

An Overview of Minnesota's Local Public Health System Structure, Mandates & Funding



Minnesota's local public health system works to protect, promote and improve the health of all Minnesotans. This system consists of approximately 70 local public health departments, which are organized as 51 community health boards (CHBs). CHBs are the legally recognized governing bodies for local public health in Minnesota. A CHB may be a single county or city health department, or multiple local health departments working together.

CHBs are mandated by state statute (Minn. Stat. §145A) to perform core public health services, which are funded by a combination of local, state and federal dollars. Local public health departments partner with other government agencies and community organizations such as schools, law enforcement, social services, nonprofits and health care providers to coordinate high quality, collaborative public health programs that fulfill state mandates and address local health priorities.

Core Services Mandated by the Local Public Health Act (MN Stat. §145A)

1. Assure an adequate public health infrastructure

e.g., Assess health priorities with community input; develop community health improvement plans to address identified needs and monitor progress.

2. Promote healthy communities and healthy behaviors

e.g., Track data trends (leading causes of death, birth outcomes); implement health promotion strategies based on community needs and priorities.

3. Prevent the spread of infectious disease

e.g., Monitor immunization levels and perform outreach to high-risk groups; run immunization clinics; investigate outbreaks and conduct contact interviews with individuals exposed.

4. Protect against environmental health hazards

e.g., Implement Childhood Blood Lead Case Management Guidelines; abate public health nuisances; monitor food and water illness data. (Note: Some local agencies also have delegation agreements with state agencies for licensing, inspecting and enforcement of food, pools and lodging establishments, the Safe Drinking Water Act, and/or the MN Clean Indoor Air Act.)

5. Prepare for and respond to disasters, and assist communities in recovery

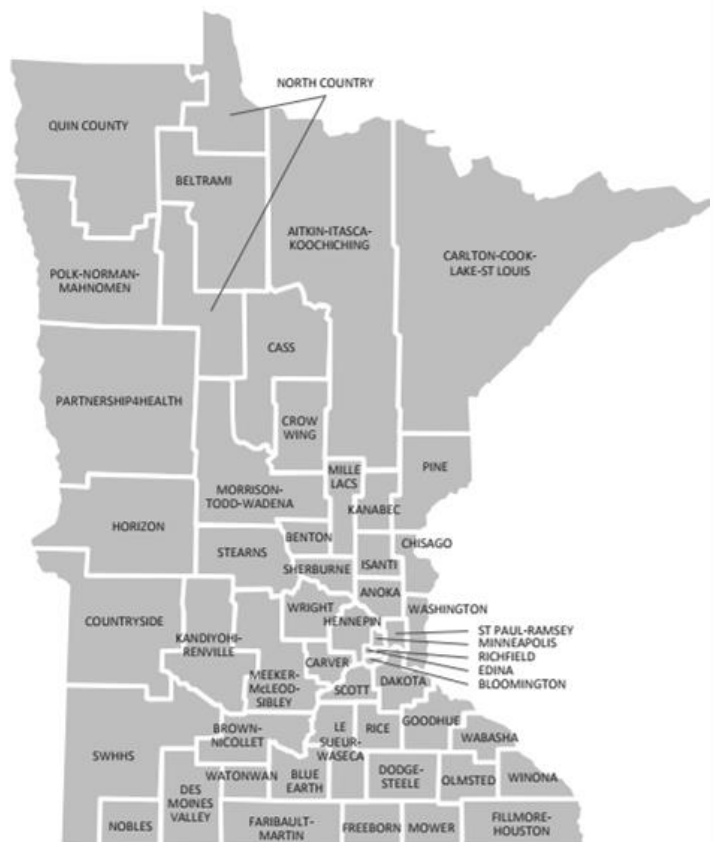
e.g., Develop and maintain response plans to address needs during disasters and emergencies (infectious disease threats like COVID-19 or TB, natural disasters, terrorist attacks); enforce emergency health orders.

6. Assure the quality and accessibility of health services.

e.g., Identify barriers to health care service and gaps in service; implement strategies to increase access to health care.



Minnesota Community Health Boards, Effective January 1, 2017



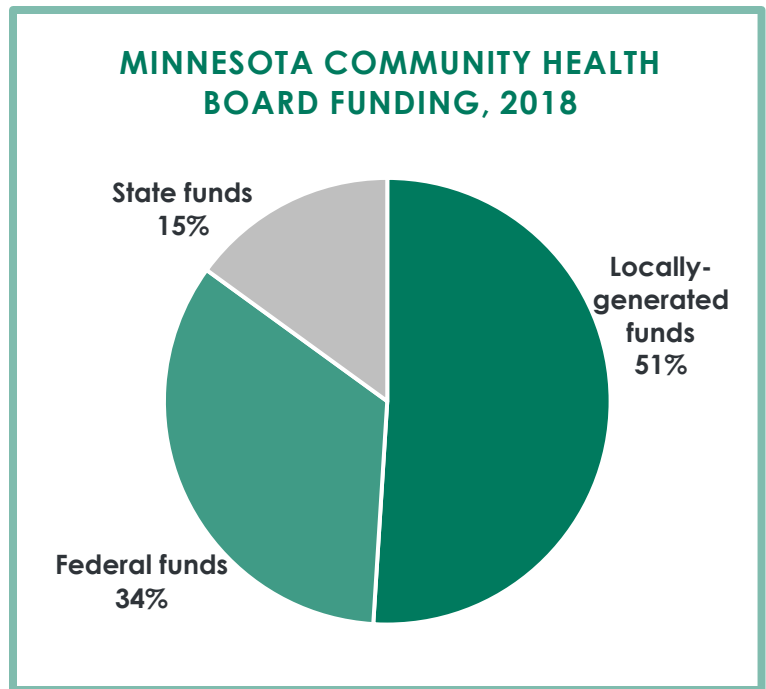
Funding for Local Public Health

Local tax levies are the single largest source of local public health funding, accounting for 35.7% of all expenses. In total, more than half (51%) of expenses are locally-generated. Federal funds contribute the next largest share (34%), while state funds make up just 15%. Compared to the nation as a whole, Minnesota's local public health departments rely more heavily on local funding.¹

The Local Public Health Grant is the state's main investment in our local public health system, yet it accounts for just 6.2% of funding and has decreased as a percentage of expenditures over time, placing a greater burden on local tax levies to meet core, state mandate services and emerging community needs.

The Local Public Health Grant and local tax levies are two sources of flexible funding for local public health departments. Flexible funding is crucial to

our local public health system, as many state mandates and core public health services are not well supported by categorical grants. It allows local governments to direct dollars where they are needed most to better address the diverse needs and local public health priorities of Minnesota communities. However, despite significant investments at the local level, the proportion of flexible funding in the system has decreased by more than 50% since 1979. A statewide increase to the Local Public Health Grant is needed to restore local capacity to meet state mandates, address emerging priorities and relieve local tax levies.



Public Health's Return on Investment

- Every 10% increase in public health system spending results in a 7% decrease in infant mortality and a 3% decrease in heart disease mortality.²
- In Minnesota, investing \$10 per person per year in proven community-based programs to increase physical activity, improve nutrition and prevent tobacco use could produce annual net savings of \$316 million per year.³
- Increases in local health department (LHD) spending per capita are associated with a 7% decrease in infectious disease mortality and a 6.6% decrease in cardiovascular disease (CVD) mortality, which suggests regions served by LHD's with more funding have fewer infectious disease and CVD deaths.⁴
- A 2017 study found a 10% increase in local public health spending per capita was associated with a 0.8% reduction in adjusted Medicare expenditures per person after one year and a 1.1% reduction after five years.⁵

About the Local Public Health Association of Minnesota



Public Health
Prevent. Promote. Protect.

The Local Public Health Association of Minnesota (LPHA) is a voluntary, non-profit organization that works to achieve a strong local public health system through leadership and collective advocacy on behalf of Minnesota's county, city and tribal local public health departments. The Association represents more than 230 public health directors, supervisors and community health services administrators throughout the state. LPHA is an affiliate of the Association of Minnesota Counties.

For more information, please contact: Kari Oldfield, Director | koldfield@mncounties.org or (651) 789-4354

¹ National Association of County and City Health Officials, 2016 National Profile of Local Health Departments (MN % local funding to national average: 49% to 30%, MN State funding to national state funding average: 15% to 21%, MN Federal funding to national federal funding average: 36% to 36%, other sources of national CHB funding average: 13%)

² Mays, GP, and Smith, SA, "Evidence Links Increases in Public Health Spending to Declines in Preventable Deaths," Health Affairs, doi:10.1377/hlthaff.2011.0196, 2011

³ Trust for America's Health, "Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities," February 2009

⁴ Erwin, PC, et al., "The Association of Changes in Local Health Department Resources with Changes in State-Level Health Outcomes," Am J Public Health, April 2011

⁵ Public Health Spending and Medicare Resource Use: A Longitudinal Analysis Of U.S. Communities, Glen Mays-Cezar Mamaril - <https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.12785>