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NEW JERSEY'S PUBLIC HEALTH AGENDA FOR THE NEXT MILLENNIUM: *HEALTHY NEW JERSEY 2010*

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NEW JERSEY'S PUBLIC HEALTH AGENDA FOR THE NEXT MILLENNIUM: *HEALTHY NEW JERSEY 2010*

The Issue: New Jersey's public health agenda for the next millennium sets forth ambitious goals regarding the activities of New Jersey's complex public health system -- whose structure is comprised of national, state, county and local administrative units. How will state policymakers and the public health community respond to achieving the new goals set for 2010?

INTRODUCTION

A Harris Poll of the American public conducted in October 1999 asked participants to identify the top issues they felt government should address at this time. For the first time since 1995, the public ranked health care -- along with education -- as the most important issues confronting the country. As part of its *Healthy New Jersey 2010* initiatives, the Department of Health and Senior Services conducted focus groups and a public opinion survey of New Jersey residents and asked them to assess the state's leading health issues.[1] General findings from both the focus groups and the survey indicate that New Jerseyans view cancer, access to health care, ability to pay for quality health care and environmental health factors -- such as pollution -- as their leading concerns regarding their health and medical care.

These findings hold great significance in any discussion of our national and New Jersey public health systems, which focus on the health of populations, via the surveillance, assessing and monitoring of health problems, disease prevention, health promotion and education activities, and the developing and oversight of public health laws and regulations. These core functions and related public health initiatives were responsible for nearly tripling the life expectancy in the U.S. during the past 150 years (Richards, 1998). What does the future hold for the public health system, its policies and programs?

HEALTHY NEW JERSEY 2010 DRAFT -- NOVEMBER 1999

The New Jersey Department of Health and Senior Services (DHSS) has released in draft form its *Healthy New Jersey 2010*, the state's "Health Agenda for the First Decade of the New Millennium." During the course of 1999, an inter-departmental steering committee comprised of representatives from several state of New Jersey departments--Education, Environmental Protection, Human Services, and Law and Public Safety[2] -- worked with the Department of

[1] Both the survey and focus groups were commissioned by the state of New Jersey and organized by the Eagleton Institute's Center for Public Interest Polling at Rutgers University. Summaries of the results of these activities can be found at the Department's web site: www.state.nj.us./health/chs.

[2] As part of the planning process, hearings to solicit input and comments from the public will be held in Newark, Trenton and Blackwood, New Jersey, on November 16, 17 and 18, respectively.

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Health and Senior Services in the development of *Healthy New Jersey 2010*:

Healthy New Jersey 2010 includes ambitious goals by setting 142 health objectives in 19 major areas of health, including health care access, maternal and child health, and the prevention and reduction of specific diseases, such as HIV/AIDS, cancer and asthma. The health objectives address the health status and related issues for New Jerseyans throughout the life cycle -- from birth to the elderly. The indicators are organized into five major areas of focus:

- Overall Health Status;
- Access to Health Care;
- Fundamentals of Good Health;
- Preventing and Reducing Major Diseases; and
- Strengthening Public Health Capacity.

Healthy New Jersey 2010 is New Jersey's first public health agenda to contain a discrete section on preserving the health of seniors, who comprise a large percentage of the state's population. Senior health objectives include such areas as target rates for influenza and pneumonia immunizations and reducing the incidence of falls in long-term care facilities. The 2010 report also contains another "first," according to Christine Grant, Commissioner of Health and Senior Services, in that it "takes an in-depth look at the health status of whites, Blacks and Hispanics, and sets ambitious targets for closing the gaps between the health of whites and minorities."

It is anticipated that *Healthy New Jersey 2010* will be released in its final form by April 2000, following the incorporation of revisions. At least two comprehensive updates on the progress on every objective will be published during the coming decade.

NATIONAL PUBLIC HEALTH INITIATIVES

The United States Public Health Service has for two decades used health promotion and disease prevention objectives to improve the health of the American people. The first set of national targets was released in 1979 as *Healthy People*: *The Surgeon General's Report on Health Promotion and Disease Prevention*. The national *Healthy People 2000* report was developed through the collaboration of governmental, voluntary, and professional organizations, as well as businesses and individuals. The framework for *Healthy People 2000* covered three broad goals: (1) increasing the span of healthy life of Americans; (2) reducing health disparities among Americans; and (3) achieving access to preventive services for all Americans.

The release of the national *Healthy People 2010* is scheduled for January 2000. Drafts of the plan indicate that this next set of national objectives differ from the 2000 report by a broadened prevention science base; improved surveillance and data systems; a heightened awareness and demand for preventive health services and quality health care, and changes in demographics, science, technology and disease spread that will affect the public's health into the 21st century (United States Public Health Service, 1999).[3] Its two

[3] The goals and objectives for Healthy People are determined by the Department of Health and

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overarching goals are to increase years of healthy life and to "reduce" health disparities among Americans. The program is further divided into four "enabling goals" and 26 "focus areas," such as chronic diseases, nutrition, tobacco and physical activity (*Medicine & Health Perspectives*, 1999).[4] Four new focus areas for 2010 are: disability and secondary conditions; public health infrastructure; health communication; and arthritis, osteoporosis and chronic back conditions (Hahn, 1999). According to the National Center for Health Statistics, at present 48 states are working on state-specific plans using the Healthy People blueprint.

Is the country meeting its established public health goals? In June 1999, U.S. Surgeon General David Satcher reported that nationally, only about 15 percent of the health goals set for the year 2000 have been met. Progress has been made on 44 percent of the objectives, but for about 20 percent "the nation is getting less healthy and moving away from its goals" (Hilts, 1999). In its *Healthy People 2000 Review*, the federal government reported that reductions in infant mortality and breast cancer rates were among the areas where goals have been met. However, nationally, as in New Jersey, this same success does not hold true across racial and ethnic lines: the death rate among black infants is about twice the rate for white infants. Areas of health in which objectives were not being met were in the level of physical activity for Americans, the number of children in physical education programs and the number of people who are overweight or obese.

HEALTHY NEW JERSEY 2010 -- LOOKING BACK, PROJECTING FORWARD

Healthy New Jersey 2010 is the second significant state public health document; its predecessor -- *Healthy New Jersey 2000* -- was released in 1991, as a response to the national *Healthy People 2000* public health initiative in which the federal government focused on the nation's goal for health promotion and disease prevention. In New Jersey's 1991 report, 67 goals were established in 11 public health areas. During the last decade, New Jersey has published two Updates to its 1991 document -- a 1996 *Update Healthy New Jersey 2000* that evaluated initial progress toward achieving the state's objective, and a 1999 *Second Update and Review* which included more current data in its evaluation of meeting its year 2000 objectives. In its 1999 *Update*, the Department reported that although gains were made in certain target areas -- including reducing the infant mortality rate for the population as a whole; reducing breast cancer death rates for all women and reducing the motor vehicle death rate for the population as a whole and among youths 15 through 24 years of age --, in other target areas, the likelihood of achieving year 2000 objectives was "unlikely." These target areas included: the percentage of New Jerseyans without health insurance or without a primary

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Human Services' Office of Disease Prevention and Health Promotion, but the product is from the collaboration between the Office and many public and private sector groups that use the Healthy People objectives to guide their public health activities. The Healthy People Consortium -- a national advisory group -- now numbers more than 600 groups (Hahn, 1999).

[4] The four enabling goals are: (1) promote healthy behaviors; (2) protect health; (3) assure access to quality health care; and (4) strengthen community prevention.

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care provider; the percentage of babies whose mothers received prenatal care and the percentages of babies born with low birth weight, and the prevalence of smoking and drug use among high school students.

HEALTHY NEW JERSEY 2010 -- BASELINES, TARGETS AND PREFERRED ENDPOINTS

The *Healthy New Jersey 2010* draft report includes a baseline rate -- either an incidence or prevalence rate or death rate for a specific disease -- for most of its health objectives, e.g. rates of uninsured lives for New Jersey's children; black infant mortality rates; immunization rates; rates of smoking among high school students; and death rates from heart disease. The report draws on measures taken from many traditional and new sources, including: vital records -- such as birth and death certificates; data reported in the state's Behavioral Risk Factor Surveillance System (information collected from a telephone survey of adult health behaviors)[5];, and measures from the state's Managed Care Report Card, such as the rates of women receiving a mammogram. In this way, it presents a complete "picture" of the health of the state and strategies for public health policies and programs.[6]

These baseline rates are set out for the total population -- whites, Blacks and when data is available, for Hispanics. For some objectives, data is also broken down by age and gender. For baseline rates, 1996 or 1997 data is reported. Projections for each health objective include two outcomes -- the 2010 target and the "preferred 2010 endpoint." The two outcomes are explained by DHSS as: "The target represents an ambitious but achievable rate, and often eliminates the health disparities between racial groups. The preferred endpoint nearly always eliminates the health disparities between racial groups and is more ambitious for all groups, including those currently doing well."

For example, one 2010 objective under the section entitled, "Access to Health Care," is to: "Reduce the percentage of children under age 19 without any health insurance during the past year to 5.0 percent." In 1997, the baseline percentage rate for all children under age 19 was 15.9 percent. The 2010 target rate of 5.0 percent represents a 68.6 percent change from the baseline data. The preferred 2010 endpoint is set at an even lower percentage, or 4.0 percent. As one of its strategies towards these outcomes, the state intends to continue marketing "aggressively" its N.J. KidCare program -- which provides subsidized coverage to uninsured children living in families at or below 350 percent of the federal poverty level -- to eligible families, as well as to expand employer involvement. According to the

[5] The Behavioral Risk Factor Surveillance System (BRFSS) is a state-based program that is a source of information on risk factors among adults 18 years and older. The BRFSS is a collaboration between the U.S. Centers for Disease Control and Prevention (CDC) and state health departments. The CDC designed this system to gather information on behaviors and conditions related to the leading causes of death in each state. Risk factor categories include alcohol, cholesterol, diabetes, exercise, health care coverage, injury control, hypertension, smoking and HIV/AIDS.

[6] A complete list of the major data sources used in the draft plan can be found in *Healthy New Jersey 2010*, II, at p. 1 (1999).

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DHSS, as of July 1999, 35,000 eligible children were enrolled in N.J. KidCare; however, social research is indicating that "not all families will take up an offer of insurance even when it is affordable; ….the preferred endpoint percentage presumes that some children will continue to be uninsured" (*Healthy New Jersey 2010* Draft, 1999).

This specific access to insurance objective includes some broad racial disparities when the baseline data is broken out among different groups. For example, while the baseline rate for the general population of all children under age 19 is 15.9 percent; it is 13.9 percent for white, non-Hispanic; increases to 16.1 percent for Black, non-Hispanic; and rises to 29.4 percent for Hispanic children. *Healthy New Jersey 2010* target and preferred endpoint percentages for these individual groups are the same as for the total population: 5.0 percent and 4.0 percent, respectively.

THE CHALLENGE TO PUBLIC HEALTH: RACIAL AND ETHNIC HEALTH DISPARITIES

The issue and complex problems of health status disparities related to race and ethnicity are pervasive throughout the United States. Historically, research in the field indicates that race and ethnicity correlate with persistent and often increasing disparities in health status. As part of the national *Healthy People 2010* objectives, the U.S. Department of Health and Human Services has alerted policymakers to address the significance of these disparities in light of the projected demographic changes in this country. "Groups currently experiencing poorer health status are expected to grow as a proportion of the total U. S. population; therefore, the future health of America as a whole will be influenced substantially by our success in improving the health of these racial and ethnic minorities" (U.S. Department of Health and Human Services, *Fact Sheet on Healthy People 2010 Objectives*, 1998; reference is also made to New Jersey Policy Forums on Health and Medical Care *Issue Brief* No. 29, "Demographics, Diversity and Accountability: The Health of New Jersey's Communities in 1999," February 24, 1999.)

The federal government, under the guidance of the Department of Health and Human Services, has set the ambitious national goal of "eliminating, by the year 2010, longstanding disparities in health status that affect racial and ethnic minorities." The six areas of health status which evidence the most significant gaps are: infant mortality, cancer screening and management, cardiovascular disease, diabetes, HIV/AIDS infection rates, and child and adult immunization. Chronic diseases and mortality associated with these conditions is disproportionately represented in minority populations, who experience higher rates of hypertension, diabetes and cardiovascular disease (i.e., coronary heart disease and stroke) (Bolster and Perez, 1999). The risk for chronic diseases among these populations is further complicated in that these same populations often lack health insurance and access to health care providers. In the government's *Update* for its *Healthy People 2000* plan, it was reported that Hispanics are twice as likely to be diabetic and African-Americans have a disproportionately higher death rate from diabetes. African-Americans are also much more likely than whites to be

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hospitalized or die from asthma (Hilts, 1999).

The federal government has launched various programs to support meeting this overarching goal to eliminate ethnic and racial disparities by 2010. The Centers for Disease Control and Prevention (CDC) will award $9.4 million to community coalitions in 18 states to help address racial and ethnic disparities as a component of its "Racial and Ethnic Approaches to Community Health" (REACH 2010) demonstration project (Department of Health and Human Services, "What's New," September 1999). The project will support projects in 32 local community-based programs that target minorities at risk in six health priority areas: infant mortality, improving breast and cervical cancer screening and management, cardiovascular disease, diabetes, improving child and/or adult immunization levels and HIV/AIDS. UMDNJ-Medical School in Newark, New Jersey, is one of the grantees; its program is focusing on breast and cervical cancer in African-American and Hispanic-American women.

The CDC also includes in its recommendations to address racial and ethnic disparity issues the development of plans to improve the process of gathering consistent data on different minority populations and chronic disease. Such strategies include the implementation of short-term, cross-sectional studies, in conjunction with large-scale, longitudinal studies (Bolster & Perez, 1999).

The national Agency for Health Care Policy and Research (AHCPR) announced in October 1999 that over the next five years it plans "to establish up to four centers of excellence that will identify practical tools and strategies to eliminate racial and ethnic disparities in the health care system" (AHCPR, *Press Release*, October 26, 1999). According to U.S. Surgeon General David Satcher: "Eliminating disparities in health will require additional research dedicated to a better understanding of the relationships between health status and race and ethnicity. . .[T]he research conducted by these centers will go beyond simply documenting disparities by putting a new emphasis on understanding their underlying causes and developing strategies to eliminate them" (ibid). A significant component of this grant program is that AHCPR expects that applicants will seek partnerships with payers, policymakers, provider groups, professional groups and community organizations in the health care community, in order to help ensure that the research and implementation of findings will have a positive impact on health care practices, policies and patient outcomes. Special target groups and areas for research funding are the study of minority children, the study of chronically ill minority elderly and the study of clinical preventive services for minority populations.

Individual states are challenged by the complexity of disparities in health status among their racial and ethnic minorities, even those considered to have strong health and medical programs. For example, a state like Minnesota, which experiences some of the highest levels of health status -- including a high percentage of "insured" among its citizens -- also has significantly higher levels of disease, morbidity and mortality rates, and rates of uninsurance, among its

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African-American and native American citizens (*Healthy Minnesotans*, 2010).[7]

NEW JERSEY'S PUBLIC HEALTH INFRASTRUCTURE

One of New Jersey's five major areas of focus in its 2010 public health agenda is the issue of strengthening public health capacity. Within the Department of Health and Senior Services, the Office of Local Health has as its mission: "[T]o build the capacity of local health departments for the delivery of essential health services by providing leadership, technical support and funding for the development of public health workforce competencies, public-private partnerships and coordinated service models, public health information and communication networks, and standards of performance which assure quality public health services and improved community health." New Jersey is one of 18 states throughout the country that has a discrete Office of Minority Health within its governmental structure[8].

New Jersey's local public health system began with a requirement in 1887 that municipalities have a local board of health.[9] The bulk of funding support for New Jersey's local health departments comes from Federal grants and other public and private sources. The state's contribution represents approximately 20 percent of the local departments' funding. Since 1966 -- when the Legislature enacted a law to provide state funding to support priority health service provided by local health departments -- a specific appropriation is set aside for Public Health Priority Funding (PHPF). The 1999 State Budget Act reduced the minimum population requirement for local health department eligibility for PHPF from 25,000 to 20,000. Each year, each eligible public health agency may submit an application for PHPF; in 1999 there are 96 local health departments eligible to receive $4.1 million in PHPF; in FY 1995, the state of New Jersey distributed approximately $3 million to local health agencies through this appropriation.[10]

The development and coordination of partnerships is a primary strategy in meeting the goals set forth in *Healthy New Jersey 2010.* Such partnerships are identified by the Department of Health and Senior Services as "a sharing of responsibility" among state agencies, health care professionals and institutions, university researchers and educators, health insurance plans, local health departments, community groups and agencies, faith-based organizations, schools and every member of the public at large (*Healthy New Jersey 2010*, p. 2).

[7] Updates on individual states and their status for state-level "Healthy People" plans can be accessed at the federal government's web site: www.health.gov/healthypeople/state/.

[8] The Office of Minority Health was established in New Jersey in 1992 (under N.J.S.A. 26:2-160; PL 1991, c.401.) As part of its charge, it develops activities to address priority areas and issues related to *Healthy New Jersey* objectives.

[9] For an historical overview of public health activities in New Jersey, reference is made to New Jersey Policy Forums' *Issue Briefs*, "Public Health at the Crossroads," dated June 21 and July 31, 1996; and Bialek, R. "Commissioner's Working Group on Local Health." Final Report. State of New Jersey. Department of Health. 1994).

[10] The Medical Society of New Jersey, supported by a grant from The Robert Wood Johnson Foundation, has formed a coalition called Public Health: Crafting a Restructured Environment (CARE), which will work to improve the state's public health infrastructure.

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One of *Healthy New Jersey 2010's* objectives under "Strengthening Public Health Capacity" is to increase the percentage of local health departments that participate in the LINCS public health information system in their respective counties to 100 percent; 1999 baseline data indicates that LINCS participation is at 60.6 percent. New Jersey's Local Information Network and Communication System (NJ LINCS) is the state's Internet-based statewide network of electronic public health information and public health professions. One of the first databases to become part of LINCS is the New Jersey Statewide Immunization Information System. The LINCS system is an expansion of the Centers for Disease Control (CDC) initiative known as INPHO -- Information Network for Public Health Officials, which began in 1992 as part of its strategy to strengthen the infrastructure of public health in the U.S. Over 15 states throughout the country have developed INPHO systems designed to meet the needs of their individual states. The INPHO initiative addresses the "serious problem that public health professionals have lacked ready access to much of the authoritative, technical information they need to identify health dangers, implement prevention and health promotion strategies and evaluate health program effectiveness" (CDC, *Summary of INPHO Initiative*, 1999). These infrastructure issues are even more critical as the American health care system continues with its shift toward a managed health care model.

CONCLUDING REMARKS

Healthy New Jersey 2010 and its national analogue *Healthy People 2010* establish plans that frame national, state and local public health activities. Historically, there have been mixed results regarding the achievement of set goals for public health prevention and promotion. As we enter the new millennium, the public health community will be confronted by new challenges – such as strategies for monitoring new and emerging diseases and threats of bioterrorism -- as it continues to grapple with significant long-standing issues such as the disparities in health status for racial and ethnic minorities, and the coordination of public health functions and services in a changing health care environment.

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POLICY IMPLICATIONS

Managed care continues to affect the public health system across all dimensions of financing, delivery system and access to services. Public health advocacy organizations, including the American Public Health Association, are concerned about the effectiveness of managed care organizations in meeting the health care needs associated with prevention and with managing chronic conditions, as well as with the underfunding of public health and prevention services. What strategies are being explored to address these concerns from policymakers and regulators?

Advocates stress that the challenge of understanding and eliminating minority health disparities is a complex process for which an incrementalist approach may not work. (Feldman et al, 1999). How will the "best" strategies be identified and employed to address these disparities?

What is the future of the role of community "safety net" providers in their performance of public health activities? What resource and funding support is available to "shore up" the safety net providers and establish within the public health infrastructure the creation of a coordinated system of care to provide services that range from primary care and clinical preventive care to specialty care from members of communities?

National and state researchers and statisticians point out the need for developing plans to improve the process of gathering consistent data as a means to implement appropriate public health policies and programs. How will consensus be reached to provide ongoing support and funding for research and analysis in public health, especially in such areas as determining the value of data-driven benchmarks?

In an environment of limited resources, what strategies are being developed to best put the numerous goals and objectives of *Healthy New Jersey 2010* into practice? Meeting these goals requires the commitment of resources for service delivery, education, research, training and outreach for health promotion and prevention activities. In an environment of limited resources, how will implementation and evaluation of outcomes be ensured?

Surveillance, monitoring and research activities in the field of public health are being driven by sophisticated new technologies, such as geographic information system (GIS) technology and advanced information processing databases. In New Jersey, for example, LINCS participation among local public health departments is at 60 percent. What strategies can be employed to facilitate access to these new systems for all public health providers? In New Jersey's technology-rich environment, what role might public/private partnerships take?

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