Policy Analysis Brief

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Establishing and Maintaining Rural Public Health Infrastructure

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Background

The Institute of Medicine in their seminal 1988 report, The Future of Public Health, stated that, "no citizen from any community, no matter how small or remote, should be without identifiable and realistic access to the benefits of public health protection, which is possible only through a local component of the public health delivery system."[1]   Yet rural communities continue to experience gaps and shortages in their public health systems.[2] Despite well-documented rural health disparities such as higher rates of chronic disease, obesity, and smoking, not all rural communities have a governmental local public health presence.[3,4,5,6] Where local public health units do exist, rural communities may still face limited access to public health services due to constraints in funding, staffing and technological capacities.[7]

Given the unique health needs of rural residents and the challenges faced in assuring access to public health services in rural communities, the NORC Walsh Center for Rural Health Analysis, with funding from the National Rural Health Association (NRHA), conducted an exploratory study to identify strategies for establishing and maintaining public health infrastructure[i] and services[ii] in rural jurisdictions. Findings are based on discussions with state health department employees and/or key local stakeholders who represent or serve communities that have limited public health infrastructure or recently embarked on public health infrastructure building initiatives. A total of nine discussions were held via telephone with state and/or local public health stakeholders from five states to identify barriers to establishing public health infrastructure. Also, three site visit focus groups were held in Maine, a state that has recently undergone local public health infrastructure development. Focus groups included governmental and non-governmental public health stakeholders at the state and local levels, and explored methods for overcoming infrastructure development barriers. Finally, findings were vetted during a session held in conjunction with the 2011 annual meeting of the National Association of County and City Health Officials (NACCHO).

Efforts to Develop Governmental Public Health Infrastructure

Findings are based largely on three different public health infrastructure building initiatives that took place in three different states. Two of these initiatives involved counties attempting to establish a local public health department. Both were grass roots initiatives led by local community leaders and/or authorities who attempted to secure support and funding through local government. The third initiative sought to establish a state-wide public health system that included a regional governmental office to coordinate local public health efforts through community partnerships. This initiative was state-funded and directed by the state through the governor's office.

KEY FINDINGS

- The communities in this study that tried to establish local governmental public health infrastructure using grass roots methods were unable to generate sufficient local support to fund the initiatives or the proposed infrastructure, even when the state contributed funding for public health infrastructure development and ongoing public health activities.

- The state-driven and state-funded public health infrastructure development initiative successfully established a state-wide local public health infrastructure but was less successful in engaging local government and did not secure local financial investment. As a result, the infrastructure and services are vulnerable to turnover in state leadership and changes in state priorities.

- Public health workforce training and strong, consistent messages articulating the benefit of public health on people's lives, health, and livelihood are necessary to secure the state and local support that will ensure that public health has the capacity to protect and serve all communities throughout the states and throughout the nation.

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[i] For the purposes of this paper, 'local public health infrastructure' refers to public health statutes and policies as well as the workforce, information systems, and funding that allow the governmental bodies with local public health jurisdiction to provide the 10 Essential Public Health Services. (adapted from "Bridging the Health Divide: The Rural Public Health Research Agenda." See reference 4 above)

[ii] Except where indicated otherwise, 'public health services' refers to the 10 Essential Public Health Services.

All three efforts were motivated by the need to assure access to public health services. While in all cases a variety of governmental and non-governmental organizations had been providing some basic public health services in lieu of a dedicated local public health entity, study participants felt that the range of services provided was insufficient and the public health service provider network was fragmented. Other reasons cited for wanting to establish local governmental public health included: poor health indicators such as low birth weight and high smoking rates; the absence of specific public health services (e.g., environmental inspections and emergency preparedness); and the lack of an official organization to secure funding and other resources necessary to provide public health services to the community.

> *"I think [residents voting down the referendum to establish a tax levy to support a public health department] had everything to do with tax increases and very little to do with the services [a local public health department] could provide."*

The grass roots efforts to establish local governmental public health infrastructure relied on local support, either through the allocation of funding from town legislators or resident support for a referendum that would create an independent tax base to fund a department of public health. To date, neither effort has secured the necessary local revenue sources due to significant local resistance over concerns of increased taxes and an expanded role of government. Interestingly, one of these initiatives took place in a state that provides funding to help communities establish local public health departments. This state also provides ongoing funding to all local health departments to support, at least in part, their providing basic public health services.[iii]

In contrast, the initiative in Maine was state-directed and state-funded and, as a result, able to overcome the challenges experienced in the other two initiatives that resulted from the need to generate broad local support. Focus group participants noted, however, that because local governments are not fully engaged in the new public health infrastructure and remain reluctant to financially support public health initiatives, the system remains fragile. In particular, participants noted that changes in state-level leadership and state priorities may create difficulties in sustaining recent successes.

Lessons Learned in Establishing and Maintaining Infrastructure

Participants identified a number of specific lessons based on their experiences in trying to establish a local public health infrastructure. Primary among these were finding funding sources for public health

Public Health Service Availability

The presence of local governmental public health in rural areas can:

- Increase the range of specific public health services that are provided, such as emergency preparedness, environmental inspections, and food safety
- Assure tracking of communicable diseases
- Assure health assessment and health improvement planning
- Increase the number of public health workers able to educate and inform the public on emerging health issues

initiatives and generating support for public health among policy makers and residents.

Funding. Participants identified a lack of funding as the greatest challenge to establishing and maintaining public health infrastructure. Participants reported that funding for public health at the state and local levels has historically been low and that multiple sectors compete with public health for federal and state funding streams. Participants also reported reduced public health funding due to current economic conditions. Finally, participants reported a growing reluctance among elected officials to fund governmental programs, and resident concerns over higher taxes as significant barriers to funding public health activities. While these challenges were seen as contributing factors to the lack of success in establishing local infrastructure in the grassroots, locally-driven communities, participants from Maine expressed similar concerns about the potential impact of these issues on their ability to sustain recent achievements. Also in Maine, when state funds were provided to support infrastructure development, participants noted that these often came with state required adminitrative and programatic activities. While the funding was necessary and the requirements helped align partners, participants commented that insufficient resources were left to address activities which might not be state priorities but may be important within a particular community.

Resident and Policy-Maker Support. The interviews and focus groups identified as a significant challenge a lack of understanding of public health among residents and elected officials. Participants noted that among policy makers there was a lack of consensus about what services and functions fell within the domain of public health, while

> *"Public health is this amoeba out there that takes on so many different things. How do you explain that to people?"*

residents frequently confused public health with governmental social services. Participants also described as a contributing factor the "relative invisibility of public health services" and that public health services were often only evident during crisis situations. Finally, participants described a culture of self-sufficiency among rural residents that impeded their accepting services perceived to be social services. The overall perception of public health as a governmental enterprise also was seen as a barrier, especially given the current political environment in which there appears to be public and elected official support for more limited governmental services. Participants reported that compounding these challenges was the difficulty in clearly and effectively articulating the mission and value of public health infrastructure and services. This factor was seen as a key challenge in establishing Maine's infrastructure, where inconsistent understanding of public health among key stakeholders necessitated that considerable time be devoted to gaining a common understanding of public health before any infrastructure development activities could take place.

Recommendations

The purpose of this study was to identify strategies for developing and maintaining public health infrastructure in rural areas to ensure that every resident and every community is served and protected by local public health. To this end, we developed the following recommendations based on interview and focus group data, as well as discussions with other public health professionals.

[iii] Here 'public health services' refers not to the 10 Essential Public Health Services but rather to activities in which local health departments are required to engage according to state public health statutes.

Recommendation 1: Combined state-driven and grass roots approaches should be considered when establishing local public health capacities, particularly in rural areas.

Participants described two approaches to establishing and maintaining local governmental public health infrastructure, a statedriven approach and a grass roots, locally driven approach. By providing leadership in the form of requirements and/or statues in addition to a single funding source, the state driven approach has the benefit requiring a lower level of investment on the part of local policy makers and resident stakeholders, and is therefore easier to implement over multiple communities than initiatives which require engagement in and financial commitment to public health infrastructure from these same local stakeholders. In fact, the communities in this study that had tried to implement a locally driven approach were unable to generate sufficient local support to initiate development of a local public health infrastructure, even when the local investment was augmented by state resources. At the same time, the state-driven approach may be particularly

> "People take for granted that we'll always have clean water. 'I had that anyway. I have smoke-free restaurants? I had that anyway.'"

vulnerable to changes in state priorities and/or leadership, creating challenges to sustainability. Blending the state-driven approach with a strong grass roots effort to increase local governmental and resident support for public health activities therefore has the potential to apply the best of both strategies to building local public health infrastructure in underserved communities.

Recommendation 2: Public health in general, and rural public health specifically, should develop consistent and compelling messages to explain how public health improves and protects people's lives, health, and livelihoods. Public health should employ trusted community partners to help carry those messages.

This is a particularly difficult economic period. Public health and other governmental agencies are experiencing unprecedented cuts to staffing and services. Participants felt that a lack of understanding of public health placed recent infrastructure building

> "At every [regional] meeting I come away with a deepened understanding and appreciation of some of the needs and priorities of some of the other groups and also some of the possibilities of the economies of scale."

achievements in jeopardy, and called for public health organizations to redouble their efforts to develop consistent messages that could be conveyed to explain

public health functions and their value. Establishing community level partnerships with trusted organizations, such as community hospitals, to help carry newly developed public health messages may be one strategy for increasing local support and appreciation for public health services to overcome these challenges.

Recommendation 3: Workforce training and capacity building should be conducted as a core part of infrastructure development, particularly in rural areas.

Focus group participants reported that workforce training and subsequent capacity building activities greatly facilitated Maine's successfully developing public health infrastructure in that they created a framework upon which future activities could be built. Workforce training may be all the more important in rural areas because, as participants noted, rural public health workforces tend to lack individuals with the diverse skill sets that may facilitate capacity building.

Recommendation 4: Regional approaches should be considered as possible strategies for developing rural public health infrastructure.

Regional approaches may be particularly important to rural jurisdictions with limited population bases to support public health activities. Regional approaches have the potential to create a critical population mass with a sufficient tax base that can help provide justification and adequate funding for local public health. At the same time, focus group participants noted that important local differences can be muted or lost when reporting health indicators at a regional level, making it more difficult to appropriately justify and target resources. Further, regional approaches are often plagued by competing interests from the different communities falling within the broader jurisdiction. Conversely, it was also noted that regional approaches may allow for competing organizations within these regions to partner more effectively by providing a "neutral space" not directly tied to competitive interests.

References

[1] *The Future of Public Health.* Institute of Medicine (IOM), National Academies Press; 1988.

[2] For this report a 'public health system' refers to the combined governmental and non-governmental stakeholders, policies, workforce, funding, and information systems that support the health of a population.

[3] *National Healthcare Disparities Report 2009.* Rockville, MD: Agency for Healthcare Research and Quality, 2009.

[4] Jackson, J. E., M. P Doescher, A. F. Jerant. "A National Study of Obesity Prevalence and Trends by Type of Rural County." *The Journal of Rural Health.* 21, no. 2 (2005): 140–148.

[5] *Health, United States, 2001: With Urban and Rural Health Chartbook.* Hyattsville, MD: U.S. Dept. of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics; 2001.

[6] *Bridging the Health Divide: The Rural Public Health Research Agenda.* Bradford, PA: Center for Rural Health Practice, University of Pittsburgh at Bradford; 2004.

[7] *Ibid.*

Maine Case Study

Maine's state public health system is classified as largely centralized, with two independent local health departments and the remainder of the state population (approximately 50%) covered under the authority of the state health department, known as Maine CDC. Centralized portions of the state have no local tax levies, so that public health activities are funded primarily with state and state-administered federal resources. Centralized portions of the state are organized into eight districts comprised of between one and four counties, and a nineth Tribal district. This case study focuses on the experience of the Downeast District.

Maine's Downeast District is comprised of two counties, Washington County and Hancock County. Both are rural counties and have older populations as compared to the state as a whole. Despite these similarities and their close proximity, they serve very different populations with distinct health indicators. Hancock County is the more affluent of the two counties, and health indicators reflect the differences in socio-economic status. According to the Robert Wood Johnson Foundation (RWJF) and the University of Wisconsin's county health ranking initiative, Hancock County is Maine's healthiest county, while Washington County ranks 15th out of Maine's 16 counties (RWJF and UWPHI, 2011).

Drivers of Change

Maine embarked on a decade-long process to establish a state-wide public health infrastructure that would reach even the most rural jurisdictions. This effort was motivated by poor health indicators, particularly high tobacco use and chronic disease burden, and the recognition that the current system was fragmented, uncoordinated, and lacked transparency. Little collaboration was taking place within or between governmental and nongovernmental public health partners and the system lacked mechanisms to direct state and federal resources to the local level. Public health leaders believed that an integrated, well-aligned system that had a strong local presence could more efficiently ensure public health service delivery to Maine's residents. Their approach consisted primarily of organizing resources and partners who were already providing services to Maine residents into organized ultimately collaborative coalitions at the state and local levels. Initial efforts focused on workforce training and community health coalition building. Between 1993 and 1997 the state health department and grass roots coalitions collaborated to provide training to coalition members, including grant writing training, which facilitated coalition growth from eight coalitions in 1997 to 22 in 2001. In 1999 they utilized Maine Turning Point grant funds to begin developing the foundational capacity necessary to establish a more robust infrastructure.

In 2001, tobacco Master Settlement Funds were used to supplement Turning Point funding, which allowed Maine to develop the Healthy Maine Partnership program (HMP) which non-competitively funded mostly existing coalitions to focus on policy and systems changes in 31 new service areas which covered most, though not all, Maine residents. Later in 2005, a second infrastructure development initiative was instituted using emergency preparedness funding. A multi-sector Public Health Work Group (PHWG), which included representatives from the coalitions and other nonprofit organizations; local, county, and Tribal governments; healthcare organizations; and state agencies including Maine CDC, Department of Education, and Department of Environmental Protection developed the local public health jurisdictions – including a new Tribal jurisdiction – which would cover all of Maine and which would be codified in Maine's public health statutes. The PHWG also defined roles and expectations for community health coalitions and created district and state coalitions, called coordinating councils, which included local stakeholders and Maine CDC representatives. The PHWG also revised statutes associated with Local Health Officers, a municipal position mainly responsible for investigating and resolving resident-reported public health problems. At the same time, the state created a Division of Local Public Health (DLPH), staffed district health offices with existing field staff, and dedicated a position to coordinate local public health partners within a district and serve as liaison between these partners and the Maine CDC, known as the District Liaison.

Successes

Focus group participants reported that Maine's new infrastructure has increased collaboration and coordination between partners, given stakeholders a better understanding of their communities' health needs and the services available to them, and has more effectively targeted resources. Partners felt that, in general, they were better able to direct residents to the resources they need as a result of stakeholders' improved awareness of Maine's public health partners. In discussing specific public health program areas, partners felt that public health emergency management is more robust. Other perceived results from Maine's infrastructure development were health policy changes, and improved health outcomes.

Challenges and Barriers

A number of challenges were identified. First, though they had a better understanding of the health issues facing their communities, participants did not feel that current funding levels would be sufficient to implement necessary interventions. Limited funding has also meant that newly formalized responsibilities have been added without being able to hire additional staff. As a result, existing staff must balance full-time obligations with these additional duties. An additional and related key challenge has been a lack of local policy maker support and local tax base to support public health activities at the community level. Inasmuch as the Maine system remains very much state-driven, it is particularly vulnerable to changing state priorities and/or leadership, and at this point has not developed local resources to replace state resources should that become necessary.

For More Information: Maine CDC Office of Local Public Health | http://www.maine.gov/dhhs/boh/olph/index.shtml

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