Note: The Public Health Improvement Plan (PHIP) for Maine is the result of discussions and activities that took place from June 1999 through June 2001. Not all participants agree with all findings and recommendations. A significant challenge in publishing a document such as this, is attempting to document the status of the discussion at a specific point in time, when in-fact the discussion continues.

The PHIP describes a vision to be accomplished over the next 10 years and as the status of public health "on the ground" changes, the PHIP will need to be revised and updated. It is our hope that the dialogue that began with Maine Turning Point and resulted in the PHIP will continue. Implementation and undertaking changes described herein, as well as the revised vision that is bound to emerge in the years ahead, is and will always be the responsibility of a wide range of individuals, organizations, and government agencies.

Report from the Work Group on Public Health Infrastructure

Summary Recommendation: Establish and or strengthen community coalitions in Health Districts in Maine.

Implementation Steps:

a) Establish Health Districts, assuring coverage throughout the state.
b) Community coalitions should be formed or strengthened in each Health District to assure the delivery of essential public health services and coordinate the use of public health resources throughout the district.
c) Technical assistance should be provided to coalitions for organizational development
d) Training in community development and public health should be provided for local staff
e) Local initiative (by coalitions and providers) should be encouraged in state-funded programs; Long term state-local partnerships should be established
f) Coordination and collaboration among coalitions should be supported through support of a Maine Network of Healthy Communities or similar mechanism.
g) Long term (multiple year) funding strategies should be pursued by Coalitions in each Health District.
h) Each Health District should have a part-time Medical Officer who acts in concert with the Coalition members.

Public Health Infrastructure in Maine

Maine is currently without a consistent community-level public health framework across the state; however there is a large range in local capacity: the City of Portland has a sizable health department and two other municipalities have less developed departments; there are established *Healthy Community Coalitions, Communities for Children, Healthy Family Coalitions, PATCH groups* and other coalitions in some areas, while other towns are completely without organized efforts to address public health issues. Most communities, however, do have a community hospital within a reasonable driving distance.

The state agencies that are charged with responsibility for public health functions have limited financial and human resources for carrying out these activities. Throughout the state a multitude of community-based organizations provide public health services, prevention, and intervention programs focused on specific populations, neighborhoods or issues with private funding or support

provided through contracts with state agencies. Schools, for example, provide health education.

The Institute of Medicine (IOM) assigns to government the responsibility for assessment, policy development, and assurance. Beyond this, the IOM identified those activities in public health for which states have unique responsibilities.*

The committee believes that states are and must be the central force in public health. They bear primary <governmental> responsibility for health. The committee recommends that the public health duties of states should include the following:

- ✓ *assessment of health needs in the state based on statewide data collection;*
- ✓ *assurance of an adequate statutory base for health activities in the state;*
- ✓ *establishment of statewide health objectives, delegating power to localities as appropriate and holding them accountable;*
- ✓ *assurance of appropriate organized statewide effort to develop and maintain essential personal, educational, and environmental health services; provision of access to necessary services; and solution of problems inimical to health;*
- ✓ *guarantee of a minimum set of essential health services; and*
- ✓ *support of local capacity, especially when disparities in local ability to raise revenue and or administer programs require subsidies, technical assistance, or direct action by the state to achieve adequate service levels.*

*The Future of Public Health, Committee for the Study of the Future of Public Health, Division of Health Care Services, Institute of Medicine. National Academy Press, Washington, D.C., 1988. pp8-9

Churches support an array of programs, from food distribution and counseling to health education and sports programs. Police departments sponsor anti-drug programs and hospitals offer health education and screening services. Public agencies and non-profit organizations alike offer individual and population-based services for the elderly, disabled and youth. YMCA's provide diverse and longstanding activities for regular exercise that are utilized by individuals as well as organized groups. These targeted programs or services are not sufficiently extensive nor are they adequately funded and staffed, but they do exist across Maine.

Work Group Process

The MTP Infrastructure Work Group was formed to investigate the public health structure, gauge the strengths and weaknesses of the current system, and develop an improved model. The work group included members with a wide variety of professional affiliations such as American Lung Association of Maine, Anthem Blue Cross and Blue Shield, Center for Community Dental Health, Family Planning Association of Maine, Farmington Healthy Community Coalition, Maine Center for Public Health, Healthkick, Maine Ambulatory Care Coalition, Maine Bureau of Health, Maine Hospital Association, Maine Medical Center, Maine Office of Substance Abuse, Maine Osteopathic Association, MaineGeneral Health, Medical Care Development, MicMac Health Department, Northeast Health and Penobscot Bay Medical Center, North Country Healthy Communities, Maine Department of Human Services (DHS) Bureau of Health and DHS Office of Rural Health, Town of Bucksport Health Planning Advisory Committee, and the University College of Bangor Dental Health Program (see Appendix D for a detailed membership list).

Work group activities included investigation of the current public health model, identification of potential alternative models, identification of the benefits and drawbacks of various models, selection of cost-effective (politically/financially) sustainable models, and identification of barriers to adoption and implementation of the selected model. The recommendations are heavily weighted

toward changes in the local coordination and delivery of public health services. This reflects both the need to create a local public health infrastructure and the limited opportunities to change state agency structures. It is important to note that success in implementing many of the recommended changes will by necessity involve the active support and cooperation of state agencies and program leaders within state agencies.

The Institute of Medicine (IOM) has clarified the core functions of public health as assessment, policy development and assurance. The Public Health Foundation has taken those three functions or roles and developed them into a list of essential public health services for the local level. The following has been developed from that list and guided our thinking for the community-based structure we sought:

1) Monitor health status to identify community health problems;
2) Diagnose and investigate health problems and health hazards in the community;
3) Inform, educate and empower people about health issues;
4) Mobilize community partnerships to identify and solve health problems;
5) Develop policies and plans that support individual and community health efforts;
6) Assure the enforcement of laws and regulations that protect health and ensure safety;
7) Link people to needed personal health services and assure the provision of health care when otherwise available;
8) Assure a competent public health and personal health care workforce;
9) Evaluate effectiveness, accessibility and quality of personal and population-based health services; and,
10) Research for new insights and innovative solutions to health problems.

Through the assessment and planning process described above, the Work Group found that very few areas have the resources or means for managing local efforts to assure that the ten essential services of public health are available for residents. There are categorical, often independently delivered prevention programs, but the scope and intensity of them vary widely from one area to the next. We want to ultimately develop the capacity so that every community in Maine has the benefit of a coordinated program that includes all ten essential services. This is not advocating for new provider organizations that existing agencies may perceive as threats to their traditional roles in the community; instead, it argues for enhanced planning, coordination, and collaboration among existing organizations.[1]

Community Health

There is a great need to enhance communication and collaboration among community-based organizations. With the advent of both the Maine Turning Point project and the Fund for A Healthy Maine (tobacco settlement fund), representatives from existing coalitions have begun meeting regularly. They have perceived a need to:

- Assist in the creation of community coalitions in Maine where similar organizations do not yet exist;
- Strengthen existing organizations through the assessment and sharing of proven community development and public health intervention methods;
- Advocate in a united fashion for a health policy agenda valuing community-based health promotion; and,
- Assist each other in efforts to gain financial and other resources.

During the planning process, coalition representatives began initial discussions that led to the formation of the "Maine Network of Healthy Communities." The evolution of this group to an autonomous non-profit organization will provide a conduit for enhancing horizontal communication and collaboration among coalitions across the state and will remain an important

[1] The Work Group has made a concerted effort to develop a vision for public health infrastructure that will work and make sense for a wide range of categorical concerns. Consequently, this document does not document or speak directly to the concerns of dental health, specific cancers, etc. It is our hope that the infrastructure envisioned here will be implemented in ways that will improve the health and well-being of all Maine residents and achieve the health improvement outcomes described in Healthy Maine 2010.

ingredient for achieving the vision described in this document. Maine Turning Point participants have advocated strongly for the support of these efforts and have stated their preference for a "bottom-up" process to shape the organizational public health model which will ultimately be adopted.

Vision and Values

Early in the planning process, the MTP Infrastructure group agreed that there were certain values or visions for Maine that should serve as a foundation upon which the public health improvement plan should be developed. It was agreed that we should seek to:

- Set public health goals for Maine that should be discussed, developed, communicated and adopted by all types of relevant organizations in the state, private as well as public, as well as ultimately by individual citizens of the state.
- Increase state and federal resources to community-based organizations (i.e. health departments and community coalitions) for core coordinating functions as well as categorical purposes. *Maine should ultimately seek to have an active health department or community coalition* **covering every community**.
- Increase the allocation of health care financial resources committed to health promotion and prevention programs and services through effective advocacy with payers and employers as well as providers. A comprehensive program should address health problems across all three levels of prevention, utilizing primary, secondary and tertiary prevention strategies for long- as well as short-term results horizons. This requires the development of clinical as well as non-clinical leadership in all of the health districts.
- Assure that effective health promotion and prevention programs as well as services reach all Maine communities, including traditionally underserved segments of the population, through technical assistance and community development efforts.
- For state-contracted services and programs, allow for latitude at the local level in the intervention strategies implemented, provided they have been proven to be effective to achieve state-determined objectives for which the contracts have been awarded.
- Provide for the strengthening of the public health workforce through a program of education and training that meets the need of Maine citizens from a wide variety of backgrounds involved in public health efforts. Education and training opportunities need to be accessible (including attention to cost, location and teaching approach) and of sufficient quality to measurably improve the competency of those educated and/or trained.
- Develop an information system that facilitates community-level planning and evaluation, as well as education. Use this system and all monitoring and evaluation efforts to develop a culture of continuous quality improvement throughout public health and health care institutions. Link appropriate information from all of these efforts to accountability at both the state and local levels as much as possible.
- Assure that health promotion as well as disease prevention and management programs at both state and local levels are based upon strategies that research has proven to be effective. Develop, as well, a capacity within Maine for applied research on public health interventions that is linked to policy development at both the state and local level.
- Enhance coordination and collaboration among state agencies (as well as private organizations) that are committed to public health goals. Encourage all appropriate state agencies to utilize the developing statewide network of health departments and community coalitions in order to build capacity at the local level.

- Assure opportunities for improved interaction and integration of public health and clinical care through structural changes and training opportunities.
- Provide a forum for clinical providers, third-party payers, and public health workers to discuss concerns, issues, policies, potential changes, and other opportunities that can advance the shared goal of improving the health of Maine citizens.
- Develop all of the above with an eye to an expansion of the evolving system beyond an initial focus upon the major chronic diseases addressed by the tobacco settlement and related behavioral risk factors. The strengthened public health system should be able to contribute to a wide range of public health issues, from infectious and emerging diseases to mental, dental and occupational health, to air and water pollution and violence prevention.

Structural Components

The next step was determining a local structure capable of carrying out the above tasks. It was expected that the form of these organizations would be different across Maine; for example some would be government and others private, some would be structurally linked to hospitals or other institutions and others might be freestanding. All, however, should be non-profit and must have the improvement of the community's health as their mission. Each organization must exhibit the following characteristics:

1) Commitment to enhancing the community's health;
2) Ability to work effectively with all types of organizations and professionals, medical as well as non-medical;
3) Commitment to coordination and collaboration;
4) Expertise to carry out public health functions from assessment to assurance to policy development;
5) Commitment to evidence-based strategies;
6) Ability to involve formal and informal local leadership;
7) Strong linkage to local government; and,
8) Administrative capacity to manage grants and contracts.

Appropriate organizational governing structure and staff expertise are both critical success factors for these organizations. In order for these organizations to be effective they need to recruit a wide range of institutions for representation on their governing or advisory boards. They would also need to involve them in community interventions if that is not already the case.

It should be noted that while the community and school tobacco grantees that were formed in recently designated Public Health Service Areas (also knows as "Tobacco Grantees") may form the starting point for the creation of Health Districts and Health District Coalitions across the state, it is not a given that these, and not some other entity, will be responsible for the convening role in that particular Health District. In addition, it is very possible that the geographic structure of the Public Health Service Areas will be changed when the state creates the Health Districts.

The new model must take into account that public health action at the local level must involve many organizations. The infrastructure must be capable of facilitating cooperation among the many organizations involved (e.g. from the Bureau of Health to the Office of Substance Abuse, as well as private organizations, including the following:

School systems;
Hospitals and health systems;
Family planning agencies;
Non-Profit organizations;
Municipal governments;
Faith communities;
Medical practices and community health centers;
Voluntary organizations (e.g. lung, cancer, heart);
Area Agencies on Aging;
Managed care organizations
Local police departments;
Colleges and universities;
Public health nursing;
Tribal health programs
Economic development organizations;
Environmental and other advocacy groups.

need to become more involved in public health issues. This is a critical success factor in public health strategies that include health promotion, as well as disease prevention and management. Maine Turning Point participants recommend that Medical Officers should be hired in each of the evolving Health Districts. These Health District Medical Officers (HDMOs) will have three functions – all of which are intended to support the local community coalition:[2]

The role of the HDMO is described in more detail in the Report from the Work Group on the Integration of Public Health and Clinical Care.

Improving State – Local Relations:

Improving health in the state of Maine is dependent upon an effective state-local partnership. Community health activists in Maine are apt to agree that more funds are required from public and private sources for health promotion and prevention activities, and that more money should be invested in coordination among the many public and non-profit agencies and other organizations already involved. Some of those same activists are less likely, however, to agree to a strong state role in setting goals or determining health improvement strategies for their own communities. As we focus on creating strong local infrastructure, however, so must we look to enhance corresponding aspects within state agencies. The success of our vision of an improved public health system depends upon effective communication, coordination and leadership throughout all of the partner organizations—government and community based.

Different perceptions of the appropriate state – local power balance often underlie the contracting and financing process. In fact, few local advocates argue for complete state delegation of authority to local organizations. Most are seeking an equal partnership with their state and federal public health colleagues with whom they share mission and values as well a commitment to developing, sharing and implementing cost-effective interventions.

This plan envisions the development of community-based units at the local level that will work *in partnership* with state (as well as federal) agencies to accomplish public health goals. Community representatives will assess the relationship as a true partnership when state and local staff work together to establish goals and strategies and when state and federal funds are shared following an open resource allocation process. The vehicles for decision-making need to be creatively re-examined in order to maximize commitment to shared goals across Maine. "Buy-in" across the state could potentially be enhanced through bi-annual public health strategic planning retreats, through additional state/local task forces on specific high priority issues, through the involvement of the emerging Maine Network of Healthy Communities in state level policy setting, and through the use of various forms of electronic communication to engage citizens in health planning.

We can expect that state funds, including the monies allocated from the tobacco settlement, will always be accompanied by explicit priorities (e.g. reduced tobacco use among youth), expressed through goals and measurable objectives. Local public health leaders, however, could still have a large measure of autonomy. First, they could participate, at least through representatives, in the state level planning process that leads to statewide goals and objectives. Second, at the local level they can supplement statewide goals with their own additional goals. Third and perhaps most important,

[2] The HDMOs are not intended to direct or otherwise "run" or "be in charge" of the Coalitions in each Health District. The HDMO functions are to operate as an adjunct activity, as directed by the State Health Officer, and as possible at the local level to provide support to the leadership and members of the Health District Coalitions.

they could have some freedom to determine how the objectives are going to be accomplished. As much as possible the new public health framework proposed by Maine Turning Point should provide for a large degree of autonomy regarding strategy determination, with the caveat that all interventions must ultimately be evidence-based and consistent with state public health goals.

No mechanism is more critical to achieving a state-local partnership or more important than increasing local involvement in the goal-setting process. Goal determination *and* monitoring activities at the local level in Maine lag behind similar efforts at the state and national levels. The three levels, however, are symbiotic; all depend upon each other for success. State and national improvements depend upon health promotion and prevention programs and services planned, provided and evaluated at the local level. Organizations at the local level are dependent upon the resources allocated from state and national levels. At the core are leadership and accountability, both of which need to be enhanced in Maine communities.

Community-based organizations should be expected to adopt their own goals some of which may not be included in statewide goals. These additional goals, however, should complement rather than replace their state-contracted responsibilities. Individual communities may well set objectives for countless issues, from substance abuse to environmental and/or oral health to improved access to primary care for the uninsured.

Financing is also a mechanism that, like goal determination and monitoring, is critical to achieving a successful state-local relationship. A major change has already been achieved through the tobacco settlement. The state's limited resources are being spread across the state for the first time using new "Public Health Service Area" designations. A second change would be to provide funding for a longer period of time; the length of the contracting period may directly relate to the strength of the local partner. A third change would be to shift funding from a contractual to a cooperative agreement format, an alteration that would more truly reflect the state-local partnership we have described.

This plan proposes that state funding to health districts be eventually divided into two distinct streams. Health departments and Community Coalitions should first receive funds sufficient to support their *core* (assessment, policy development and assurance) *local functions at a basic level.* At a minimum they should provide for at least one staff member (usually a coordinator), basic equipment and operating expenses. This "core" support should be provided on a long-term (3-5 year or on-going formula) basis in order to provide the stability that this model of state-local partnership requires. The formula determining the "core" level of support for each coalition or department should reflect the size of the population served and could be weighted for other factors such as population density. "Core support" should be separated from the second stream of funds — those provided for categorical purposes, because categorical funding can be expected to vary substantially from year to year based on national, state and municipal priorities.

Enhancing State Level Coordination

Development and coordination at the local level is difficult to achieve without parallel efforts at the state level. If the new local public health system is to achieve its potential over time, it will require financial and other support from multiple state agencies, reflecting the comprehensive and collaborative nature of public health. In addition, there is a need for enhanced statewide planning and accountability among the diverse (non-profit as well as governmental) set of organizations charged with improving public health in Maine. Those same organizations need to be effective

advocates for public health goals. As noted earlier Maine has a large number of non-profit agencies that have taken on responsibilities that are provided by government agencies in other states.

In response to these needs we recommend that the state of Maine:

a) Enhance coordination and collaboration among the following agencies[3]: • Department of Corrections • Department of Education • Department of Environmental Protection • Department of Human Services • Department of Mental Health, Mental Retardation and Substance Abuse Services • Department of Economic Development • Department of Public Safety • Legislature	This can be accomplished through existing state government committees, task forces or some new entity. An example of the first option would be the expansion of the existing "Children's Cabinet" (which already includes many of the above agencies) to status as a multi-agency task force committed to addressing public health issues *across age groups*. The effectiveness of this approach can be measured by the amount of state resources being channeled to community coalitions, as well as by the number of state agencies providing that support.
b) build upon the existing structure of the Maine Public Health Association to enhance collaboration among state agencies and non-profit organizations to develop increased effectiveness in advocacy for public health purposes.	Collaborative efforts could focus on state-wide health planning organizations such as the Maine Center for Public Health and the Maine Network of Healthy Communities, provider organizations such as the Maine Hospital Association, the Maine Medical Association and the Maine Osteopathic Association, non-profit special purpose organizations such as the American Lung Association of Maine, advocacy organizations, and public health technical assistance organizations such as Medical Care Development, Inc. The model for this body may ultimately be the Economic Development Council.

It may be most effective to begin this effort to enhance collaboration at the state level with a task force charged with overseeing the implementation of the Fund for a Health Maine. The organizations selected to be involved should therefore reflect this initial purpose. Over time the task force can become a council with a wider public health focus. As the focus widens other relevant non-state organizations can be added.

The effectiveness of this strategy can ultimately be assessed by measuring the level of resources committed by state government for public health purposes.[4]

[3] Certainly some of these agencies currently cooperate on a variety of projects. The emphasis here is on enhancing their ability and desire to coordinate their efforts on a broad range of health concerns.

[4] During the process of developing the Public Health Improvement Plan the Governor appointed a Blue Ribbon Commission on Health Care. Their report, published in November of 2000, recommends developing a collaborative government and private sector community-based public health infrastructure. They also recommended a state level health "Council" to address many of the horizontal management issues outlined in this report. For a copy of their report, go to http://www.MDF.org

Discussion and Recommendations

The mission of Maine Turning Point is to strengthen public health in Maine. It is the goal of the Infrastructure work group that we do this by strengthening and utilizing community-based coalitions across Maine, and not by developing an excessively standardized public health framework. The strengthened public health system envisioned in this document will reflect the community diversity and initiative at the core of Maine's Yankee heritage.

> **Recommendation:** Health Districts should be established across Maine and structured in such a way as to assure that they have rational boundaries and are developed in ways that make sense at the local level as well as for State purposes.[5]

Capacity for evaluation related to the development and testing of new public health models in Maine should be developed. Evaluation first informs managers of relative efficiency and effectiveness so that they can enhance the cost-effectiveness of their efforts. But it is also necessary to convince those outside the public health system, including legislators and private sponsors, in order to continue, much less enhance, financial support.

> **Recommendation:** Community coalitions should be formed or strengthened in each Health District to assure the delivery of essential public health services for all communities in the district.

There are knowledgeable and experienced community organizers, educators, health care professionals and other relevant individuals across Maine. They need to be utilized efficiently to develop efforts in communities that currently are not organized to advance public health goals. The success of community development efforts will depend heavily on the capabilities of local leadership, both paid and volunteer. Local organizations must be capable of addressing important functions of strategic planning, coordination and collaboration, monitoring and evaluation, and community/state accountability. It is essential that staff and members of community coalitions, and even staff of health departments receive additional training in public health disciplines.

> **Recommendation:** Training in community development and public health should be provided for local staff.

> **Recommendation:** Technical assistance should be provided on a regional basis to coalitions for organizational development. Providers of such assistance should include both public health professionals and experienced community coalition leadership peers.

In recent years an increasing amount of statewide health data has become available for state leaders. This information has been critical to recently successful efforts to generate legislative support for

[5] The current Community and School Tobacco Grantees are located in newly designated Public Health Service Areas. These grants and the creation of the 31coalitions provide a potential stepping stone toward creation of Health Districts. However, it is already clear that the shape of the current regions will need to be adjusted in some areas prior to designation of Health Districts. Furthermore, the current Community and School Tobacco Grantees may apply to be the lead organization(s) in the new Health Districts but should not assume that they will take on this role. In some areas there may be a morphing of the grantee into a Health District Coalition but other coalitions may choose not to broaden their mission or may find that another organization would be a more appropriate lead agency for the Health District.

increased resources to meet Maine's chronic disease epidemic. A similar database has not yet been developed for community leaders.

Recommendation: Local initiatives (by coalitions and providers) should be encouraged in state-funded programs; long-term state-local partnerships should be established.

Recommendation: Coordination and collaboration among coalitions should be enhanced through support of a Maine Network of Healthy Communities or similar mechanism.

Recommendation: Long-term (multiple year) funding should be provided for the coalitions in each district. Funding for the district-wide coalition might then be shared with sub-district healthy community coalitions.

Physicians in Maine need to become more involved in public health issues. This is a critical success factor in public health strategies that include health promotion, as well as disease prevention and management. Currently state officials are limited in their capacity to undertake surveillance for these threats and to provide clinical guidance and public health leadership throughout the state due to limited human and financial resources.

Recommendation: Each Health District should have a Health District Medical Officer (HDMO) who acts in concert with the community coalition and provides services for the Bureau of Health.[6]

[6] The recommendation was approved by the MTP Steering Committee and by the MCPH Board of Directors with language stating that the HDMO should be a physician. However, there has been considerable and ongoing debate regarding that stipulation. As initially conceived, the primary function of the individual in this position would be to provide local assistance to the State Health Officer with investigation of emerging infectious disease outbreaks. Consequently, as the role and function of this position is defined in greater detail, the State agency will determine the credentials needed in this position.

Notes for Future Consideration:

While there has been support for developing a regional or "district" approach to a public health infrastructure in Maine, the creation of Public Health Service Areas (PHSAs) and the Community and School Tobacco Grants to coalitions in those area has raised a number of new issues in the time since the MTP Steering Committee approved the recommendations included in this document. Consequently some people believe that there is a need to develop a process for resolving the issues that have been raised, addressing the creation of Health Districts at a higher level of detail, and strengthening support for the regional or district approach to developing a public health infrastructure in Maine. This turn of events does not represent a failure but rather is a symbol of success in that the PHSAs provide a "test" for the vision. The issues that have arisen will allow us to refine and revise the vision to assure implementation as well as increase future strength and viability.

In addition to the above, there are other unanswered questions related to the development of a public heath infrastructure in Maine that have not yet been fully addressed. These include measures for accountability at the local level, public representation in coalition governance and leadership, and methods for assuring the competency of public health service providers and HD staff, among others. When there has been further progress on defining the shape (geographic and organizational) of the Health Districts and funding is closer to being secured, it will be necessary to complete the process by addressing these additional levels of detail.

Financing Public Health Services

Focus of Activities

The MTP Finance Work Group was composed of members with the following affiliations: the Maine Hospital Association, Maine Bureau of Health, Maine Center for Public Health, Medicaid, Medicare, Blue Cross/Blue Shield of Maine, Maine Philanthropy Center, Martin's Point Healthcare, Medical Care Development, Cigna Healthsource, Maine Medical Assessment Foundation, and MaineHealth. Their mission was to develop a plan for financing public health service infrastructure development generally, and the provision of prevention services specifically. The work group planned to investigate current funding and focus of public health dollars to identify those parts of the public health system that are not adequately funded.

Findings

The Finance work group began by requesting per capita public health spending figures for Maine and other states in order to identify current funding and focus. What they found is that comprehensive data of that kind is not readily available.

Once the need for data was identified by the work group, interest was generated in public health circles and Turning Point was able to undertake a study to identify baseline data on public health funding using legislative appropriation documents. The appropriations data provided a starting point from which to have more in-depth discussions with leaders in several state agencies. It will be helpful in the years ahead to develop and undertake a long-term analysis of Maine's financial commitment to public health. Such an examination would help policy makers develop a realistic understanding of public health funding in Maine and suggest areas for policy development and change.