Wisconsin Public Health Council
2007 Report to Governor Jim Doyle

The Public Health Council, created in mid-2004 by the Legislature, advises the Governor, the Legislature, Wisconsin citizens and the Department of Health and Family Services (DHFS) on progress in implementing the state health plan, *Healthiest Wisconsin 2010*, and on the coordination of responses to public health emergencies. The Council strives to serve as a respected, objective, and balanced source of information for the Governor, the Legislature, and the DHFS.

Council Organization

Public Health Council membership is through appointment by the Governor. The Council includes three committees: the Executive Committee, consisting of elected officers and committee chairs; the State Health Plan Committee; and the Emergency Preparedness Committee. The Council meets six times a year. Meeting agendas include an open forum at the beginning of each meeting for public input, and reports from each of the committees. The Council maintains a Web site where agendas and minutes are posted; most Council meetings are recorded as webcasts and can be accessed from the Web site at the following address: http://publichealthcouncil.dhfs.wi.gov/webcast/ .

2007 Council Action

- **Endorsed a multi-part resolution to support certain legislative public health issues in the 2007-09 state biennial budget. (See Attachment A.)** The action took place as an outgrowth of a special meeting on the Legislature's biennial budget. The resolution, which the Council conveyed to the Legislature and others, included these positions:

    1. **Medicaid-related fiscal issues:** The Public Health Council supports Governor's Doyle's provisions related to the Health Care Quality Fund;

    2. **Tobacco control initiatives:** The Public Health Council reiterates its support for previous Public Health Council resolutions to increase the sales tax on cigarettes by $1.25 per pack; and to direct revenue generated by such a price increase to support a comprehensive tobacco control effort; and that such a comprehensive tobacco control effort should meet minimum funding standards of $30 million per year established by the U.S. Centers for Disease Control and Prevention.

    3. **Program administration reorganization for the Women, Infants and Children (WIC) nutrition program:** The Public Health Council supports creation of a new Department of Children and Families, but supports a state administrative structure in which WIC remains in the Department of Health and Family Services.

- **Endorsed a resolution to support provision of funding for statewide emergency preparedness activities. (See Attachment B.)** The resolution proposed action to provide state matching funds in connection with the Pandemic and All Hazards Preparedness Act of the 109th Congress. This federal law requires state matching of Public Health Preparedness funds, beginning in federal fiscal 2009. The Public Health Council urgently requests that matching funds—5 percent of federal preparedness funding in federal fiscal year 2009 and 10 percent in subsequent years—be included in the next state biennial budget.

- **Approved Division of Public Health follow-up action proposed by the State Health Plan Committee on specific policy recommendations related to the alcohol and other substance use and addiction health priority. The recommendations are to:**

    1. Promote measures for law enforcement to increase restrictions on the distribution and sale of alcohol and substance use;
    2. Partner with the Governor's state council on alcohol and other drug abuse systems to incorporate public health, mental health, and maternal child health in a coordinated action plan;
    3. Endorse and support the increase of taxes/surcharges on alcoholic beverages as a means of funding a comprehensive prevention and control program; and alcohol and substance abuse treatment;
    4. Recruit and retain behavioral health workers trained in alcohol and other drug abuse treatment and prevention programs; and
    5. Endorse measures that will improve data collection on the efficacy of substance abuse programs.

- **Endorsed a multi-part resolution to address childhood lead poisoning prevention in the state. (See Attachment C.)** The resolution supports a recommendation that the Governor:

    1. Lower the public health investigation and intervention level from 20 mcg/dL or persistent levels of 15/mcg/dL to 10 mcg/dL, and fund the additional public health workload by budgeting an additional $1 million for the program.
    2. Propose legislation creating an annual investment pool of $10 million for lead pollution control measure. In addition, we support the creation of a window replacement loan fund and a housing trust fund with a dedicated proportion of funds for lead hazard control as measures that would rehabilitate old housing. This would allow us to dramatically accelerate our efforts to prevent lead poisoning.
    3. Propose legislation to allow local governments to establish fees/taxes specifically for the establishment of housing trust funds at the local level. These new fees/taxes must be exempt from any levy caps imposed by the state.
    4. Encourage partners to develop and coordinate housing action plans that make lead hazard control a priority. Encourage lenders to make loans more attractive to property owners to correct lead paint hazards. For maximum effectiveness at protecting children, targeted loan programs should focus on housing built before 1950.
    5. Propose legislation that would require that paint on property built before 1978 be in intact condition before property is rented or sold.

- **Approved a report from the Ad Hoc Finance Subcommittee that met through much of 2007. (See Attachment D.) The report was conveyed to DHFS Secretary Kevin Hayden in 2008.** The report describes current levels of governmental public health funding in Wisconsin and

emphasizes the relatively low level of state investment, and its impact on limiting implementation of the State Health Plan. It cites a recent national study in which Wisconsin ranked 47th among states in state investment for public health, at slightly more than $34 million in support in 2004-2005. As a first step to increasing the state's investment in public health, the Finance Subcommittee proposed that the state per capita public health investment be raised from $6.24 per capita to $12.50. This increase would be achieved by the state investing an additional $33 million annually, which would create a more equitable financing structure in Wisconsin between local, state, and federal government sources. The Council believes that the requested additional $33 million in general purpose revenue should be become part of the Governor's next biennial budget proposal. These funds will be directed at the State Health Plan priorities and goals of obesity, alcohol and health disparities.

2006 Council Action

- Endorsed a voluntary national accreditation program for state and local public health departments, proposed by the Exploring Accreditation Steering Committee.
- Developed an influenza vaccine priority access policy statement. These emergency methods were not invoked during the 2006-07 influenza season.
- Endorsed Clearinghouse Rule 05-033, which allows dental hygienists to be certified as Medicaid providers and allows hygienists to bill the Medicaid program for preventive dental health services provided to eligible patients. The Legislature has since enacted a rule to allow dental hygienists to be certified as Medicaid providers and allows hygienists to bill the Medicaid program for preventive dental health services provided to eligible patients.
- Approved Rules of Order to govern the Council's organization and activities.

Briefings and Deliberations

Briefings and Council deliberations in 2007 included the following topics:

- Health Disparities (December, 2007)
- Prenatal Care Coordination in Medicaid (December, 2007)
- Wisconsin Minority Health Leadership Council (October, 2007)
- Public Health Modernization Act II (October, 2007)
- State Health Plan Committee Prioritization of Recommendations (October, 2007)
- Childhood Lead Poisoning Prevention (October, 2007)
- Selected Public Health Issues in the Legislative Biennial Budget (July, 2007 and August, 2007)
- Future of Farming and Rural Life in Wisconsin (June, 2007)
- Human Papillomavirus Vaccination (June, 2007)
- Briefing of Gov. Doyle on Public Health Issues (April, 2007)
- Nomination and Elections of Council Officers (February, 2007)

Committee Reports

The Council's two standing committees for 2007 carried out the activities described in the following two sections of the report.

Emergency Preparedness Committee

The mission of the Committee on Emergency Preparedness is to provide guidance and oversight to the planning and implementation of the public health, hospital and pre-hospital emergency preparedness programs. This committee is also charged through the agreement between the Division of Public Health and the Department of Health and Human Services to provide oversight to the state pandemic influenza planning.

The Emergency Preparedness Committee, meeting four times, identified four strategic priorities that it addressed in 2007:

- The state is to have a GPR budget, in addition to federal preparedness funding, that will sustain public health and hospital preparedness.
- The state and all emergency responders are to have the ability to respond to pandemic diseases and other all-hazards catastrophic incidents.
- The state and its emergency responders are to have the ability to recognize and address the needs of special needs populations in response to pandemic diseases and other all-hazards catastrophic incidents.
- The public is made awareness of these three goals, in order to support the sustainability of public health and hospital preparedness.

State Health Plan Committee

The Committee's mission is to propose public health policy recommendations and strategies to achieve the Council's responsibility to monitor progress of the legislatively mandated state health plan. The current 10-year state health plan, *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public*, is mandated in Wisconsin Statutes, Chapter 250.07. The primary stewardship responsibilities of the State Health Plan Committee are: (1) monitor, evaluate and communicate progress toward achieving the state health plan; (2) champion achievement of the state health plan; and (3) promote broad-based ownership for achieving *Healthiest Wisconsin 2010*.

Healthiest Wisconsin 2010 is widely held as a groundbreaking model for state health plans and is being considered as a model for the upcoming national health plan. This model integrated epidemiologic priorities with the expert review of public health and community partners. As Wisconsin begins developing its new state health plan, it is critical that adequate resources are provided to:

- Ensure adequate representation of community health partners in the development process, recognizing that public health requires a broad definition of health, e.g., agriculture, environment, social services.
- Use a risk-factor approach to priority setting.
- Include the needed State of Wisconsin staff to facilitate the process.

Committee Organization:
The current Chair is Mary Jo Baisch, PhD, RN. She succeeded Mr. Richard Perry as Chair in June 2007.

New and continuing members include: Leah Arndt, PhD (UW-Milwaukee); Shannon Chavez-Korell, PhD (UW-Milwaukee); Carol Graham, MS, RN (Public Health Advocate); Marilyn Haynes-Brokopp, MS, RN, BC (UW-Madison); Susan Garcia Franz (Planned Parenthood of Wisconsin); Catherine Frey (UW-Madison); Gary Hollander, PhD (Diverse and Resilient); Lynn Johnson, PT, MHA (Waukesha Memorial Hospital); Christopher Okunseri, DDS (Marquette University); Mark Powless, MS (Marquette University); Patrick Remington, MD, MPH (UW-Madison); Jan Seibert, ND (Seibert Health and Wellness); Pa Vang, BS, RN (Public Health of Madison and Dane County); Kathryn Vedder, MD, MPH (Public Health Advocate).

Resignations during 2007: Peggy Hintzman, MBA (Wisconsin State Laboratory of Hygiene); Mark Huber, MA (Aurora Health Care); Amy Murphy (Medical College of Wisconsin); JoAnn Weidmann (Public Health Council); Julie Willems Van Dijk (Marathon County Health Department); Rachel Morgan, RN (Black Health Coalition), in addition to Perry as Chair.

The Committee uses broad criteria to select its 15 members. The Committee held eleven meetings in 2007; formally reviewed progress on three additional statewide public health priorities (access to primary and preventive health services, mental health and mental disorders, high-risk sexual behavior), and will make policy recommendations to the Public Health Council for these three health priorities in 2008. The Committee has designed an effective evaluation model to measure progress and propose policy recommendations on *Healthiest Wisconsin 2010* to the Public Health Council. The Committee is staffed by Margaret Schmelzer, MS, RN, of the Division of Public Health.

During 2006 – 2007, the Committee formally evaluated progress in achieving 12 of the 16 priorities (75 percent) set forth in *Healthiest Wisconsin 2010*. Policy recommendations concerning public health financing were instrumental in the appointment of a special study committee of the Public Health Council to study and make recommendations to assure equitable, adequate, and appropriate financing of Wisconsin's public health system. (This financing report is included as Attachment D.)

Evaluating Progress of Healthiest Wisconsin 2010:
In 2007, the State Health Plan Committee heard testimony regarding the following statewide health priorities:

- *Healthiest Wisconsin 2010* Priority: Access to primary and preventive health services
- *Healthiest Wisconsin 2010* Priority: High risk sexual behavior
- *Healthiest Wisconsin 2010* Priority: Mental health and mental disorders

Policy Recommendations to the Public Health Council:
The Committee prepared policy recommendations based on its formal evaluation of the following four statewide health priorities and five statewide public health infrastructure priorities.

Statewide Health Priorities
1. Adequate and appropriate nutrition
2. Alcohol and other substance use and addiction
3. Overweight, obesity, and lack of physical exercise
4. Tobacco use and exposure

Statewide Public Health Infrastructure Priorities
1. Integrated electronic data and information systems
2. Community heath improvement processes and plans
3. Coordination of state and local public health system partnerships
4. Sufficient, competent workforce.
5. Equitable, adequate, and stable funding

A complete list of policy recommendations submitted to the Public Health Council may be found in Attachment E. The State Health Plan Committee remains committed to providing collaborative policy leadership to protect the health and safety of the people of Wisconsin.

2007 Public Health Council Membership

Sandy Anderson
Bevan Baker
John Bartkowski
Jayne Bielecki
Christopher Fischer
Susan Garcia Franz
Catherine Frey (Secretary)
Gary Gilmore (Vice Chair)
Stephen Kirkhorn
Terri Kramolis
Loren Leshan
Corazon Loteyro
John Meurer
June Munro
Douglas Nelson
Richard Perry
Ayaz Samadani (Chair)
Lynn Sheets
Thai Vue
JoAnn Weidmann
Julie Willems Van Dijk
Jeanan Yasiri

Recorded by Kevin Wymore and Jane Conner
Bureau of Health Information and Policy

Catherine Frey, Secretary Date

Attachment A

Biennial Budget/Public Health Issues Resolution
For the 2007-09 State Biennial Budget

Approved by the Wisconsin Public Health Council August 10, 2007

WHEREAS, the Public Health Council recognizes its statutory duty to advise the Governor, the Legislature and the public on matters pertaining to the State Health Plan, *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public*, and on emergency preparedness issues;

The Public Health Council supports the following three-part resolution to advise the current Conference Committee of the Senate and the Assembly:

1. **Medicaid-related fiscal issues:** The Public Health Council supports Governor's Doyle's provisions related to the Health Care Quality Fund;

2. **Tobacco control program grants:** The Public Health Council reiterates its support for previous Public Health Council resolutions to increase the sales tax on cigarettes by $1.25 per pack; and to direct revenue generated by such a price increase to support a comprehensive tobacco control effort; and that such a comprehensive tobacco control effort should meet minimum funding standards of $30 million per year established by the U.S. Centers for Disease Control and Prevention.

3. **Program administration reorganization for the Women, Infants and Children (WIC) nutrition program:** The Public Health Council supports creation of a new Department of Children and Families, but supports a state administrative structure in which WIC remains in the Department of Health and Family Services.

Attachment B

Emergency Preparedness Funding Resolution

Approved by the Wisconsin Public Health Council April 13, 2007

The State of Wisconsin recognizes the primary importance of emergency preparedness and response to the continued vitality of the state, its economy, and population. Therefore we will strive to fully fund emergency preparedness plans and systems. To this end, we propose action to provide state matching funds in connection with the Pandemic and All Hazards Preparedness Act of the 109th Congress. This federal law requires state matching of Public Health Preparedness funds, beginning in federal fiscal 2009. The Act states that:

> "Beginning in fiscal year 2009, in the case of any State or consortium of two or more States, the Secretary may not award a cooperative agreement under this section unless the State or Consortium of States agree that, with respect to the amount of the cooperative agreement awarded by the Secretary, the State or consortium of states will make available (directly or through donations from public or private entities) non-federal contributions in an amount equal to—
>
> (i) for the first fiscal year of the cooperative agreement, not less than 5 percent of such costs ($1 for each $20 of Federal funds provided in the cooperative agreement); and
>
> (ii) for any second fiscal year of the cooperative agreement, and for any subsequent fiscal year of such cooperative agreement, not less than 10 percent of such costs ($1 for each $10 of Federal funds provided in the cooperative agreement).

Therefore, because of this recent legislation, and in order to sustain the preparedness levels Wisconsin has achieved, the Public Health Council urgently requests that matching funds -- five percent of federal preparedness funding in federal fiscal 2009 and 10 percent in subsequent years -- be included in the next state biennial budget.

Attachment C

Wisconsin Public Health Council
Policy Resolution on Childhood Lead Poisoning Treatment and Prevention

Approved by the Wisconsin Public Health Council October 12, 2007

Whereas, more than 40,000 Wisconsin children since 1996 have been identified with lead poisoning. This identification level equals 10mcg/dL or greater of lead in blood. The vast majority of scientific research shows that children identified as lead poisoned suffer losses in intelligence. A study of 8,627 North Carolina children found that those exposed to lead in their pre-school years had lower third grade math and reading test scores. Lead paint in older homes is the primary lead exposure source for infants and children. Compared with other states, Wisconsin ranks 6th in the number of lead-poisoned children.

Whereas, lead poisoning in Wisconsin can be eradicated by rehabilitating our old housing. Many of these homes, with a small investment, will provide safe affordable housing for the next century. At the current rate of reducing lead paint, tens of thousands of Wisconsin children will become poisoned.

Whereas, because low income and minority families are limited in their housing choices, and sometimes are forced by many factors to live in hazardous housing, their children are at increased risk for lead poisoning. Lead poisoning contributes to other socio-economic factors that produce other unacceptable health disparities for Wisconsin's low income and minority children. It negatively impacts our state's educational and correctional system costs.

Whereas, our current policy of public health investigation and intervention at a blood lead level of 20 mcg/dL or a persistent level of 15 mcg/dL is unacceptable. This is because we know that damage occurs at blood lead levels below 10 mcg/dL. In 2006, Wisconsin provided $1 million to local public health agencies to respond to and to prevent lead poisoning. If we lower the investigation and intervention blood lead level to a blood lead level of 10 mcg/dL, and budget an additional $1 million to investigate the increased caseload, we can save children.

Whereas, incentives to property owners are needed to effectively control lead hazards**.** Lowering the blood lead level at which property owners are required to control lead hazards in housing will create demands for additional financing for property owners to make the investments needed to rehabilitate old housing. Creating an annual fund of $10 million for lead hazard control measures, i.e., housing rehabilitation loans and grants, would address this need.

The Wisconsin Public Health Council recommends that the Governor:

1. Lower the public health investigation and intervention level to 10 mcg/dL from the current 20 mcg/dL or persistent levels of 15/mcg/dL, and fund the additional public health work load by budgeting an additional $1 million for the program.
2. Enact legislation creating an annual fund of $10 million for lead hazard control measures. In addition, we support the creation of a window replacement loan fund and a housing trust fund with a dedicated proportion of funds for lead hazard control as measures that would rehabilitate old housing. This would allow us to dramatically accelerate our efforts to prevent lead poisoning
3. Enact legislation to allow local governments to establish fees/taxes specifically for the establishment of housing trust funds at the local level. These new fees/taxes must be exempt from any levy caps imposed by the state.
4. Require partners to develop and coordinate housing action plans that make lead hazard control a priority. Encourage lenders to make loans more attractive to property owners to correct lead paint hazards. Targeted loan programs should focus on housing built before 1950, which is where lead hazards are greatest.
5. Enact legislation that would require that paint on property built before 1978 be in intact condition before property is rented or sold.

Attachment D

A Proposal to the Public Health Council
From the Ad Hoc Finance Committee

Increased State Financing of Governmental Public Health

Wisconsin Department of Health and Family Services
Public Health Council

December 7, 2007

Public Health Council Ad Hoc Finance Committee
Julie Willems Van Dijk, chair
Bevan Baker
Carol Graham
Catherine Frey
Doug Nelson
David Ahrens

Authored by: Traici Brockman, MPH

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Patricia Guhleman

Table of Contents

PURPOSE

In response to concern about inadequate financing of Wisconsin's public health system, the Public Health Council appointed an Ad Hoc Finance Committee to further examine and analyze the financing of public health in Wisconsin. The committee's charge included developing a proposal to increase state funding of state and local governmental public health entities. The charge acknowledged that the work of public health occurs in both governmental and private sector settings, but that such a comprehensive analysis would be beyond the scope of the current report. Thus, this report represents a first step in understanding the full public health financing system; its recommendations focus on improved financing for the governmental public health system. It is recommended that future analysis expand this work to study public health financing in non-governmental systems and offer further recommendations for improvement.

WISCONSIN'S HEALTH CRISIS

Many measures reflecting the basic health status of a community document Wisconsin's failure to adequately protect and promote the health of its residents. For example, Wisconsin's African American infant mortality rate was once ranked third best in the nation. A lack of attention, combined with inaction, has driven Wisconsin to the worst African American infant mortality rate among 40 reporting states; in Wisconsin, African American babies are three times more likely than white babies to die before they reach their first birthday.[1] Increasing rates of chronic diseases also place heavy financial burdens on the health care system and lead to increased disability and death for Wisconsin residents. The adult obesity rate has doubled since 1990, and more than half the adult population (60%) is classified as overweight or obese.[2] Accordingly, obesity can be linked to two of the top three causes of death in Wisconsin – heart disease and stroke. Alcohol abuse represents another chronic disease that not only has perilous effects on health but increases crime and decreases public safety. Wisconsin leads the nation in current drinking among high school students (49%), current drinking among adults (68%), binge drinking among adults (22%) and chronic heavy drinking among adults (8%).[3] This has led to an alcohol-related motor vehicle death rate, an alcohol dependence and abuse rate, and drinking and driving rates that all exceed the national average.[4]

Failure to fully implement the State Health Plan is one of the reasons these problems show little-to-no improvement and threaten to become even more burdensome. Wisconsin's State Health Plan, *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public*, was created as a guide to transform Wisconsin's public health system through focus on 11 major health priority areas. The plan includes an implementation guide that contains long-term objectives for addressing each health priority, and identified actions that can be taken to address education, social support, laws, policies, and behavior change – all essential to creating lasting improvement in health outcomes. The plan includes detailed short, medium, and long-term objectives expected to be met during the decade. The state health plan is a detailed, clearly defined strategy, grounded in science and based on the most current evidence-based practices to provide solutions to improving health outcomes in Wisconsin.

The State Health Plan provides direction for addressing many of Wisconsin's poor health outcomes but has not been fully implemented. The major impediment to full implementation of the plan is that minimal state resources are appropriated for implementation. Wisconsin invests miserably in public health. A 2007 report from the *Trust for America's Health* ranked the 50 states according to their respective state public health investments. Wisconsin ranked 47th. Compared to neighboring states in the upper Midwest, Wisconsin ranks last in public health investment, spending only one-quarter of the average of these states on funding public health.

Without adequate and sustained financing it is difficult to improve the public's health in the near and long term and impossible to implement the State Health Plan, which provides the guidelines to solve Wisconsin's major health crises. Experience demonstrates that dedicated and consistent financing of public health can reduce negative health-related

[1] Wisconsin Health Facts: Racial and Ethnic Disparities in Infant Mortality, Wisconsin Department of Health and Family Services, January 2006. http://dhfs.wisconsin.gov/healthybirths/pdf/InfantHealthFactSheet.pdf (Accessed 09/28/2007).
[2] The Importance of Nutrition and Physical Activity in the Prevention of Obesity and Other Chronic Diseases - A Joint Statement, Wisconsin Department of Health and Family Services. http://dhfs.wisconsin.gov/health/physicalactivity.pdf_files/JointStatement-Final.pdf (Accessed 11/16/2007).
[3] Impact of Alcohol and Illicit Drug Use in Wisconsin, University of Wisconsin Population Health Institute, October 2007.
[4] Impact of Alcohol and Illicit Drug Use in Wisconsin, University of Wisconsin Population Health Institute, October 2007.

behaviors and improve health outcomes. For example, dedicated and sustained funding for tobacco control efforts has led to significant decreases in youth cigarette smoking (12% of middle school youth smoked in 2000, compared to 5.8% in 2006; 38% of high school students smoked in 1999 compared to 20% in 2006); fewer establishments that sell tobacco products to minors; declines in per capita consumption of cigarettes (94.0 packs sold per capita in 1990 versus 71 packs per capita in 2006); and decreased smoking rates among pregnant women (23% in 1990 compared to 13% in 2005). Reductions in prenatal smoking affect not only the health of the women, but also generate significant health care cost savings and health benefits to the infant since maternal smoking contributes to costly low birth weight and preterm births.[5] These tobacco control successes are laudable; they were possible because a commitment was made to direct sufficient resources to target the problem using evidence-based solutions, and the funding remained consistent and sustained. The same types of success can be produced in other areas affecting the public's health with a similar commitment to provide sustainable resources.

IMPORTANCE OF PUBLIC HEALTH SERVICES

Public health's goal in Wisconsin is the improved health of the 5+ million residents of Wisconsin. "Public Health is defined as a system, a social enterprise, whose focus is on the population as a whole."[6] The public relies on this system to prevent injury, illness, and the spread of disease; create a healthful environment and protect against environmental hazards; promote healthy behaviors and mental health; respond to disasters and assist communities in recovery; and provide accessible, high-quality health services. When public health is under-resourced the ability to fulfill these functions is threatened and the results are a less healthy population and higher medical care costs.

The governmental sector is a critical part of the public health system. "Health officials are either directly elected or appointed by democratically elected officials."[7] The public expects that government will monitor the population's health, and intervene when necessary via laws, policies, and regulations; it expects that government will appropriate the necessary resources to carry out these functions. Under the state constitution state and local governments have primary responsibility for maintaining population health.[8] This responsibility is fulfilled by engaging in the activities that constitute monitoring the public's health. State and local policymakers must also make available sufficient and sustained resources that allow those activities to continue.

FINANCING GOVERNMENTAL PUBLIC HEALTH

National Comparisons

Compared with other states, Wisconsin's state investment in public health financing ranks very low. A report from the *Trust for America's Health* published in 2007 ranked the 50 states according to their state per capita investment in public health (2 states were excluded because of inability to obtain reliable data). For the 2004-2005 period Wisconsin ranked 47th; its public health spending amounted to only $6.24 per capita, which translates into a total investment of just over $34 million (Table 1, next page). It is important to note that this number includes all state GPR funds appropriated for public health activities – including state health department spending, pass-through to local health departments, and pass-through to community-based organizations.

[5] Wisconsin Department of Health and Family Services, Division of Public Health, Wisconsin Tobacco Prevention and Control Program Annual Report, 2006 Activities; April 2007.
[6] Wisconsin's State Health Plan, *Healthiest Wisconsin 2010*, p. 10.
[7] "The Future of the Public's Health in the 21st Century." *Institute of Medicine, 2003, p. 101.*
[8] "The Future of the Public's Health in the 21st Century." *Institute of Medicine, 2003, p. 102.*

Table 1: National Rankings of State Investment in Public Health FY2004-2005

State	Rank	Per Capita	Total
Hawaii	1	$123.10	$155,458,776
Wyoming	2	$ 89.65	$ 45,408,089
Georgia	3	$ 80.35	$ 709,400,466
Idaho	4	$ 74.28	$ 103,485,100
Alabama	5	$ 68.37	$ 309,750,247
California	6	$ 64.58	$2,318,112,000
Oklahoma	7	$ 64.34	$ 226,720,000
West Virginia	8	$ 63.28	$ 114,883,938
New Mexico	9	$ 63.05	$ 120,003,800
Vermont	10	$ 60.44	$ 37,555,659
Nebraska	11	$ 59.72	$ 104,344,393
Arkansas	12	$ 51.25	$ 141,082,698
Minnesota	13	$ 47.83	$ 243,993,000
Utah	14	$ 41.36	$ 98,805,900
South Carolina	15	$ 38.86	$ 163,119,348
Alaska	16	$ 37.29	$ 24,440,600
Rhode Island	17	$ 37.12	$ 40,109,206
Maryland	18	$ 36.01	$ 200,162,000
Delaware	19	$ 35.58	$ 29,542,100
Kentucky	20	$ 35.36	$ 146,613,334
Florida	21	$ 34.35	$ 597,539,043
Virginia	22	$ 33.61	$ 250,703,431
Tennessee	23	$ 31.15	$ 183,829,600
Washington	24	$ 29.97	$ 371,845,528
Pennsylvania	25	$ 29.27	$ 363,108,000
New Jersey	26	$ 28.81	$ 250,592,000
Michigan	27	$ 25.52	$ 258,028,300
Illinois	28	$ 24.42	$ 310,415,600
North Dakota	29	$ 23.25	$ 29,494,441
New Hampshire	30	$ 21.69	$ 28,186,104
Montana	31	$ 20.99	$ 19,459,374
Connecticut	32	$ 20.32	$ 71,185,754
South Dakota	33	$ 20.04	$ 15,449,514
Massachusetts	34	$ 19.67	$ 126,209,229
Arizona	35	$ 15.31	$ 87,947,400
Colorado	36	$ 14.93	$ 68,704,761
North Carolina	37	$ 13.62	$ 116,310,280
Texas	38	$ 13.59	$ 305,545,630
Kansas	39	$ 11.48	$ 31,396,513
Indiana	40	$ 11.29	$ 70,394,726
Ohio	41	$ 10.85	$ 124,279,084
Mississippi	42	$ 10.01	$ 29,062,469
Oregon	43	$ 9.07	$ 65,173,871
Missouri	44	$ 7.98	$ 45,943,007
Iowa	45	$ 7.88	$ 23,267,142
Maine	46	$ 7.04	$ 9,277,644
Wisconsin	**47**	**$ 6.24**	**$ 34,356,000**
Nevada	48	$ 3.76	$ 8,774,904

Source: Levi, J, Julianno, C, and Richardson, M. "Financing Public Health: Diminished Funding for Core Needs and State-by-State Variation in Support." *Journal of Public Health Management and Practice* 2007, 13(2) pg. 97-102.

Out of this $34 million only $13.4 million supports the governmental public health system in Wisconsin. The remaining $20.6 million supports non-governmental public health entities. Table 2 indicates how Wisconsin compares to other upper Midwest states in their investment in public health:

Table 2: Comparison of State GPR Expenditures in Public Health among Upper Midwest States, FY2004-2005

State	Rank	Per Capita	Total
Minnesota	13	$ 47.83	$ 243,993,000
Michigan	27	$ 25.52	$ 258,028,300
Illinois	28	$ 24.42	$ 310,415,600
Iowa	45	$ 7.88	$ 23,267,142
Wisconsin	**47**	**$ 6.24**	**$ 34,356,000**

Source: Levi, J, Julianno, C, and Richardson, M. "Financing Public Health: Diminished Funding for Core Needs and State-by-State Variation in Support." *Journal of Public Health Management and Practice* 2007, 13(2) pg. 97-102.

Structure of Financing Governmental Public Health

A mix of federal, state, and program revenues and a small amount of segregated appropriations finance governmental public health on the state level. At the local level public health programs are financed primarily by local tax levies along with a mix of federal, state, and program revenues. These financing structures often constrain local and state health departments by placing categorical restrictions by the funding source on the use of these funds. Very little of the revenues received by state or local government have flexible uses; therefore, these revenues cannot always be used for the most pressing problems of the community or state.

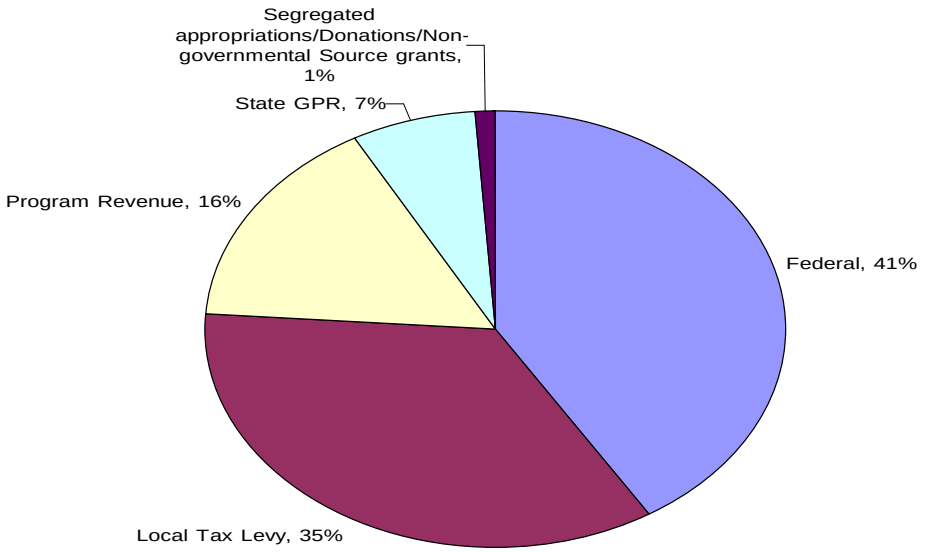
In Figure 1 (next page), federal funds (41%) refer to grant money received from the federal government. These funds are usually received by the state Division of Public Health, which retains approximately 20% for its operations. Much of federal funding is passed on to local partners, including local public health agencies (about 17%) and private community-based organizations (the remaining 63%). Federal funds are always for a specified purpose, such as the maternal and child health block grant, WIC funds, immunization grants, public health preparedness funds, and the prevention health block grant.

State funds (7%) are state general purpose revenue (GPR) granted to the state Division of Public Health, which retains about 12%; about 26% is passed to local health departments and 62% to private community-based organizations. Examples of this funding include monies for childhood lead poisoning prevention and the Wisconsin Well Woman cancer screening programs.

Program revenues (15%) are monies collected by state or local governments for services such as licensing, fees, certifications, and registrations. Donations are any monies received as gifts; and non-governmental source (NGS) grants are funds obtained through a competitive grant process from private foundations (for example, United Way and the Robert Wood Johnson Foundation).

In summary, governmental public health is financed by a mix of funds from different sources. Most of these funds carry categorical restrictions on their use, which may not allow health authorities to address the most pressing problems for the state or the local community. An examination of each of the funding sources referenced above and their contribution to financing Wisconsin's public health system in 2005 reveals some disturbing inequities.

Figure 1: Percent of Funding for Governmental Public Health in Wisconsin by Source – 2005



Source: Wisconsin Department of Health and Family Services, Bureau of Fiscal Services, SFY 2002-2005 Annual Expenditure Reports; Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Local Health Department Surveys 2002-2005.

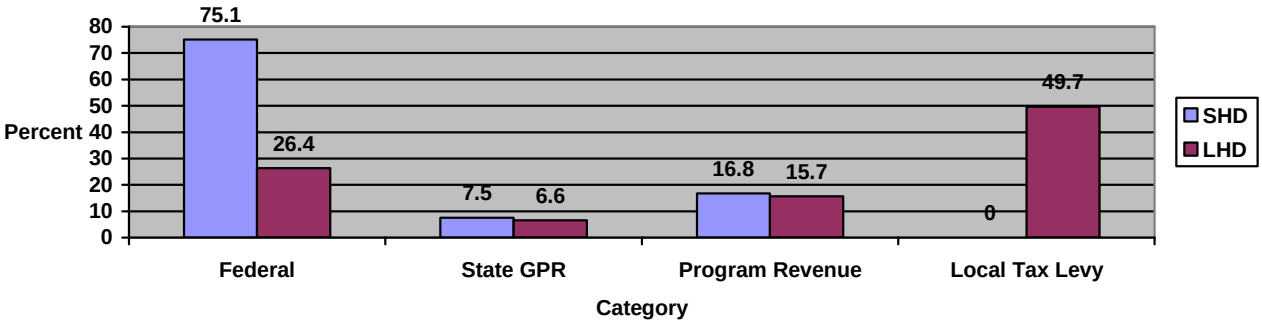
Data indicate that Wisconsin is heavily dependent on federal funding and local tax levy revenues to finance its governmental public health activities – these two sources contribute over three-quarters of all funding for governmental public health. State revenue contributes relatively little (7%) to support the public health responsibility for improved health outcomes for residents of the state.

Problems associated with being heavily reliant on federal funding and local taxes include:

- All federal revenue is categorical – if priorities and appropriations change at the federal level it will directly affect the ability of Wisconsin public health practitioners to focus on public health priorities.
- If significant decreases occur in federal funding, state and local public health agencies will need to drastically reduce the services they can provide to the state and individual communities.
- Because few of the dollars are derived from state sources, the state cannot define or implement its health priorities. If the state determines, for example, that ground water protection, diabetes prevention, and reductions in infant mortality are important, it has little revenue to direct to these priorities. The priorities that are deemed important at the federal level may not be what is most important for improving the health of Wisconsinites.
- Significant variation exists between counties' local tax bases; wealthier counties may have the ability to provide more and better programs and services than other counties, leading to increased disparities in service availability and delivery across the state.

Our analysis reveals that the state health department in Wisconsin has become dependent on federal revenue to finance 75% of its public health activities. Local health departments are dependent upon local tax levies for 50% of their funding and federal revenue for about 25% of their funding. In each case the state investment is minimal. In 2005, GPR contributed about 7.5% of state health department revenues and 6.6% of local health department revenues.

Figure 2: Sources of State and Local Health Department Revenues in Wisconsin – 2005



Source: Wisconsin Department of Health and Family Services, Bureau of Fiscal Services, SFY 2002-2005 Annual Expenditure Reports; Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Local Health Department Surveys 2002-2005.

Analysis of trends in funding over the past five years does not indicate significant changes in total or per capita expenditures or the relative contributions of revenue from each funding source (see Appendix for more detail of funding in the past few years). In general, funding amounts have remained relatively flat and often when adjusted for inflation have decreased. (Table 3 displays per capita expenditures from each source of funding.) At the same time, greater demands are being placed upon governmental public health to perform services required by statute, respond to new and emerging threats, and make progress toward the goals of the State Health Plan. Without more and sustained resources it will be impossible for governmental public health to adequately and sufficiently accomplish these tasks.

Table 3: Per Capita Spending on Governmental Public Health by Source of Funding – 2005

Funding Source	Per Capita Spending	Total Expenditures
Federal	$14.36	$79,000,000
Local tax levy	$12.35	$67,900,000
State GPR	$6.24	$34,356,000

Source: Wisconsin Department of Health and Family Services, Bureau of Fiscal Services, SFY 2002-2005 Annual Expenditure Reports; Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Local Health Department Surveys 2002-2005.

PROPOSED RECOMMENDATIONS

1. This committee recommends that the state increase its per capita investment in public health to $12.50. This would require an annual increase in funding of $33 million.
2. The committee further recommends that the funding be appropriated to the state health department but will be divided between both state and local governments; these entities can decide to use their funding to subcontract with private partners.
3. The committee recommends that the funds be used to implement evidenced-based approaches and strategies to address the health problems of obesity, alcohol abuse, and health disparities; some funding will also be available to address other health priorities of the state health plan.
4. The committee recommends that this new funding be generated via a $0.10 increase in the tobacco excise tax. Other options for funding would include a tax on alcohol and/or a tax on sugar-sweetened beverages.

Recommendation 1
An increase of the state's per capita investment to $12.50 is a starting point to better financing of governmental public health in Wisconsin because it will provide resources to improve the public's health. It will also produce equity among the three top funding sources in the state. This increase would move the state to a comparable investment to what local

governments are spending on public health activities. It would also move the state closer to the federal government's investment in Wisconsin's public health system. Holding other things equal, this increased investment would move Wisconsin's per capita investment ranking from 47th to 39th. It would also increase Wisconsin's investment to half the average investment of its upper Midwest neighbors.

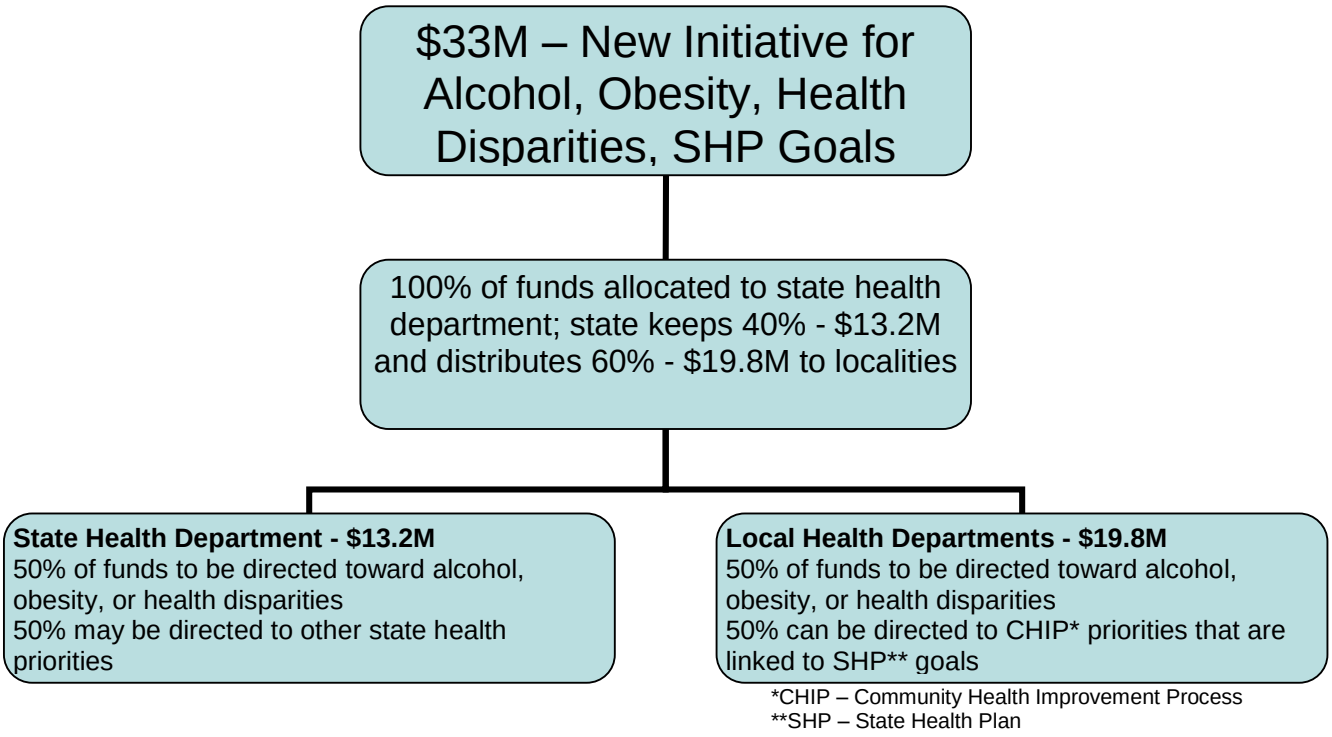
Recommendation 2

These new funds would be divided between state and local government. All funds would be directed to the state health department, which would retain 40% of the funds – approximately $13.2 million – and would distribute 60% - approximately $19.8 million - to local governments. This recognizes that both state and local governments have an important role in improving the public's health. The state health department will serve a leadership role in coordinating efforts to address Wisconsin's top health problems by disseminating best practices for the identified health problems and providing technical assistance to the localities. Distributing the greater percentage of funds to local governments recognizes that the most effective way to affect health issues is at a local level, where services and strategies connect with people.

State and local government would use these funds to address the increasing health problems of alcohol abuse, obesity, and health disparities. State and local health departments could also use some funds for addressing priorities from their community health plans, which are linked to state health plan goals. This approach assures that a significant portion of the new funds will be directed to three of Wisconsin's most pressing health issues, and incorporates enough flexibility to address other health priorities identified by the state health plan and local assessments.

Figure 3 describes how the money would be distributed between the two governmental institutions.

Figure 3: Description of New Funding Initiative and Priorities for Wisconsin Public Health



Under this model the state and local health departments would have discretionary authority regarding the use of this additional funding. Half of the funding would be designated for use in the areas of alcohol, obesity, and health disparities. Funds could be used to focus on one of those priorities or all three; however, at least half of the funding would have to address alcohol, obesity, or health disparities in some way. The other half of the funding would address the need to allow the state and localities to address other priorities within the state health plan that are identified through their community health plans if they so choose. They may also opt to direct 100% of their funds to alcohol, obesity, and health disparities.

Recommendation 3

While Wisconsin ranks well in a number of health outcomes there is indeed cause for alarm. Wisconsin is consistently dropping in national health rankings. The United Health Foundation annually publishes *America's Health Rankings,* a report based on a determinants-of-health model, which ranks the 50 states according to numerous health outcomes. When these rankings began in 1990 Wisconsin ranked 3rd, by 2000 that ranking had fallen to 8th. In 2006, Wisconsin was 10th and the recently released 2007 report shows Wisconsin has fallen another two spots to 12th.[9] Other analyses of Wisconsin show that although the state is often improving its health outcomes it is not improving as fast as other states or the national average; this causes Wisconsin to drop in national rankings despite making some improvement in health outcomes. A 2004 report from the Wisconsin Population Health Institute analyzed Wisconsin's ranking of all-cause mortality for persons under 75 years of age. Wisconsin ranked 16th but making improvements at its current pace was projected to drop to 18th by the year 2010.[10] Health outcomes consistently mentioned as areas that threaten the health of Wisconsin and will provide future challenges to maintaining a healthy state include health disparities, alcohol abuse (specifically binge drinking), and the increasing prevalence of obesity. Each of these issues was chosen as a priority on which to focus new funding because of the current intensity of the problems, the lasting burden they will place on the health care system, and their negative impact on the health of Wisconsin's people.

These funds will be targeted to implementation of evidence-based approaches and best practices to address the following pressing health priorities.

- ***Health Disparities***
  In Wisconsin, minorities, those with less income and education, and those in rural settings often have poorer health outcomes. Wisconsin's minority populations experience a disproportionate burden of many adverse health conditions and health outcomes. The *Health of Wisconsin Report Card* (July 2007) gave Wisconsin an overall health disparity grade of "D," and in many categories Wisconsin received a health disparity grade of "F." Wisconsin is failing to protect the health of many of its citizens, especially its minorities and those in the most vulnerable age groups. The infant mortality rate for the African-American population is more than three times the rate for the white population (17.6 deaths per 1,000 live births v. 5.1 deaths per 1,000 live births)[11]. The population referred to as children and young adults (ages 1-24) also shows disparity in mortality rates. African American and American Indian populations experience a child and young adult mortality rate of 66 deaths per 100,000 population compared to a rate of 39 per 100,000 for whites and 41 per 100,000 for Asians.[12] For adults aged 25-64, mortality rates are highest for those with high school or less education (459 per 100,000 compared to 188 per 100,000 for those who are college graduates) and African American and American Indian populations (624 per 100,000 and 592 per 100,000, respectively).[13] These disparities are differences in health outcomes due in part to inequality and indicate that many Wisconsinites are not experiencing optimal health outcomes.

[9] "America's Health Rankings 2007." United Health Foundation http://www.unitedhealthfoundation.org/media2007/shrmediakit/ahr2007.pdf (Accessed November 27, 2007).
[10] Kempf, AM, Peppard, PE, Kindig, DA, and Remington, PL. "How Fast Can Wisconsin become Healthier? A Framework for Setting State Objectives." http://www.pophealth.wisc.edu/UWPHI/publications/issue_briefs/issue_brief_v05n09.pdf (Accessed November 27, 2007).
[11] Booske, BC, Kempf, AM, Athens, JK, Kindig, DA, and Remington, PL. *Health of Wisconsin Report Card.* University of Wisconsin Population Health Institute, July 2007, p 4.
[12] Booske, BC, Kempf, AM, Athens, JK, Kindig, DA, and Remington, PL. *Health of Wisconsin Report Card.* University of Wisconsin Population Health Institute, July 2007, p 6.
[13] Booske, BC, Kempf, AM, Athens, JK, Kindig, DA, and Remington, PL. *Health of Wisconsin Report Card.* University of Wisconsin Population Health Institute, July 2007, p 8.

- ***Alcohol Abuse***
  A recent report, *Impact of Alcohol and Illicit Drug Use in Wisconsin* (October 2007) found that Wisconsin has the highest rates in the nation of current drinking among high school students (49%); current underage drinking (39%); current drinking among adults (68%); binge drinking among adults (22%); and chronic, heavy drinking among adults (8%). Such intense alcohol use and abuse leads to a number of alcohol-related consequences such as motor vehicle fatalities, cirrhosis of the liver and various cancers, hypertension and heart disease, and homicide and family violence. Alcohol and drug abuse resulted in the expenditure of nearly $190 million of public funds on hospitalizations and treatment for this problem.

- ***Obesity***
  Obesity is another health problem affecting Wisconsin with great intensity. According to 2005 data from the Centers for Disease Control and Prevention's (CDC) Behavioral Risk Factor Surveillance System (BRFSS), 60% of Wisconsin adults are overweight or obese (37% overweight and 24% obese). Also, in the CDC's ranking of states based on the percentage of adults that were overweight or obese, Wisconsin ranked 26th in 2004. Obesity contributes to a number of adverse health conditions such as hypertension, type 2 diabetes, some forms of cancer, coronary heart disease, and stroke. The economic burden of obesity is significant. State-level estimates of annual medical expenditures in Wisconsin attributable to obesity reported total expenditures of $1.5 billion; nearly half those costs were born by public programs, with Medicaid and Medicare incurring $626 million.[14] The 2006 and 2007 health ranking reports cited obesity as a continuing challenge for Wisconsin because of its increasing prevalence.

Recommendation 4
It is recommended that this new funding be generated from an increase in the tobacco excise tax. An increase in this tax has been supported by the Governor, the Legislature, the Public Health Council and other public health organizations. Analysis of cigarette consumption patterns after implementation of a tax increase shows that a $0.10 increase would be enough to generate the $33 million outlined in this proposal. Other options that could be considered to fund this initiative would be taxes on alcohol and/or sugar-sweetened beverages.

EXPECTATIONS AND ASSUMPTIONS

Coupled with this new funding would be expectations and accountability mechanisms for both the state and local governments that receive funds. The state Division of Public Health would act as a leader and disseminate best practices on preventing alcohol abuse, obesity, and health disparities as well as provide technical assistant to the localities, including readily accessible data related to the three health priorities to assist all parties in monitoring progress toward improvement. Local health departments would be expected to have already completed their community health plans and identified the priorities that are most pressing for the communities. These funds would not be available for them to complete the plans. Local governments could – and would be encouraged to – contract with private and community partners to help address the health problems discussed earlier. Also, accountability would be further ensured by using the state measures linked to the State Health Plan implementation guidelines. These guidelines should direct local activities. It would also be expected that local government should not see this new funding as a way to supplant current funding levels and decrease tax levy support for public health. The expectation would be for funding levels from all sources to remain at current or increased levels following this increase in state funding for public health. This would also be seen as a first step in improving the financing of governmental public health. Based on further public health financing analysis and experience through this initiative, it is expected that this funding will be sustained and increased over time as appropriate in order to maintain and improve the health of Wisconsin's people.

[14] "The Importance of Nutrition and Physical Activity in the Prevention of Obesity and Other Chronic Diseases – A Joint Statement." Wisconsin Department of Health and Family Services http://dhfs.wisconsin.gov/health/physicalactivity/pdf_files/JointStatement-Final.pdf (Accessed November 16, 2007).

Appendix

Table 1: Funding for Wisconsin State and Local Governmental Public Health Activities, 2001-2005

Year	Federal	Local Tax Levy	State GPR	Program Revenue	SA/Donation/NGS	Total
2002	$69,355,145	$61,542,132	$14,694,378	$33,343,604	$2,445,523	$181,380,783
2003	$76,420,640	$67,895,561	$14,300,223	$31,421,962	$2,363,996	$192,402,382
2004	$81,082,194	$67,780,839	$13,243,017	$29,613,514	$2,573,963	$194,293,527
2005	$78,956,387	$67,913,612	$13,369,064	$31,072,652	$2,379,241	$193,690,956

Source: Wisconsin Department of Health and Family Services, Bureau of Fiscal Services, SFY 2002-2005 Annual Expenditure Reports.
Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Local Health Department Surveys 2002-2005.

Table 2: Percent of Wisconsin Governmental Public Health Funding by Source, 2001-2005

Year	Federal	Local Tax Levy	State GPR	Program Revenue	SA/Donation/NGS
2002	38.2%	33.9%	8.1%	18.4%	1.3%
2003	39.7%	35.3%	7.4%	16.3%	1.2%
2004	41.7%	34.9%	6.8%	15.2%	1.3%
2005	40.8%	35.1%	6.9%	16.0%	1.2%

Source: Wisconsin Department of Health and Family Services, Bureau of Fiscal Services, SFY 2002-2005 Annual Expenditure Reports.
Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Local Health Department Surveys 2002-2005.

Table 3: Funding for Wisconsin State Health Department Public Health Activities, FY 2000-2001 – 2004-2005

FY	Federal	State GPR	Program Revenue	Segregated Appropriations	Total
2000-2001	$40,202,363	$6,712,278	$9,044,832	$370,400	$56,329,873
2001-2002	$44,827,115	$5,572,827	$11,378,300	$387,100	$62,165,343
2002-2003	$46,038,459	$5,607,491	$10,962,195	$393,300	$63,001,445
2003-2004	$46,914,932	$5,052,530	$9,434,653	$406,538	$61,808,653
2004-2005	$42,863,647	$4,297,842	$9,581,321	$325,663	$57,068,473

Source: Wisconsin Department of Health and Family Services, Bureau of Fiscal Services, SFY 2000-2005 Annual Expenditure Reports.

Table 4: Wisconsin State Health Department Public Health Activities: Percent of Funding by Source, FY 200-2001 – 2004-2005

FY	Federal	State GPR	Program Revenue	Segregated Appropriations
2000-2001	71.4%	11.9%	16.1%	0.7%
2001-2002	72.1%	9.0%	18.3%	0.6%
2002-2003	73.1%	8.9%	17.4%	0.6%
2003-2004	75.9%	8.2%	15.3%	0.7%
2004-2005	75.1%	7.5%	16.8%	0.6%

Source: Wisconsin Department of Health and Family Services, Bureau of Fiscal Services, SFY 2000-2005 Annual Expenditure Reports.

Table 5: Funding for Wisconsin Local Health Departments, 2001-2005

Year	Federal	State GPR	Program Revenue	Donation	NGS grants	Tax Levy	Total
2002	$24,528,030	$9,121,551	$21,965,304	$441,589	$1,616,834	$61,542,132	$119,215,440
2003	$30,382,181	$8,692,732	$20,459,767	$228,390	$1,742,306	$67,895,561	$129,400,937
2004	$34,167,262	$8,190,487	$20,178,861	$375,735	$1,791,690	$67,780,839	$132,484,874
2005	$36,092,740	$9,071,222	$21,491,331	$389,357	$1,664,221	$67,913,612	$136,622,483

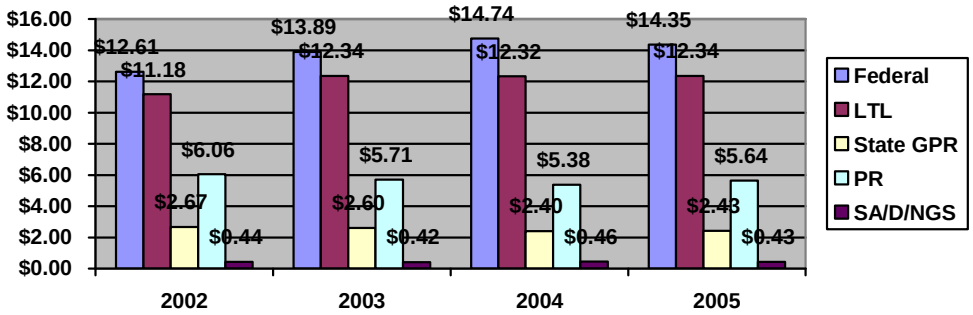
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Local Health Department Surveys 2002-2005.

Table 6: Local Health Departments in Wisconsin: Percent of Funding by Source, 2001-2005

Year	Federal	State GPR	Program Revenue	Donation	NGS grants	Tax Levy
2002	20.6%	7.7%	18.4%	0.4%	1.4%	51.6%
2003	23.5%	6.7%	15.8%	0.2%	1.3%	52.5%
2004	25.8%	6.2%	15.2%	0.3%	1.4%	51.2%
2005	26.4%	6.6%	15.7%	0.3%	1.2%	49.7%

Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Local Health Department Surveys 2002-2005.

Figure 1: Per Capita Spending on Public Health by Source of Funds, Wisconsin, 2002-2005



Source: Wisconsin Department of Health and Family Services, Bureau of Fiscal Services, SFY 2002-2005 Annual Expenditure Reports. Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Local Health Department Surveys 2002-2005.

State Health Plan Committee Summary
Policy Recommendations
Selected *Healthiest Wisconsin 2010* Priorities (2007)

Policy Recommendations Statewide Priority	Lead Accountability		
	Date Sent	**PHC Action**	**Comment**
Adequate and Appropriate Nutrition and Overweight, Obesity, and Lack of Physical Activity	**2/07**		
Food insecurity: Promote awareness of the levels of food insecurity throughout the state and support funding mechanisms to expand continued improvement, particularly among at-risk populations.	**2/07**		
State nutrition plan: Endorse and support funding mechanisms to disseminate and implement the *Wisconsin Nutrition and Physical Activity State Plan.* ➢ Key actions include: o strengthen infrastructure to prevent and manage obesity and chronic disease; o facilitate consistent messages; create healthy environments; o develop and implement a comprehensive policy agenda; o coordinate interventions and use evidence-based practices; o strengthen data-based actions through improved surveillance and evaluation; o eliminate disparities among those disproportionately affected.	**2/07**		
Nutrition workforce: Secure funding for a full time epidemiologist to provide leadership and expertise necessary to establish and maintain a nutrition and physical activity surveillance system that best describes the status of nutrition and food security in the state.	**2/07**		
Endorse and support funding to assure a public health nutritionist in every local health department.	**2/07**		
Advocate for public health nutritionists in state statute.	**2/07**		

Policy Recommendations Statewide Priority	Lead Accountability		
	Date Sent	**PHC Action**	**Comment**
Nutrition surveillance: Expand nutrition surveillance to identify populations that are at disproportionate risk for food insecurity, overweight and obesity, including young children and youth where data are lacking.	**2/07**		
Evidence-based practices: Promote awareness, disseminate, and implement best-practices and improve resources among state policy makers, agencies, and organizations that serve communities most at-risk.	**2/07**		
Nutrition policies: Encourage a specific action for policy strategies at the state or local level that impact health food choices and a physically active lifestyle such as those highlighted in the Wisconsin Nutrition and Physical Activity State Plan. ➢ Key actions include: o adoption of K-8 policies for physical education; o adopt school wellness policies; o policies for health insurance providers and plans to include coverage for prevention, assessment, and management of overweight and obesity; o work site health promotion policies; o state and local policies (food security, breastfeeding, access to facilities, bike trails, food assistance programs).	**2/07**		
Tobacco Use and Exposure			
Restore the $31 million needed to support a comprehensive program: Endorse a comprehensive prevention and control program through statewide policy changes and expanded funding. The elements of this have been outlined by the U.S. Centers for Disease Control and Prevention. (The Wisconsin Tobacco Prevention and Control Advisory Group endorsed a set of complementary recommendations March 1, 2006.)	**2/07**		

Policy Recommendations Statewide Priority	Lead Accountability		
	Date Sent	**PHC Action**	**Comment**
Endorse a $1.25 per pack cigarette increase: Endorse the cigarette tax increase as a means of funding a comprehensive prevention and control program, tobacco treatment, and health improvement activities.	**2/07**		
Aggressively support the infrastructure: Aggressively support the infrastructure necessary to achieve health improvements by: ➢ Providing the public health system partners with adequate funding ➢ Providing systems for data collection of health data in a timely, locally-based, and standard format.	**2/07**		
Deploy resources to support a comprehensive tobacco control program: Critical features/elements of this program include: establish user and purveyor fees; support tobacco addiction treatment especially for disparately affected population; support the Executive Order making all State office buildings and vehicles smoke-free; support local levels of government to adopt more restrictive measures to protect residents from second-hand smoke; promoting completely smoke-free workplaces; target youth tobacco use.	**2/07**		
Critical Infrastructure Priority Action Steps in 2007	**2/07**		
Accept and adopt the transformation report: Presented by the State Health Plan Committee to the Public Health Council on February 9, 2007.	**2/07**		
PHC should establish, in coordination with the State Health Plan Committee, a commissioned study group to develop strategies and implementation steps in 2007 for the needs identified in the sections below titled: ➢ General Needs for Transformation. ➢ Adequate and Stable Financing and ➢ Integrated data. **Note:** The other three infrastructure priorities are included, but due to the projected workload that the first three issues will precipitate, action on these issues will probably need to be delayed until 2008. However,	**2/07**		

Policy Recommendations Statewide Priority	Lead Accountability		
	Date Sent	**PHC Action**	**Comment**
any action taken by either the Public Health Council or its two subcommittees need to consider all of these infrastructure issues when making policy or program decisions. All of the infrastructure priorities are vital to be included in any planned changes in public health policy or the public health system. **Note:** Repeat this survey to determine the progress of change in 2009/10 prior to implementation of the 2020 state health plan.			
General Needs for the Public Health System Transformation	**2/07**		
Define concrete indicators: Indicators are necessary to assess progress of public health system infrastructure goals. Indicators should go beyond impressionistic responses or opinions.	**2/07**		
Develop a public marketing or social marketing campaign: This campaign is necessary to aid and clarifying the public health system to various stakeholders. Campaign goals should include: ➢ Increased understanding of public health and the various partner roles in it; ➢ Increased awareness of the array of services involved in public health: Who is involved in providing services and who is served; and, ➢ Increased partnerships with media outlets to cover health and public health system information.	**2/07**		
Examine public health system across the rural-urban continuum: ➢ What are the variations in these subsystems? ➢ Are the variations intentional? ➢ Do these variations reflect a rational approach to service delivery?	**2/07**		
Consider what is acceptable and what is optimal for the "health" of the State: The recent report on "Causes of Excess Deaths in Wisconsin" compares Wisconsin to the best states in several outcomes. Is that the optimal scenario or the acceptable one? This discussion is critical for financing arguments. The cost of either one will be expensive but exponentially more for optimal health outcomes. Do	**2/07**		

Policy Recommendations Statewide Priority	Lead Accountability		
	Date Sent	**PHC Action**	**Comment**
we start at acceptable and move towards optimal?			
Equitable, Adequate, and Stable Financing	**2/07**		
Develop a common definition for 'Public health expenditures' for private, not-for-profit, voluntary, community-based, and government organizations.	**2/07**		
Develop a risk-based standard for funding which addresses the community needs and total statewide system needs. What are the resources needed to accomplish the State health needs?	**2/07**		
Collection of financial data should be integrated into the database for all state health plan priorities.	**2/07**		
All state health legislative action regarding health programs, rule making, and statute revisions should have a public health component identifying how it impacts on the public's health.	**2/07**		
Annual report of progress being made to reach health plan goals should include all expenditures, including cost of evaluation, to improve and/or accomplish the goals.	**2/07**		
Establish accounting mechanisms to track state budget to health priorities, including apportioning parts of administration to most highly funded priorities.	**2/07**		
Integrated Electronic Data and Information Systems	**2/07**		
Establish measurable indicators that define progress for each priority health and infrastructure goal.	**2/07**		
Collect relevant health data that can assist in clarifying health disparities: Before data can be integrated they must be collected. To date, there has been progress on data reporting and some integration, but little progress on data collection. This paucity severely hampers the ability to address issues of disparity. This data collection needs to include electronic reporting by all public health partners.	**2/07**		

Policy Recommendations Statewide Priority	Lead Accountability		
	Date Sent	**PHC Action**	**Comment**
Output data needs an improved process to be accessible: For example, a summary chart of public health priorities by specific geographic areas is critical. Such a "topical" approach would allow the users of the data system to mine the data to meet their own analysis needs.	**2/07**		
Data needs to reflect needs and abilities of the partners in the system.	**2/07**		
All public health system partners need to participate in the input of the data system: Refer to Dr. Lawrence Hanrahan's report as to why the e-medical record is vital to public health.	**2/07**		
Sufficient and Competent Workforce			
Clarify and expand the meaning of diversity of the workforce: Diversity should include race, ethnicity, language, disability, gender, gender expression, sexual orientation, age, academic or professional preparation, and social-economic status of the workforce.	**2/07**		
Identify programs that are supplying public health workforce: ➢ Identify demographics of graduates per year starting in 2002-2006 and of current year students thereafter; ➢ Identify "pipeline" program demographics, success rates, and outcomes reflecting public health understanding and beginning public concept preparation; ➢ Increase understanding of goal of achieving a diverse workforce as more than meeting current patient/client demographic needs, but rather as one mechanism to create better thinking and a more just and equitable society – [a legitimate public health goal – a core value of how we understand health and well being] ➢ Identify "non-graduates" or community workers that are part of the public health workforce.	**2/07**		
Clarify and expand definition of public health workforce.	**2/07**		

Policy Recommendations Statewide Priority	Lead Accountability		
	Date Sent	**PHC Action**	**Comment**
Track demographics of each of the various job titles: Articulate the various players in the public health system and their appropriate functions. (This will take wide-spread discussion and development.)	**2/07**		
Include issues of public health in teacher preparation and in-service: This should occur at all levels (primary through college) including a broad public health system understanding from public safety, transmission of infections, disease prevention, and public health careers.	**2/07**		
Enumerate the base capacity needed to provide public health services: Possibly use County as a base level of service. How many and what type of public health workers does it take to meet the community standard for public health services?	**2/07**		
Coordination of State and Local Public Health System Partnerships	**2/07**		
Use the "Lewin Group" report characteristics of depth, breadth, and penetration: and anticipated expense associated with these in state contracts and foundation grants, rather than cost savings that have yet to be found. ➢ The state needs to take a leadership role in establishing true partnerships. State employee responses indicate that depth, breadth, and penetration of partnerships has declined, this trend must be reversed. All other groups felt that partnerships had increased but were very tenuous at times.	**2/07**		
Provide training, techniques, and resources to partners in areas that include: ➢ Change management ➢ Cooperation ➢ Collaboration ➢ Shared vision - goal development ➢ Communications within partnerships ➢ Working with challenges in order to work towards resolution ➢ Establishing trust relationships ➢ Working in a fluid leadership model to accomplish specific goals ➢ Identifying the correct mix of community partners for each situation	**2/07**		

Policy Recommendations Statewide Priority	**Lead Accountability**		
	Date Sent	**PHC Action**	**Comment**
Community Health Improvement Processes and Plans (CHIP)	**2/07**		
Carefully monitor the cost/benefits of CHIP, now viewed as a vital process in community development for healthier communities. ➢ Determine efficiency and effectiveness of the CHIP process as a mechanism for resource allocation, community engagement and improvement of outcomes for diverse populations. ➢ Develop an understanding of the reasons for transfer of technology and information in both directions of partnerships. ➢ Use widely available adult education program(s) and principles to implement, disseminate, and foster implementation of CHIP process. ➢ Capacity building needs to be funded; and ➢ CHIP processes needs be topically and/or locally based, not only a mandate from State Government. ➢ Leadership of the CHIP process needs to be fluid; local health departments need to a vital partner, but not always the lead organization during the CHIP process.			
Alcohol, Substance Use and Addiction	**10/07**		
Policy 1. Promote measures for law enforcement to increase restrictions on the distribution and sale of alcohol and substance use.	**10/07**		
Policy 2. Partner with the Governor's state council on alcohol and other drug abuse systems to incorporate public health, mental health, and maternal child health in a coordinated action plan.	**10/07**		
Funding 3. Endorse and support the increase of taxes/surcharges on alcoholic beverages as a means of funding a comprehensive prevention and control program; and alcohol and substance abuse treatment.	**10/07**		

Policy Recommendations Statewide Priority	Lead Accountability		
	Date Sent	**PHC Action**	**Comment**
Workforce 4. Recruit and retain behavioral health workers trained in alcohol and other drug abuse treatment and prevention programs.	**10/07**		
Data 5. Endorse measures that will improve data collection on the efficacy of substance abuse programs.	**10/07**		
Data 6. Promote a standard data format/process to collect data from key partners.	**10/07**		
Prevention 7. Support long-term awareness campaigns and quit programs to reduce youth and young adult drinking and drug use.	**10/07**		
Prevention 8. Promote and support marketing campaigns to the dangers of alcohol and drug use.	**10/07**		
Prevention 9. Promote and support the increase of school and community based programs to educate students on perceptions of risk and that underage drinking is illegal.	**10/07**		
Treatment 10. Promote and support screening and increasing access for alcohol and other drug abuse for access to treatment.	**10/07**		
Treatment 11. Support the development of support groups and facilities to address the health needs of family members of individuals with alcohol and substance use disorders.	**10/07**		