, drink, drive fast, jump out of tall buildings, practice unsafe sex, cheat and pollute? Talk about role models for public health!

- **THE ADVERTISING INDUSTRY.** They make money by persuading us to over consume every product and service under the sun. When public health pays them as much as pharmaceutical companies do, they'll sell it.

- **PROFESSIONAL POLITICIANS.** They need money from the above groups to get re-elected. Where are the "deal makers" in public health?

- **YOU AND I.** We should all take a long, hard look in the mirror before we bemoan the bad habits and selfish behavior of others.

The *Politics* of Public Health

When we talk about treating the health of the "whole person," we often forget, as the philosopher Aristotle pointed out over two centuries ago, that part of the whole person is her political self.

Health care providers talk glibly about the health of the "total community," but to the extent that they neglect encouraging people to participate in the political process – and fail to participate in it themselves – they foster an incomplete view of health that is limited to personal health alone. The fact that America has some of the best personal health care in the world, and some of the worst public health outcomes among industrialized nations, is at the heart a political issue.

Talk is Expensive

This is a subject that is not easily discussed in public health circles. Being politically active requires advocacy and risk, and the personal price can be high for public health leaders in state and county government, many of whom are in "uncovered" positions and answerable to political leaders who often have relationships with special interest groups not always supportive of a public health agenda.

Talk is expensive in politics. Speak out, and you can lose your job. One former employee of ADHS tells the story of asking the department head if he could conduct an advocacy campaign for fluoridation of water in Arizona communities. "You can advocate," the department head told him, "but be quiet about it."

Off the record we heard some poignant – and pointed – stories about public health officials who "annoyed" their agency heads and elected officials with pesky public health issues (fluoridation, tobacco, teenage pregnancy, firearms, unhealthy food in schools, etc.) or voiced a strong opinion on contentious health policy issues in public. At best, they got their hands slapped; at worst, they were fired.

A climate that stifles advocacy and involvement by public health officials in community health issues is directly related to leadership at the top and in the legislature, as well as to the general political and economic climate at the state and local levels. Some observers hearken back to a perceived "golden age" of Arizona politics in the late seventies and early eighties, when political leaders forged a coalition to create AHCCCS and other public health programs. They believe that the political climate today in Arizona is considerably more fractured and contentious, dominated by ideologues and special interests, and that many good people in state government have been pressured to retreat behind a curtain of assessment and regulation instead of stepping forward on public education and advocacy.

Pressure from the Outside

This view gains credence in light of public health programs that were introduced in the 90s through the citizen's initiative process. For example, implementing tobacco taxes and expanding AHCCCS eligibility were the result of coalitions of organizations and individuals pressuring government from the outside, and not the direct result of government officials and the legislative process.

Hospitals led the charge on implementing tobacco taxes, but once they did and funds started to flow, ADHS responded with a highly effective anti-tobacco campaign that helped to propel Arizona to the front of states with declining smoking rates. The entire process took

political courage and calculated risks for a number of key leaders, and as the saying goes, no good deed goes unpunished. In a climate of fear and reprisal, it takes a special kind of leader, either outside or inside government, to step forward and take the political heat.

Unrealistic Expectations?

Because of this, some believe that it is unrealistic to expect state public health officials to "step out" of the box and use the bully pulpit to advocate for things like funding for health care for the uninsured, family planning, getting fast food out of the schools and other potentially controversial public health issues. Government culture doesn't encourage it; the personal costs are too high. Better to work at grassroots advocacy at the local level and use political pressure and tactics to get government to respond.

Others dispute this. They point to public health officials who are speaking out on issues, especially at the county level, and counsel them to get more sophisticated in how they approach public education and advocacy through the use of public-private partnerships and social marketing techniques.

In addition to speaking out themselves, they can be effective in encouraging and supporting the work of others through better dissemination of public health information, attending coalition meetings and providing advice, encouraging the development of new policies and public health projects, and initiating contact with groups not fully engaged in public health issues, such as schools and universities.

Take Politics Out of It

Finally, there are those who say that if it's difficult for public health officials to be directly involved in public education and advocacy activities, Arizona ought to look at taking at least some of the politics out of government public health functions by having public health report directly to an independent commission, board or council under some type of contractual agreement, where the chief public health office is hired to accomplish specific public health objectives without being "told what to do" by the legislature and high ranking government officials.

Arizona ought to look at taking at least some of the politics out of government public health functions by having public health report directly to an independent commission, board or council under some type of contractual agreement.

Interestingly, state boards of health were quite common throughout much of the twentieth century (including Arizona), but were disestablished and devalued in the rush to consolidate state health services in the 70s and 80s (State Public Health Law Assessment Report, p. 20).

Outside of the feasibility of this arrangement in Arizona, one would want to know more about the relationship between the structure of public health functions and outcomes in other states, and whether any particular type of structure leads to less political meddling and better outcomes. It would also be useful to study potential structural changes for public health departments at the county level (health districts, regions across counties, etc.) and how a realignment of ADHS could support cooperation and shared resources across political borders.

When *Cultures Collide*
Medicine *and* Public Health

"Physicians are the intersecting point for disease. Everybody wants them involved, but they never get anything in return.

Physicians can't see public health as anything other than 'I have to report something.'"

David Landrith, Vice President for Policy and Political Affairs, Arizona Medical Association

"Medicine makes you better after you get sick, while public health keeps you healthy so you won't get sick."

The question is whether this commonplace distinction perpetuates two separate and distinct "cultures" of care that need to be more tightly integrated into one seamless system of prevention, treatment and management of care to effectively respond to major demographic, economic and social trends that are pushing America's health care system to the brink of crisis.

*Here is the standard "public health vs. medicine" framework in practice today:**

Public Health	Medicine
Focus on populations	Focus on individuals
Public service ethic	Personal service ethic
Emphasis on prevention, health promotion for the whole community	Emphasis on diagnosis, treatment and care for the whole patient
Paradigm is a spectrum of interventions aimed at the environment, human behavior/lifestyle, and medical care	Paradigm places predominant emphasis on medical care
Multiple professional identities with diffuse public image	Well-established professional identity with sharp public image
Variable certification of specialists	Uniform certification of specialists
Clinical sciences peripheral to professional training	Clinical sciences an essential part of professional training
Biologic sciences move between laboratory and field	Biologic sciences move between the laboratory and bedside
Social sciences an integral part of education	Social sciences tend to be an elective part of education

* Adapted from "The Population Approach to Public Health," Association of Schools of Public Health (www.asph.org).

Metaphorically speaking, medicine traditionally looks *inward*, while public health looks outward. This is both restrictive and counterproductive at a time when:

- Some 70 percent of chronic diseases are thought to be preventable. Medicine can increase its effectiveness by looking *outward* to lifestyle choices and prevention strategies to integrate with well established diagnosis and treatment skills.
- Public health can increase its effectiveness by looking *inward* to establish better communication – and incentives – to make it easier to involve physicians in both the reporting and managing of diseases and public education focused on prevention. The medical care setting remains the pivotal epicenter for the treatment of disease in America.

Arizona is not without examples of cooperation between medicine and public health. The Arizona State Immunization Information System (ASIIS) links up physician offices and public health departments to track immunizations, and the **Arizona Partnership for Infant Immunization (TAPII)** is a public-private partnership with both physicians and public health officials on board who collaborate on a number of successful public campaigns to increase the rate of infant immunization.

Another successful example is **Baby Arizona**, a public-private partnership between the medical and public health communities to increase the rate of women who receive early and continuous prenatal care. The important point to note here is that in addition to providing a common reporting and information structure between medicine and public health, both examples are built on **public-private partnerships**, which are key to bridging the gap between the two cultures. We keep coming back to this point.

What will it take to further cross collaboration between medicine and public health and build a shared culture at the ground level of service and prevention?

- **Education.** Medical students need an introduction to public health principles and practices, and a better understanding of lifestyle choices, treatment and complications. Public health students need a thorough grounding in medical standards and practices, and how they can be applied in public health settings.
- **Technology.** The technology and training Arizona will put in place to improve its bioterrorism preparedness and response is a start at developing a seamless technological infrastructure that reaches down to the physician's office and makes it easy for him/her to report and track diseases and even lifestyle indicators. The health system generally has been slow to adopt new technology, especially compared to other industries. This has to change.
- **Incentives.** Collaboration between medicine and public health may be "the right thing to do," but it won't become lasting and significant without incentives – financial and otherwise – for medical professionals to get more involved in the detection and prevention of disease, and for public health professionals to include the medical community at the outset in public detection, prevention and assessment programs.
- **Communication and Collaboration.** Relationships take time, patience and plenty of listening. Historically, medicine and public health have gone their separate ways because no one asked them to get together and provided a common ground for dialogue, understanding and cooperation. Fortunately, that's beginning to change. We need more of it.

Turning *Turning Point*

Turning Point is a national project funded by the W.K. Kellogg and Robert Wood Johnson Foundations to stimulate public health partnerships in states and local communities and to bridge the gap between traditional medicine and public health. Arizona was one of 21 states to receive the initial grants made to state health departments to start the program, and to date a number of successful public-private partnerships in Arizona are up and running as a result of *Turning Point*.

Interestingly, *Turning Point* itself has "turned" from a prescriptive, top-down approach (state health departments down to local communities) to a much more participatory process of developing shared authority and responsibility between the public and private partners, and driving decision making down to the local level.

One good example is the improved communication between Arizona Native American tribes, ADHS and county health departments as a result of relationships developed through *Turning Point*. The Gila River Native American Community Project led the way. This eventually resulted in the Arizona County Health Officers Association changing its name to the Arizona Local Officers of Health Association to include the tribes.

It's amazing what basic, ongoing communication can accomplish.

Blood *From a* Stone
Recharging *the Public Health Workforce**

It will come as no surprise to those familiar with workforce shortages in health care that public health departments face major difficulties in finding and retaining qualified and skilled employees.

For starters, public health workers generally earn less than other sectors of the health care marketplace. Public health nurses, especially those in underserved areas with few resources, are lured by higher salaries elsewhere; epidemiologists, biostatisticians, lab techs and other specialties important to public health settings find better opportunities in private business.

To make matters worse, Arizona faces a billion dollar budget shortfall. ADHS and other government sectors with public health responsibilities face across-the-board cuts, static and even declining salary levels, reduced staffing and even the curtailing of critical services. You can't hire skilled workers and expect them to stay without competitive salaries and modern infrastructure. It's like squeezing blood from a stone.

That's the **resource** issue. There are other issues as well:

- **SCOPE OF PRACTICE.** In the words of one veteran observer, "Superacademics are demanding that everyone have a public health credential. They haven't a clue about the real local community. We need to honor and respect people who are there. How can we build on that?" In Arizona, there are reportedly large numbers of persons in public health positions that lack a college degree and specialized training. Can we provide training and support for these people without requiring a public health degree or specific credential? How can we expand the scope of public health practice into other professional and community settings?

- **TRAINING.** We've already mentioned exposure to public health principles and practices in the training of medical professionals, and exposure to medical standards and practices for public health students. According to the CDC, we should also add a "performance-based approach" to skill assessment to insure that public health professionals can hit the street running. What is still missing, according to many observers, is increased training in communication skills, marketing and advocacy.

- **PROFESSIONAL GROWTH AND PROMOTION.** Another dimension of the resource issue. Besides inadequate salaries, many public health departments lack opportunities for staff to access further training and career ladders with clear opportunities for promotion. Along those lines, the Arizona Turning Point Project has recommended that exchange programs be developed among ADHS, local health departments, the tribes, community health centers, universities and nonprofit organizations to provide professional growth and understanding outside one's "silo" of practice.

RELATIONSHIPS. As one health department official told us, "In the end we have to pick up the phone and talk with people we know to get things done. If you don't have the bodies in your department, you have to jerryrig something. It happens all the time." All the more reason for increased emphasis on developing communication and advocacy skills in public health professionals.

* The complex structural issues in health care that affect workforce supply and preparation are discussed more fully in SLHI's Arizona Health Futures Spring 2002 issue brief, *Boom or Bust: The Future of the Health Care Workforce in Arizona*. It is available at **www.slhi.org**.

Public health departments face major difficulties in finding and retaining qualified and skilled employees.

The Promise of Collaboration: The Arizona College of Public Health

The Arizona College of Public Health is a relatively new (2000) collaborative effort between the University of Arizona, Arizona State University and Northern Arizona University that was initiated "to challenge traditional thinking about participation and accountability" in the preparation of public health professionals. An overview of their mission, programs, resources and partnerships can be found at **www.publichealth.arizona.edu**.

It will be interesting to track the progress of this tri-collaborative venture in "reframing" how public health professionals are not only educated, but also deployed in local community settings, where the ability to work across professional and political fault lines will be tested by lack of resources and "traditional" roles and relationships.

It will also be tested by the traditional culture of schools of public health themselves, which are more oriented to producing academics and researchers than local practitioners. Nationally, only 20 percent of public health graduates go to state and local health agencies; more go to federal agencies.

Many with whom we talked about public health issues in Arizona are optimistic about prospects for the College to foster closer relationships with ADHS, county health departments and other public health settings. They believe Arizona hasn't always had close communication and cooperation between the universities and state and local public health departments in the past.

Building a Public Health Movement in Arizona
The Core Issues

In the end, it all comes down to relationships and leadership.

By way of summary, here are the core interlocking issues we need to address in Arizona in order to build an effective public health movement.

Resources

RESOURCES. Arizona mirrors the rest of the nation in allocating about two percent of total health care resources to public health. This is what we're spending on keeping people safe and healthy compared to when they're sick, and it's clear that our priorities are hugely out of whack. If we want to lower health care costs overall, we can start by allocating more resources to public health. It's ironic that in our obsession with reducing total health care costs in this nation, we've shortchanged investing in public health and actually driven up costs. Prevention works. The problem is making it pay in a health care system overly dependent on delivering acute care services.

Infrastructure

INFRASTRUCTURE. Inadequate public health infrastructure – surveillance and warning systems, response and service systems, information and communication systems, a trained workforce – is the result of inadequate resources. Inadequate resources are the result of inadequate attention. Inadequate attention is the result of inadequate public education. Inadequate public education is the result of inadequate advocacy. Inadequate advocacy is the result of inadequate leadership. Leadership is what it will take to improve Arizona's public health infrastructure.

Jurisdiction

JURISDICTION. This is the "system" issue. Arizona is a hodgepodge of 22 sovereign tribal nations, 15 counties, myriad cities and towns and a porous border with Mexico. Figuring out who's responsible for what, who does what, and with whom; who gets what – and what for – is a gargantuan task. The unequal spread of public health resources across counties is part of this; so, too, are roles and relationships prescribed by law and perpetuated by the inertia of history, and not necessarily by communication and cooperation across artificial boundaries and performance-based practice. Simply saying "it's not our responsibility" won't cut it anymore. "Good fences make good neighbors," as the poet Robert Frost said, but they can still be moved, rearranged and even crossed over to forge a more clear and efficient path to improving public health. Two recent Arizona examples of crossing fences are illustrative:

- A small $25,000 grant from the U.S.-Mexican Border Health Commission helped to jumpstart a collaboration between University Medical Center (UMC), Tucson Medical Center (TMC), the Holy Cross Hospital in Nogales, Arizona and the main public hospital in Nogales, Sonora. They are beefing up the ability to stabilize, treat and transport emergency and trauma patients on the Mexican side in order to ease the burden of providing uncompensated emergency care on the Arizona side.
- During the disastrous Rodeo Chedeski fire in Arizona, the town of Show Low had to be evacuated, including its hospital and women expecting babies. The White River Apache tribe, Indian Health Services and private physicians in the area quickly stepped in and collaborated to provide the necessary obstetric services on the nearby White River Reservation.

In each case, committed health professionals saw a problem, picked up the phone, crossed jurisdictions and got things done. In the end, it all comes down to relationships and leadership. What we need in Arizona are flexible laws, regulations and boundaries that encourage – and do not inhibit – the building of an ever expanding network of public health reciprocity.

CONTINUITY. This is the leadership issue. Public health has been a revolving door for leaders at the state level, whose fortunes are often more linked to politics and who sits in the Governor's chair than they are to commitment and competency. It takes time and stability to develop leadership, and that's true from the top down to the bottom of our public health system. Public health officials who sit farther down the food chain in "protected" positions see the leaders in "unprotected" positions at the top come and go. No wonder they become cynical about change. Currently, Arizona has three strong leaders at ADHS, DES and AHCCCS who work well together. It would be nice if they could stay around for awhile. Continuity in leadership has been better at the county level, but even there politics is a factor, especially among elected officials insufficiently educated in the importance of public health functions.

MISSION AND FOCUS. Clearly Arizona has to pick its public health targets carefully. Lack of resources and infrastructure alone will force the state to take care of first things first, then zero in on those issues where a concerted effort can make an appreciable difference in our citizens' health and well being. At the top of the list are the issues of public safety and emergency services. The recent infusion of federal funding will help. Beyond that, the larger issue is the balance between providing individual health care services (currently over 70 percent of Arizona's public health expenditures) and activities directed toward public education, prevention and advocacy. Many believe that public health should be a provider of last – not first – resort for health safety net services. Others dispute this and point out that the public not only expects public health to provide those services, but believe that is their prime mission. Until public health is more than a "ghost sector" and moves out into the light of highly charged public education and advocacy, its mission and focus – not to mention funding – will remain problematic.

COMMUNICATION. This is more than getting together and talking with each other. It's about listening, building relationships and trust and taking calculated risks. Public health officials at all levels need to be communicating with K-12 schools and the universities, the media, business and nonprofit sectors, faith-based organizations and all manner of local individuals and groups that have direct interface with people in their communities. In addition to encouraging and building partnerships at the local level through better communication, public health officials need to learn how to apply the techniques of marketing to frame their messages in ways that prompt constructive action, and not alienation. This is a question of resources, but it is also a skills issue.

Building a Public Health Movement in Arizona
Strategies for Action

Here are action steps we can undertake today in Arizona to go from a *ghost sector* in public understanding and support to a full-fledged public health *movement.*

Step 1

First things first:

- **LEVERAGE FUNDING.** The planning, training and enhanced electronic communications and laboratory capabilities that will be provided in Arizona through increased federal funding for bioterrorism preparedness can be used to leverage other planning and capacity building activities around important public health issues like reducing the burden of chronic diseases, access to health care for underserved groups, and health disparities among populations. The Governor's newly appointed task force on bioterrorism response is one place to start.
- **ASSESS, PLAN, EXECUTE, EVALUATE.** Undertake a statewide, county by county assessment to determine whether essential public health services are being provided to Arizona citizens at reasonably the same level. Develop a plan to determine how gaps will be addressed in each county. Develop public-private partnerships to find the resources and execute steps at the local level to meet identified needs. Evaluate the results based on consensus performance standards.
- **UNDERTAKE A SYSTEMATIC REVIEW OF STATE PUBLIC HEALTH LAWS.** Our laws and regulations should be assessed against today's needs and standards, not yesterday's. This review could be considered as part of the planning undertaken with federal funding.

Step 2

Then, to start the process of creating a public health movement in Arizona:

- **FOCUS ON TWO OR THREE PUBLIC HEALTH ISSUES IN HEALTHY ARIZONA 2010,** and not 12. Resources and attention dissipate when spread too thin. Based on the global burden of disease and recent trends, mental health is one good candidate; the issues around obesity, physical activity and nutrition are another.

Step 3

Once we have a public health focus, we build the movement with these strategies:

- **FORGE A COMMON STATE PUBLIC HEALTH AGENDA.** Public health doesn't speak with one voice in Arizona; hence it's not on the radar screen of most elected officials. Hospitals and physicians are often not included in public health discussions; hence they run parallel, and not integrated, public health agendas. ADHS, the counties, the Arizona Public Health Association, the Arizona Hospital and Healthcare Association and the Arizona Medical Association need to get together on a regular basis. No one group is responsible for public health. It will take constant communication and collaboration to build this agenda.

- **GET INVOLVED IN GRASSROOTS ORGANIZING AND COMMUNITY DEVELOPMENT.** Change results from pressure. Local communities are ripe for organizing around public health issues (access to care, water, pesticides, air quality, etc.). Funders ought to support more of this activity; the public health establishment needs to reach down to the local community level to drive the pressure up to the top.
- **COMMUNICATE.** Have we mentioned this before? It's amazing how many people involved in their own little public health corner of the world don't know what's going on next door. More efforts like Arizona's Turning Point project, which brings together local and state players in public health issues for dialogue and possible collaboration, need to be encouraged.
- **DEVELOP NON-TRADITIONAL PARTNERSHIPS.** For all the rhetoric, schools and universities aren't at the public health table. There are major cultural differences and incentives between education and what passes for the "traditional" public health sector; simply involving school nurses and teachers in developing and then executing a common public health agenda would be a start to breaking down those barriers. For their part, universities need to train more people for public health practice at the local level.

The toxic combination of ingredients in our "public health stew" mentioned earlier isn't going to go away anytime soon. But if we start with a few critical public health issues and focus on relentless communication, education and advocacy – and if we refuse to succumb to the inertia of familiar roles and relationships, as well as a pervasive sense of cynicism about economics and politics – we might be surprised at how far we can go in building a public health movement in Arizona.

No more whining. It's a place to begin.

Our Mission

To improve the health of people and their communities in Arizona, with an emphasis on underserved populations and building the capacity of communities to help themselves.

The purpose of *Arizona Health Futures* is to unravel an important health policy topic of relevance to Arizonans, provide a general summary of the critical issues, background information and different perspectives on approaches to the topic; tap into the expertise of informed citizens, and suggest strategies for action.

Arizona Health Futures is available through our mailing list and also on our web site at **www.slhi.org**. If you would like to receive extra copies or be added to the list, please call 602.385.6500 or email us at info@slhi.org.

Comments and suggestions for future issues, as always, are welcome.

St. Luke's Health Initiatives is a public foundation formed through the sale of the St. Luke's Health System in 1995. Our resources are directed toward service, public education and advocacy that improve access to health care and improve health outcomes for all Arizonans, especially our state's most vulnerable citizens.

ARIZONA HEALTH FUTURES

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