

Chapter 8¹

Lessons from the Turning Point Initiative: Implications for Public Health Practice and Social Justice

Vincent Lafronza

Overview

Communities across America are struggling with increasing health inequities whose root causes are often beyond the scope of contemporary public health practice. This work presents unique challenges for public health practitioners. In this chapter, I have the privilege of sharing lessons learned by local public health agencies (LPHAs) about their vital roles in addressing health inequities from the upstream journeys of community partnerships that participated in the national initiative entitled, *Turning Point: Collaborating for a New Century in Public Health*.

Many LPHAs struggle with the notion that their programs should address issues of social justice. How could one agency tackle deep-rooted injustices related to racial and class discrimination, socioeconomic disadvantage, poor housing stock, and a myriad of other social forces that drive population health status? Shouldn't LPHAs just focus on their mission to provide everyday public health services such as preventing the spread of West Nile Virus, inspecting restaurants, family planning programs, immunizations, communicable disease surveillance, and so on? Won't inequities in health be addressed by providing access to services to all community residents?

These questions are understandable. History has shown that indeed one agency simply cannot address these issues, nor should one agency attempt to do so. However, given the clear case for the legitimate role of public health practice presented in Chapters One and Two, LPHAs can indeed significantly influence the scope of practice that a community undertakes and its impact on reducing the inequities in health status found in every community.

Turning Point's lessons can assist LPHAs to identify the roles and functions they can play in organizing a partnership to address social determinants of inequities in health. Much of this leadership role can be effectively achieved by expanding the scope of public health practice to address social issues that influence health outcomes. As discussed throughout this guidebook, this approach differs significantly from disease-based approaches that target illness after its onset. The lessons presented below can provide ideas from field-tested approaches to adopt a community-health model that engages the widest public audience possible in the interest of identifying causes – structural and otherwise – of poor health and developing a comprehensive framework to improve population health outcomes. Every community must develop approaches tailored to the unique issues and political contexts. The ideas and strategies presented herein can be readily adopted in other locales.¹

¹ Chapter appears in, *Tackling Health Inequities Through Public Health Practice: A Handbook for Action*. National Association of County and City Health Officials, July, 2006, p. 137-154.

Turning Point's Background: A Demonstration Program to Revive Public Health

The 20th century has brought major advancements in the health of the American public. People live approximately 30 years longer today than they did 100 years ago. More so than advances in medical treatment, this accomplishment is largely the result of improvements in our ability to improve health at a population-wide level through prevention and health promotion, the principal function of the public health system. Twenty-five of those 30 added years are due to public health successes, such as improvements in water and food quality, healthier living and working conditions, increased understanding of disease epidemiology, and greater public awareness about health concerns.² America's investment in creating an infrastructure for public health work made these and similar improvements in the population's health possible. In 1900, only a small number of cities had local health boards, and no county health agencies existed.³

At the turn of the 21st century, almost 3,000 public health agencies serve most of our states, regions, counties, territories, and cities, as well as a wide range of other governmental and private/non-profit organizations and community groups. While too often overlooked, a tribal health infrastructure exists, and serves 562 federally recognized tribes, and also includes Urban Indian programs in many cities.⁴ This infrastructure helps to provide services to over 4.1 million American Indians and Alaska Natives.

As public health practitioners work to enhance their efforts and increase public support, the country has never needed a strong public health system more. The U.S. faces challenges related to the emergence of new diseases such as HIV/AIDS, and the re-emergence of old ones like tuberculosis, which is gaining new strength. Increasing numbers of toxicants pollute the environment. These and many other health threats exist in a social context brought on by such trends as increasing control of national economies; dramatic demographic shifts; uncontrolled urban sprawl; reduced federal and state revenues for investments in basic human needs and community infrastructure; and a new political climate hostile to publicly funded social services.

In the past few years, America was not ranked among the industrialized nations' top ten for protecting and promoting the public's health. Exemplifying this, recent data show the U.S. ranked 24th (down from 19th in 1989) among industrialized nations in infant mortality, the single most common public health indicator.⁵ Overall, social and economic disparities have increased dramatically in the last 25 years, and highly correlate with increasing health disparities.⁶ Most health inequalities are strongly related to cumulative factors sometimes viewed as outside the purview of public health's mission: wealth and income inequality, inequities in social and economic status, and social conditions associated with unsafe housing, poor education, turbulent labor markets, institutional racism, and unsafe working conditions.⁷

In recent years, public health practice has moved still further from its *social roots* through the gradual adoption of a more biomedical approach.⁸ Reducing health inequity, and therefore reducing social and economic inequity, is shown to be directly related to health improvements not only for targeted population groups, but for the overall population as well.⁹ Hence, public health advocates must become advocates for social change related to improving social conditions. Systems improvement demands an honest look at how issues of race, class, and gender influence who is healthy and who is not, who is a partner in

systems improvement and who is not, how the community defines health problems, who has decision-making power, and which communities/neighborhoods and organizations have resources, and taking action to change these realities.

Turning Point: Meant to Revive and Modernize Governmental Public Health

In light of the aforementioned issues, and based on experience from previous foundation programming, W.K. Kellogg Foundation (WKKF) and The Robert Wood Johnson Foundation (RWJF) developed Turning Point: Collaborating for a New Century in Public Health. Inaugurated in 1996, Turning Point's goal was to transform and strengthen the current public health infrastructure so that states, tribes, communities, and their public health agencies may respond to the challenge to protect and improve the public's health. To achieve this mission, the developers attempted to create a safe learning environment for partners to work collaboratively on analyzing and addressing significant challenges pertaining to public health systems improvements.

Grants to community partnerships were small by design, and meant to supplement organizational and financial resources already within the community. Seventeen of 41 communities received up to \$100,000 of additional support toward the continuation of innovative implementation activities through 2001. Due to the governance structure of governmental public health and considerable scope of work, two National Program Offices were established to provide program direction and technical support to partnerships. Funded by WKKF, NACCHO supported communities and tribes; RWJF funded the University of Washington School of Public Health and Community Medicine (UW) to support participating states (to view a list of all partnerships, visit www.turningpointprogram.org).

The national Turning Point effort sought to facilitate systems improvement by providing public health practitioners and their diverse array of partners with support to 1) consider innovative strategies for collaborating, and 2) transform and strengthen public and community health practice. In this light, partnerships are working to develop a more organized, collaboratively-based public health system. Effective partnership approaches transcended government-only models that vested sole or primary responsibility for public health within one or a few agencies. They also moved toward more broadly shared responsibility, engaging a variety of sectors and constituencies in communities, states, and tribes.

At the conclusion of the local planning and implementation process, local partnerships anticipated that they would have:

- ❖ defined key public health functions and services relevant to addressing current and future community needs and priorities;
- ❖ engaged and actively involved the entire community including those segments of the community with more severe problems in the identification of significant public health challenges;
- ❖ assessed changes needed to assure increased understanding and application of community-based public health principles for improving community health;
- ❖ agreed upon an appropriate array of health protection, health promotion, and preventative/primary health care services for the whole community, including uninsured, underserved and otherwise disadvantaged populations;

- ❖ developed and initiated a community health improvement plan to enhance policies and programs for advancing the public's health;
- ❖ established an effective public/private partnership to advocate for and sustain the necessary shifting and sharing of responsibilities for building a healthy community;
- ❖ promoted significant integration of the clinical health care and public health systems; and
- ❖ promoted significant integration of the public health systems with health-related activities in fields such as agriculture and environmental protection.

Public Health Practice: Context and Assumptions

The initiative was not designed specifically to address issues of social justice. But its premises, described below, and strong community component provided a unique opportunity to focus on the root causes of poor health status and quality of life. This approach presented opportunities to work with those most affected by poor health status to inform the changes needed in the public health and health care systems.

Addressing these issues from a social justice issues lens was challenging for many working in local government. The system did not readily reward this type of focus, and partnerships quickly learned addressing the root determinants of inequities in health requires upstream practice changes to address conditions that cause populations to become ill. These struggles are not new. The Institute of Medicine has argued that the public health system is highly fragmented and both inefficient and ineffective at community and state levels. Advocates for public health have argued that the fragmentation in service delivery was partly the result of uncoordinated funding streams and the absence of social and political support for assuring population-based health improvements. The Turning Point initiative, therefore, supported integrating all of the entities that play a role in improving health. This involved creating partnership systems that could better address root causes of inequities in population health status. But Turning Point participants learned that public health problems differentially affect disparate populations/constituencies, and often, the constituencies most adversely affected have little voice in policy making or service delivery. Turning Point sought to engage the broadest public participation in sharing responsibility for decisions that affect public health, making special efforts to engage those historically excluded from participating in planning and decision making.

Addressing fragmentation through partnership development required a comprehensive approach that integrated multiple processes and functions and coordinated decision making and health planning that reflect communities' perspectives. Turning Point sought to facilitate this systems building by providing public health practitioners and their partners with a learning environment to examine innovative strategies to reshape the future of public and community health practice. Effective partnership approaches transcended government models that vested sole or primary responsibility for public health within one or a few agencies, and moved toward more broadly shared responsibility engaging different institutional sectors, as well as all constituencies in communities and states. In the long run, these strategies made additional resources available and created much larger and diverse constituencies actively engaged in supporting public health.

Turning Point promoted the formation of new and innovative partnerships where partnerships were viewed as a means to improve public health. This approach was based on the following assumptions:

1. Groups with different histories, cultures, missions, authority and jurisdiction can best coordinate their efforts and investments in public health if they understand each other and can determine the most appropriate contribution for each group.
2. Experience working together contributes to increased trust, which is essential to confront inevitable and periodic conflict without undermining working relationships.
3. Identifying and influencing the social determinants of health, such as poverty, demands leveraging many resources across neighborhood, local/jurisdictional, state, tribal and national levels.
4. Effective improvements in health require enhanced integration of diverse fields to address a broad scope of public health activity.
5. Improving the health of a community necessitates the collective voices and efforts of its members.

Turning Point's view of an effective public health system is one that actively participates in collaborative decision making with various organizations and institutions about housing, transportation, crime, employment, agriculture and other vital realms of social life that affect the health of communities. This means that improving health transcends the traditional functions performed by public health authorities. In this light, an effective system extends to engaging a broader constituency of diverse fields to take anticipatory action to develop healthy communities, instead of responding to problems as they arise. Such an approach requires states and communities to anticipate and address inequitable distributions of social resources and differential impacts of plans and actions designed to improve health. Effective and sustainable solutions necessitate engaging multiple fields in activities to promote healthy communities, recognizing the health status implications of interlocking determinants of health, including but are not limited to culture, poverty, income, and education.

Critical to this process is a greater emphasis on community dialogue involving constituencies from diverse cultures, educational backgrounds and political affiliations. Participants from education, faith communities, housing and social services, business leaders, insurers, providers, payers, and others sectors were involved in the integrated planning process for community health improvement. The anticipated result of these interactions and planning processes is the creation of an efficient public-private system of strategic interventions that improve the health of the public. In this light, Turning Point seeks to create a process that moves beyond individual leaders, relationships and subsequent networks to a *system*, as reflected in operations, policies, practices and values.

Highlighted Lessons Learned About Transforming Governmental Public Health Practice

Among the many lessons learned, the following five areas capture important insight for LPHA leadership in addressing health inequities.

Stimulating Public Health Practice Innovation Requires a Safe Haven

The foundations and national program offices experimented with a number of learning approaches and technical assistance efforts to support the experimentation of grantees. We realized that the initiative's purpose was quite challenging, and that practitioners, many of

whom worked in state and local governments, were forced to operate in fairly rigid systems that failed to encourage innovation. Moreover, successfully embracing the mission of Turning Point required working with organizations not directly responsible for health. It also required working with a broader public and building organized constituencies capable of working together on common issues that would impact health. These efforts require great leadership, skill, and risk taking. Not surprisingly, the foundations and national program offices often disagreed on what approaches would best support grantees. State- and community-level obstacles and tasks naturally differed. The following themes depict salient lessons learned about community partnership development and coordinated action to achieve Turning Point's mission.

Community Forums Are an Important Venue for Addressing Health Inequities

Building on the momentum from the Turning Point-affiliated *Race, Class, and Health* satellite teleconference, health inequities and the social determinants of health are now major focus areas for NACCHO. The 2001 NACCHO conference, *Confronting Disparities: Addressing the Social Determinants of Health*, was dedicated entirely to the subject. Further, NACCHO's role in assisting the New Orleans and Tri-County New Mexico Turning Point partnerships in launching planning and action to address specifically health disparities and social conditions that impact health has led to greater insight on how to support communities in such efforts.

To advance this progress, NACCHO applied what was learned from the work of New Orleans and the Roswell area of New Mexico, as well as from the exemplary process of the Minnesota Health Improvement Partnership (an RWJF-funded Turning Point group), and sponsored a two-day pilot national workshop for a group of communities on creating a sustainable community movement and developing action plans to confront health inequities. NACCHO also worked closely with three rural health partnerships in Onslow (North Carolina), Cochise (Arizona), and Fort Peck (Montana) on the injustices associated with health inequities and the social determinants of health. This work focused on the following topics: a) What do we mean by health inequities, what does the research show, why do they exist, what are the main causes, and why are they bad for everyone? b) Why is it so difficult to address and discuss them in relation to policy and social change beyond educating individuals, and services to individuals? c) How can we reframe the way we look at inequities so others will understand what we mean? And d) What can we do to address them?

These three community workshops proposed a visioning exercise with the three partnerships that would enable them to work with their constituents to: a) explore what a socially just society looks like and what values it would express; b) identify public policy agendas and the type of social change necessary to realize a socially just society, and c) develop a useful strategy for getting there, however slowly, based on their goals and objectives. Questions included: a) what kind of society they could imagine assuming the power and resources to bring it about; b) the barriers to realizing what they imagine; c) public policies or other kinds of social change required to achieve a healthier and more desirable community and overcome the barriers; and d) the process and organizing strategy to get there, and the communications strategy, concepts, and language that will be needed to offer opportunities for insight, shift consciousness about what is desirable and possible, and about the ideas necessary to get there.

New Orleans and Roswell Focus on Health Disparities

In New Orleans, the Healthy New Orleans Partnership led the discussion on a range of issues, particularly institutionalized racism, poverty, social and class inequality, health education, and low wages. As part of the suggested action plan, participants advocated for collecting and presenting more information on community health status, educating the community on the nature and effects of institutionalized racism, promoting knowledge of inequities in the mass media, and organizing community health councils to develop neighborhood action plans.

In Roswell, a city with considerable poverty and high mortality rates, participants discussed the impact of racism, violence, lack of resources, bureaucracy in the health and justice systems that create inequities, and the effects of economic disinvestments. Participants, led by the Tri-County Partnership, determined that improved public health services are needed in the city's poverty-stricken areas and that there is a strong need to invest in children, better enforce child support laws, provide equal protection and enforcement of laws, and provide resources to assist residents with the health and justice systems.

In both communities, the dialogue helped to strengthen alliances and draw attention to the systemic forces and decisions that make populations vulnerable to health inequalities. Participants at each workshop included health practitioners, public officials, community residents, educators, and representatives from faith-based groups, among others. Both dialogues explored the effects of economic development on community health.

Many of us who participated in the initiative did not fully appreciate the challenges we would face with respect to forming and sustaining new partnerships. We frequently encountered philosophical challenges regarding public health's mission and scope. Many community partnerships were eager to embrace a wide spectrum of issues that impacted population health status, committing to focus on violence prevention and youth development, as examples. Some state and local health departments were challenged by the diversity of issues community partners raised. These lessons demonstrate the wide array of obstacles that must be addressed to work collaboratively on addressing health status, and in particular, health inequities. Addressing population health inequities requires adopting broad approaches and working with diverse partners outside the realm of state and local government. Governments provide services to citizens. Service delivery models are readily adaptable to disease-specific health problems, but can present challenges to community-wide interests to address larger social and economic causes of health problems triggered by social injustice. Partnerships that embraced and facilitated a broad scope of public health activity reported greater success at engaging sustainable community involvement in problem identification and solution development.

In almost every Turning Point site, groups learned that *community participants* (those outside of the formal public health system) were eager to help identify root causes of poor health outcomes and reduced quality of life. Many individuals did not necessarily trust those working in government, but nonetheless were willing to participate in community action. The approach is important, and can significantly influence the success of participation. Often, an intermediary organization outside of a governmental entity (i.e., a faith-based organization or other CBO) was the most effective vehicle to engage participants

and create a community dialogue on health and its improvement. By working with a wide array of partners, Turning Point partnerships quickly broadened the scope of public health practice available to the public, including but not limited to crime prevention and economic development. Participants described the importance of the process and experience, which created the opportunity for learning and perspective transformation. Many partnerships now have a productive relationship with the mass media. This takes great effort initially, but over time, media representatives also began to see the value in providing a voice for those whose living and working conditions created disproportionate levels of poor health outcomes.

These lessons are important for any public health practitioner. Delivery systems must be assessed continually and modified to meet the needs of impacted populations, and the organizations most trusted by those impacted can be valuable contributors. Almost all partnerships reported beneficial outcomes, and over time, a few Turning Point sites now report evidence of population health improvement resulting directly from their new collaborative capacities.

Organizational Policy Change Can Advance Community Development

Partnerships embarked upon efforts to increase the capacity of community-based groups that could participate in and contribute to public health practice. In light of NACCHO's audience, the Chicago Partnership for Public Health provides the most applicable example of how local government can develop policies and a structure to engage a broader public. The Chicago Partnership provided the following description of their work.

Policy Change Can Promote Collaborative Public Health Practice across Jurisdictions

Currently, there are 569 Federally-recognized Tribes throughout the U.S. Under U.S. law, these Tribes operate as sovereign nations within the U.S. (a governance model often referred to a "sovereign within a sovereign"). Public health issues, however, transcend borders, and coordination among state, county, tribal, and federal governments is necessary.

Chicago Partnership for Public Health, by Erica Salem

Under Chicago's Turning Point initiative, the Chicago Partnership for Public Health developed a plan to strengthen the local public health system. Key among the plan's recommended strategies were those designed to create a public health constituency and build the capacity of communities to participate in and affect the priorities and resources of public health and related systems. The Chicago Partnership envisioned that this would be achieved through the establishment of a linked network of community-based coalitions, supported by both the Chicago Partnership and the Chicago Department of Public Health (CDPH).

With Turning Point implementation funds, the Chicago Partnership piloted a model for community-based coalition development and planning. The early successes of this experience within a single Chicago neighborhood prompted the City's health commissioner to create an organizational division within the public health department: The Center for Community Partnerships (the Center). The Center actively engages communities as partners in health improvement and system change and in this way is working to shift the balance of power towards communities. Today the Center is supporting seven neighborhood partnerships across Chicago. The Center is staffed by three persons who provide technical and administrative support for these local partnerships to engage in community-based strategic planning. While each partnership follows a common planning framework, all decisions are determined locally.

The public health department recognizes that for coalitions to be effective they must have adequate resources and support. Thus, each coalition is provided with funding for a full-time community coordinator who is charged with identifying, recruiting and convening local residents, organizations and other members; facilitating meetings; providing staff support to the coalition and its committees; overseeing local data collection efforts; and conducting the work of the coalition between meetings. Coalition coordinators are accountable to their coalition steering committees. The department also provides financial support for residents to assist in local data collection activities, for office space, and other costs as needed.

The outcomes experienced at the community level have been encouraging. Some pertain directly to the locally-developed plans, such as increasing the availability of fresh produce in neighborhood stores and greater community participation in crime reduction efforts. Other outcomes have resulted more from the collaborative process, such as the forging of new partnerships between community organizations.

For the Chicago Department of Public Health (CDPH), the effects of this effort have been invaluable. These include new partners in public health, new opportunities for collaboration, and most importantly, a new way of doing business for the Department. Prior to Turning Point, CDPH's work with communities had largely involved a review of available data (often already existing within the agency's own walls) and then the development of programs. As a result of Turning Point, the flow of information has changed so that decision-making is based on information collected and analyzed by community partners and provided to CDPH. Programs are either designed solely by the community coalition or in collaboration with CDPH. It is the Department's job to support these programs.

Situated just outside Phoenix, the Gila River Indian Community (GRIC) participated in the Turning Point initiative. They focused their efforts on policy issues, especially as they relate to working with state and county governments. Wall and Worgess write: “Relationships between public health agencies and tribes range from non-existent to telephone contact throughout Arizona. These contacts occurred because many of the 19 reservations in the state may cover two or more counties, cross boundaries into other states, and in one case, straddle an international boundary. Also, because of the provision of many health care services to the tribes by the federal Indian Health Service, state and county public health departments often believe that Native Americans in their areas have adequate health care, and therefore do not require assistance from them. A lack of understanding between the two groups and the sovereignty of the tribes, requiring government to government relationships, have also contributed to this difficulty in developing working relationships between tribes and state/county public health agencies in the state. The Arizona Turning Point Project included a special section in its public health improvement plan that called for the strengthening of these relationships, with the goal of improving the health status of Native Americans in Arizona.¹⁰

Gila River’s experience is a powerful example of how partnership activities can be successful. Gila River Indian community (GRIC) and the Arizona Department of Health Services (ADHS) signed a data-sharing agreement. This agreement made Arizona history, winning the “Project of the Year” award from the Arizona Rural Health Association and the Arizona Rural Health Office. Now GRIC receives the same data that the state provides to counties, enabling the Tribe to strengthen its own public health surveillance and response system.

Arizona Health Officers Association Changes Policy to Include Tribal Health Directors

By Teresa Wall and Barbara Worgess

A second success was the first-ever coming together of the tribes and the county health departments at the Annual Retreat of the Arizona County Health Officers Association (ACHOA) in August of 2000. This meeting promulgated a needed change in ACHOA’s by-laws to open up membership to tribal health directors. Subsequently, the bylaws were changed and the organization renamed the Arizona Local Health Officers Association (ALHOA). The overall purpose of the organization remains the same; however, the network includes both counties and tribes, and the focus encompasses the entire population of Arizona, including those residents living on Indian Reservations.

The Pinal County (AZ) Department of Public Health and the Gila River Indian Community Department of Public Health jointly prepared and submitted a proposal for collaborative planning to establish a shared data network to address issues of communicable disease control, service delivery, and to develop policy strategies between the two agencies. Their proposal was funded and the two agencies worked on activities that will allow data sharing, including procedures to share specific clinical information to facilitate follow-up and avoid duplication of services to individuals who seek care both on and off reservation.

Broadening Community Voice and Building Community Capacity

A critical Turning Point theme relates to reorganizing the roles, responsibilities, and relationships among organizations in order to share and maximize public health resources

and decision making to engage the broader community. In many of these communities, an established governmental public health agency existed that sought to connect more meaningfully with community-based organizations and the public. Examples include:

- ❖ Further development of a system of community public health coalitions linking to county-level program and policy development (Cochise County, Arizona)
- ❖ Creation of a system of neighborhood/borough coalitions linked to city-level program and policy development (Chicago, New Orleans, Los Angeles, New York)
- ❖ Onslow County Community Health Improvement partnership leveraged Turning Point leadership to secure new housing for those economically disadvantaged residents through a Federal Community Development Block Grant (Onslow County CHIP, North Carolina)
- ❖ Development of an integrated system of public health policy setting, service delivery, and resource allocation with strong youth voice and leadership (Chautauqua County, New York)

These four examples demonstrate partnership efforts to engage a broader base of non-governmental participants interested in improving population health. Addressing inequities in population health status requires broad involvement of diverse groups who are often most impacted by inequities. This process naturally broadens the scope of public health practice and makes additional system capacity available to a community.

Several Turning Point communities sought to improve public health policy and strengthen the process of public health policy formulation. While not all policies address health inequities, some partnerships attempted to address determinants of inequities in health, not treatment of diseases, by focusing on policies and practices that govern the scope of public health practice and increase interaction and collaborative action with elected officials, regional groups, and non-governmental organizations. Highlights include:

- ❖ Initiation of state-level policy discussions related to local/regional public health authority models. Further forming and promoting regional policy agenda. Eventual decisions reached to establish new local health departments across the state (NCCCP, NE).
- ❖ Development of inter-town and state-region policies and processes to support authority and capacity at the regional level (CCNTR, NH).
- ❖ Development of a communications plan to guide establishment of working interactions with public elected officials. Preparing community members (including youth) to communicate with elected officials and producing training materials and press kits (Tri-County, NM).
- ❖ Collaboration with the private sector to create a work plan specifically to address engagement of the business community and the relationship of health and economic development. Examining related statutes, regulations, policies, and procedures (Tulsa, OK).
- ❖ Development of tools for policy planning to aid the community in targeting policies for public review and action and working with elected officials. Additionally, the partnership formed an independent entity to work directly with the community, entitled the Center for Empowered Decision-making (New Orleans, LA).
- ❖ Successful development and approval of a new community ordinance that requires the removal of all soda machines in public schools in the Gila River Indian Community. Additionally, the Gila River partnership now collaborates with Pinal

County officials on a myriad of cross-jurisdictional public health issues, including tribal-county emergency response planning. The momentum gained by Turning Point also enabled the statewide Arizona Local Health Officers' Association to alter its bylaws to include tribal entities (via tribal health directors). This group was able to leverage policy change at the state level, making Arizona the second state in the nation to provide funding directly to each tribe (20 across the state) for bioterrorism capacity-building. This progress reflects significant policy achievements that will benefit population health (Gila River Indian Community, AZ).

Part of the Cochise County Turning Point initiative focused on health and social problems associated with the high number of illegal border crossings that take place in the county jurisdiction. This partnership participated in the NACCHO documentary entitled, *The Edge of America: Fighting for Health and Justice* (see www.naccho.org to order a copy of this resource). The partnership leveraged their participation in the documentary to conduct a study of the impact of border crossers on local services and economy.

Living On the Edge: The Effect of Federal Immigration Policy on Cochise County

By Cochise County Health Department & Toltec Evaluation & Educational Research Services

A tragic outcome of the federal government's policy on undocumented immigration from Mexico has resulted in Southern Arizona being home to one of the most serious human rights injustices in the United States. The number of undocumented immigrants who perish while attempting to enter the United States calls into question the federal government policy of channeling undocumented immigrants through the harsh desert environments found along the Arizona/Mexico border. Since federal policy has resulted in large numbers of undocumented immigrants crossing into Cochise County from Mexico, the citizens of Cochise County should not have to bear the expense associated with these undocumented immigrants. The partnership developed the *Turning Point Initiative Undocumented Immigration Cost Study* to answer three questions concerning undocumented immigration and its impact upon governmental agencies and private property owners in Cochise County: 1. Do law enforcement, hospitals, fire and rescue agencies, and Cochise County departments collect data on their interactions with undocumented immigrants? 2. What are the quantifiable costs to law enforcement, medical facilities, fire and rescue agencies, and Cochise County departments with regard to providing services to undocumented immigrants? 3. What are the out-of-pocket expenses to property owners— primarily ranchers, in the immediate border area? *For a copy of the full report, see <http://archive.naccho.org/Documents/Living-on-the-Edge.pdf>.*

The Cochise County example demonstrates that LPHAs can play crucial roles in shaping public policy and funding. The local government is not able to solve causes of illegal immigration, but by focusing on data collection of financial impacts to county, their efforts raised public awareness and increased pressure on the federal government to provide increased assistance to the border-crossing problems.

Taken together, these examples illustrate partnerships' experimentation with broadening the scope of public health services, where collaboration better enabled partnerships to address determinants of health and not just disease. Working with a multitude of community partners enabled the public health system to address inequities in health at a

strategic level not necessarily driven by health indicators but by social and economic concerns (which are often determinants) expressed by community partners. These strategies can be very effective since community health status data become available only after the onset of disease. Further, disease reporting processes typically do not shed light on the determinants of poor health or health inequities.

New Directions for Public Health Practice

While the lessons learned across all 41 Turning Point communities are too numerous to describe herein, the five themes presented reflect similar patterns across many sites. Close examination of Turning Point activity supports the need to focus on social determinants of inequities that create population health or ill health, as health is a creation of society, not merely a reaction to disease.

The U.S. public health system is a complex arrangement of many systems that work together to protect and improve the health status of those living within U.S. borders. The U.S. remains the only industrialized nation that does not produce a national report on the social health of the nation. This is clearly not sound public policy. Balancing economic development, increasing pressure from health care market forces supporting healthy land use policies, and safe and affordable housing with population health continues to present enormous challenges to those interested in reducing inequities in the distribution of disease and illness. Continued under-investment in tribal communities is also of grave concern, as life expectancy rates for American Indians/Alaska Natives trail behind non-Indian communities by at least six years, and in many communities, the disparities are staggering.

In the U.S., public health functions, while largely carried out by public agencies, also require substantial contributions from private organizations such as hospitals, private school systems and businesses, and a significant number of community, tribal, state and national non-profit organizations whose missions are to protect and improve the public's health and well-being. Generally, public health practice does not include the direct provision of primary, secondary or tertiary medical care services, although in many communities, both public and private organizations work together to provide medical services to people who otherwise would not have access to affordable medical care. But as of this writing, estimates of uninsured in the U.S. exceed 44 million. The relative separation of public health and medical care in the U.S. is likely one of the most significant differences in organization and function with respect to the systems that operate in many European countries.

European communities are experimenting with investment strategies that produce population health while the U.S. has shifted its national attention to anticipate bioterrorism events and war. "Historically, our public health culture championed a scientific approach to emerging threats and supported the principals of social justice and improved health and health care for all. That culture has shifted in a post-September 11, 2001, world."¹¹ Meanwhile, U.S. life expectancy rates are slipping behind other nations, and the most significant threats to health remain outside the direct purview of medicine and public health practice. But partnerships can make enormous differences in communities despite these challenges.

Clearly, new approaches to addressing health inequities are needed. Lessons learned from national demonstration initiatives like Turning Point raise important questions about the

structure of population health services and activities with respect to eliminating health inequities. Moreover, the examples of and themes within Turning Point activity discussed herein point to new directions on health systems evolution. Such evolution is inevitable, though the signs that shed light on future directions are understandably easily missed in the everyday work environs in which we function. In research and curriculum, schools of Public Health and Public Administration promote partnership approaches, but too often do so absent a research agenda closely aligned with practice. Federal and state governments follow suit and promote partnership approaches absent specific financial and personnel systems required to provide necessary incentive and basic support. This approach often rewards grant writers to exercise maximum creativity in the application phase, but absent support structures, program leaders struggle to operationalize the scope of work. Over time, many partnerships fade out slowly and some collapse immediately after the funding cycle ends. Others learn how to continue their work, but usually with great adaptation. What are the alternatives to partnerships? Are the current structures incapable of supporting sustained and effective partnership activity?

Reducing Health Inequities: What Can Your LPHA Do?

Turning Point Partnerships experimented with a variety of approaches to address social determinants of inequities in population health. The following activities offer examples of specific actions LPHAs can take to provide community leadership in addressing health inequities:

1. Provide ongoing mechanisms and venues for public forums that give community voice and work with those groups most impacted by social and economic inequalities to mobilize communities to action. Support this with policy and provide staff training to ensure sustainability.
2. Develop strategic alliances with CBOs and other groups that are working to improve housing, economic development, living wages, and other conditions that influence health status.
3. Support the development of community-based partnerships with sustainable capacity to address issues such as inadequate housing, lack of access to mass transit, and unemployment that traditionally fall outside of the health arena.
4. Collaborate with the state health department offices of workforce training, minority health, universities, public health institutes, and other state and local organizations to develop workforce recruitment and training programs that emphasize health and social justice competencies.
5. Implement a performance management system that specifically targets closing gaps in population health status.
6. Produce (on an annual or bi-annual basis) a community social indicators report or publication that includes multiple determinants of inequities in health, communicates progress, and engages public opinion.
7. Assess and revise your LPHA practice model (e.g., ten essential services or other model) to ensure that addressing health inequities is clearly defined, included in staff orientation programs, program development and performance monitoring activities.
8. Launch your own Turning Point process in your jurisdiction to engage individuals and organizations in a community-wide dialogue and strategic planning process focused on population health status.

9. Include a special focus on addressing health inequities and provide resources on your LPHA Web site.
10. Develop a succession planning process to ensure that the future LPHA workforce will continue to address health inequities.
11. Work with the local board of health (or other similar governance body) to engage them in dialogue and planning related to addressing health inequities in your service delivery areas.
12. If your community is near any American Indian or Alaska Native tribes, explore opportunities to support their public health efforts and invite representatives to meetings, SACCHOs and other events (resources are available at www.nihb.org or www.ihs.gov)
13. Develop new “essential services” frameworks to support an expanded scope of public health practice.
14. Explore governance models that better address an expanded scope of public health practice.

The power of collaboration enables a community to achieve goals and realize visions that transcend achievements within the reach of an individual organization. Partnerships reflective of a given community can play a critical role in health protection and improvement in rural areas where it is not fiscally prudent to establish a fully functioning governmental local public health agency. These partnerships can collaborate effectively with state or other regional public health entities that may be responsible for an entire territory but may not have any meaningful understanding of community life in the service delivery areas. Turning Point also demonstrates that public health practice in the U.S. is much more than mere service delivery; it is a social enterprise that weaves art and science, and requires leadership, commitment, flexibility and perseverance.

Community-based partnerships can also play a critical translation role, as population health data often do not shed light on the root causes of disease or changes in rate patterns. Community-based partnerships can augment governmental public health agency capacity by identifying problems, developing and implementing long-term strategies, and achieving advancements in population health and well-being in areas that traditionally would fall outside of the purview of governmental public health practice focused on disease rates. Many community partners are naturally inclined to address root causes of health inequities such as promoting living wage policies or improved land use planning efforts, whereas governmental public health practice in the U.S. primarily emphasizes the prevention of disease outbreaks. Sustaining these efforts is challenging.

Community partnerships can provide a unique catalyst function to promote social change needed to “produce” a healthier society, which requires moving beyond services that address disease to taking action that measures and actively produces health. Partnerships can play an intermediary role for issues that may present challenging political situations for state or local governments. Partnerships may also bring credibility to policy agendas and may garner additional and critical support beyond the traditional purview of community health programming.

National demonstration programs also illustrate weaknesses in partnership approaches. Turning Point participants also learned about the many challenges associated with

sustaining partnership activity. When grant funding and external technical support end, it is exceedingly difficult to sustain coordinated effort among a group of individuals placed in different working environs. Often, these environs (with timeline pressures, policies, etc.) do not provide sufficient incentive for employees to maintain their involvement in partnership activity. Additionally, leadership turnover can immediately impact the extent of support for continued engagement. This caused many Turning Point partnerships to lose momentum, and where priorities were shifted to address those introduced by new leadership, other partners ceased their support.

Turning Point also teaches us that in the current definitions of organizational arrangements, partnerships are not substitutes for public health agencies nor are public health agencies by themselves sufficient components of a public health infrastructure. What do these lessons learned suggest about current infrastructure models? Are partnership approaches sufficient models to address health inequities? As stated previously, in 1900 no county public health agencies existed. Perhaps we find ourselves on a new precipice of public administration, and to make the next advancements, new community structures need to evolve.

The past century has brought great advancements in health. But the U.S., with chronic disease as our most significant threat, struggles to create solutions. Moreover, government's role in combating infectious disease has evolved into a fairly standard practice. But this is clearly not the case for chronic disease, as the extent of government influence over the conditions in which chronic disease has increased remains quite limited. Public health agencies are struggling to organize comprehensive action to reduce chronic disease, and the nation is on the brink of exploring the potential value of accreditation for local public health practice. Now is the time to ask challenging questions that may lead to even greater health improvements for the 21st century. How might we structure an arrangement of public and private organizations to advance health equity? What types of agencies (in terms of institutions and advocacy roles) are needed to achieve this? Turning Point's lessons clearly show the need to build broader, more integrated systems to address the sources of health inequities which lie beyond the scope of any one profession, and that doing so is both challenging and valuable, and perhaps the natural direction for health systems evolution.

Notes

1. Much of the basis for this chapter – including some actual text in the background section below – was taken from NACCHO’s 2001 publication entitled, *Advancing Community Public Health Systems in the 21st Century: Emerging Strategies and Innovations from the Turning Point Experience*. [Interested readers can order copies of this text and a number of other products by visiting www.naccho.org. Additional state-focused publications and products can be found at www.turningpointprogram.org.]
2. Centers for Disease Control and Prevention, “Ten Great Public Health Achievements – United States, 1900-1999.” *Morbidity and Mortality Weekly Report* 48(12) (April 2, 1999): 241-243.
3. A. R. Hinman, “1889 to 1989: A Century of Health and Disease,” *Public Health Reports* 105(4) (1990): 374-380.
4. See Institute of Medicine, *The Future of Public Health* (Washington, D.C.: National Academy Press, 1988).
5. World Health Organization, *World Health Statistics Annual, 1997-99 Edition* (Geneva: WHO, 1999).
6. See Robert Beaglehole and Ruth Bonita, *Public Health at the Crossroads* (Cambridge: Cambridge University Press, 1997); Bruce Kennedy, Ichiro Kawachi, David Williams, David Blane, et al., *Health and Social Organization: Towards a Health Policy for the 21st Century* (New York: Routledge, 1996).
7. See the introduction and articles in part one of Ichiro Kawachi, Bruce P. Kennedy, and Richard Wilkinson, eds., *The Society and Population Health Reader: Income Inequality and Health* (New York: The New Press, 1999); N. Moss and Nancy Krieger, “Report on the Conference of the National Institutes of Health,” *Public Health Reports* 110 (1995): 302-305; Beaglehole and Bonita, Chapter 3; John W. Lynch et al., “Income Inequity and Mortality in Metropolitan Areas of the United States,” *American Journal of Public Health* 88 (May, 2000): 690.
8. Elizabeth Fee and Theodore M. Brown, “The Past and Future of Public Health Practice,” *American Journal of Public Health* (May, 2000): 690.
9. For more discussion, see Institute of Medicine, *The Future of Public Health* (Washington, D.C.: National Academy Press, 1988).
10. T. Wall and B. J. Worgess, “Advancing Statewide Collaborative Partnerships Between County and Tribal Health Programs,” *NACCHO Exchange* V1(2) (Summer 2002).
11. B. Berkowitz, R. Nicola, V. Lafronza, and B. Beckemeier, “Turning Point’s Legacy,” *Journal of Public Health Management and Practice* 11(2) (2005): 97.