

3723

Obtaining Resources for Prevention:
A Michigan Case Study

Submitted to:
Centers for **Disease** Control

by:
Macro Systems, Inc.

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Foreword

Prevention has broad appeal as an approach to enhancing the public's health and containing health care costs. Although many people embrace the idea of health promotion and disease prevention, translating support for the concept into funded programs persists as a challenge. Traditionally, prevention has not competed well for funding; prevention often gets uplifting rhetoric, whereas medical technologies and treatment programs win the lion's share of the resources.

Advocates for prevention need to appreciate that the decisions about resource allocation are inherently political. To compete successfully for their fair share of resources, prevention advocates must enter the political arena and learn to make the process work to their advantage.

It is perhaps most compelling for people at the State and local levels to participate in the political process to secure funding for prevention and health promotion programs in their communities. Much of the responsibility for such programs has shifted from the Federal to State and local governments. Prevention advocates should not expect increasing Federal dollars for health promotion, and, instead, should look more to their own State and local systems as a source of funding.

The task is not simple. Advocates must abandon the notion that legislators will support prevention simply because it is "the right thing to do" and instead, must seek ways to make the issue benefit all key players in the political arena. The job of winning support for prevention and health promotion is not a task for the faint of heart: it is frustrating, time-consuming, and sometimes tedious. It requires political acumen, marketing insight, skill at working with coalitions, and plenty of persistence.

Prevention advocates in the State of Michigan succeeded against overwhelming odds in winning a substantial, stable source of funds for health promotion. The story of how Michigan health workers accomplished the seemingly impossible can guide and inspire others in their effort to secure funds from State legislatures or local governments. Public health advocates in Michigan succeeded because they understood the political climate in their State, they knew how to work with the State legislature, and they appreciated the value of broad-based coalitions. The Michigan experience can serve as a blueprint for other States. Each State will have its own unique set of constraints and opportunities in its quest for resources; no one will be able to replicate Michigan's experience exactly. But others can learn from the process and can apply lessons from Michigan to advantage in their own settings.

Chapter I

**Linking Risk Reduction and
Cost Containment in Michigan**

Chapter I. Linking Risk Reduction and Cost Containment in Michigan

I. Introduction

During the period 1984 through 1988, the State of Michigan developed a unique approach for funding a major public health prevention program. Based upon behavioral risk factor data and cost/benefit data, convincing arguments were made for the value of health promotion and disease prevention programs as a means of health care cost containment. This information was strategically used to support State legislation authorizing comprehensive statewide health promotion programs.

This report documents the processes, strategies, and events that led to the successful passage of legislation and subsequent implementation of the program. Its purpose is to summarize lessons of the Michigan effort that may be helpful to other State and local units that are interested in adapting it to their own settings.

The report is organized in six chapters. Chapter I sets the scene for the introduction of risk reduction as a long-term strategy for cost containment in Michigan. Chapter II discusses the initial legislative effort--its failure to secure funding, but its success as the foundation for a second attempt. Chapter III explains the activities leading to the second attempt and Chapter IV documents the successful effort. Chapter V presents the lessons learned, and Chapter VI summarizes implementation of the risk reduction program.

Reconstruction of the Michigan experience was achieved through an extensive review of documents associated with the effort and personal interviews with 19 key individuals involved in the process.

II. The Prevention Climate in the Nation

The focus on health promotion that resulted in the Michigan Health Initiative began more than a decade ago. In the late 1970s and early 1980s, a new perspective on health was sweeping through the public health world. This new viewpoint held that the major causes of -death and illness, chronic diseases and injury, were largely preventable. In many cases, individuals hold the key to prevention by changing personal behaviors such as smoking, substance abuse, poor nutrition, and sedentary lifestyle.

The landmark Canadian document published in 1974, *A New Perspective on the Health of Canadians*, widely known as the Lalonde report, framed the issue. The report presented a conceptual model that characterized the health field by four elements: human biology, environment, lifestyle, and health care organizations. Lifestyle problems accounted for a significant portion of disease and death, yet typically, programs to modify health risk behavior received minimal support from government, especially in comparison with funding for health care. The Lalonde report suggested that significantly increased resources be directed at efforts to modify lifestyle behavior.

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In the United States, an analysis of factors contributing to the leading causes of death estimated that at least half the deaths in 1976 were due to unhealthy behavior or lifestyle and were potentially preventable. Two major U.S. government documents articulated the new perspective and influenced public health planning. ***Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*** announced in 1979 that "prevention is an idea whose time has come" and set national risk reduction goals for people in various age categories. The report addressed necessary elements of health promotion--smoking cessation, reducing alcohol and drug misuse, improved nutrition, **exercise** and fitness, and stress control--and recommended preventive health services and environmental protection. ***Preventing Disease: Objectives for the Nation*** followed in 1980, setting specific, measurable targets for health improvement by the end of the decade. The net result of these publications and other initiatives of the Federal Government was to coalesce interest in health promotion efforts.

The Health Education Risk Reduction Grants Program (HERR), initiated in 1980 and managed by the Centers for Disease Control, was an innovative Federal grants program that enabled virtually all State health departments to enhance their internal capacity to organize and support the delivery of health promotion programs at the local level. With HERR program support, numerous States, including Michigan, established rather sophisticated programs. In 1983, the Reagan Administration's decision to combine categorical grants into "block grants" resulted in substantial cutbacks in the HERR program three years after its initiation. To the credit of health promotion leaders in the States, most programs survived the unexpected changes and still use block grant resources for support, although some programs were severely cut and a few totally eliminated.

At the same time, escalating health costs related to rises in health insurance premiums, disability benefits, and sick leave were creating real pressures for business. The business community was beginning to consider health promotion as an approach to health care cost containment. Improved health of employees could reduce absenteeism, increase productivity, keep health insurance rates stable, and generally translate into improved economic conditions for industry.

111. The Economic and Political Climate in Michigan

In Michigan, economic conditions were particularly depressed in the early and mid-1980s. The recession hit Michigan's automobile **industry** severely, affecting both company profits and the State tax base. And health costs continued to escalate. By 1987, an estimated \$17.5 billion was spent on health care in Michigan. That figure amounts to 12.4 percent of Michigan's personal income, or \$1,902 annually for every man, woman, and child in the State. Policymakers cited the cost of health **care as a** major barrier to attracting new business into the State. Thus, legislative interest in health care cost containment was growing. The approach to cost containment was largely short-term and **traditional--reduce** services and practitioners. A massive education campaign would be required to change this mind-set.

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Many of Michigan's health **problems** were potentially preventable. Heart disease, cancer, stroke, and injury, which accounted for more than 70 percent of deaths in Michigan, were, to a great extent, related to lifestyle choices. Even if legislators could be convinced that (1) contrary to their beliefs, prevention encompassed more than health education, and (2) it could reduce health care costs, funding for health promotion programs seemed unlikely in Michigan's political climate **during** the early and mid-1980s. The recession had significantly eroded the State's tax base. Any proposal to raise taxes was considered political suicide, especially at a time when Michigan was trying to attract new business into the State. In fact, after an income tax increase was enacted, disgruntled voters demanded a recall election that resulted in a shift from Democratic to Republican control of the Senate. Furthermore, legislators were wary about earmarking funds for specific **programs**. Considering Michigan's shaky economy, legislators wanted the freedom to allocate tax funds from year to year as the needs of various programs changed.

Chapter II

Development of the Initial Prevention Legislation

Chapter II. Development of the Initial Prevention Legislation

I. Steps Leading to Vitality in Michigan (VIM) Legislation

In May of 1983, the Michigan Senate passed Resolution 113, creating a special committee to study alternative approaches to health care cost containment, make recommendations, and draft relevant legislation. In April 1984, Senator Alan Cropsy, the Republican Chairman of the Senate Special Committee on Health Care Cost Containment, appointed an "Ad Hoc Medical and Health Provider Committee" and charged it with studying constructive, **long-term** strategies to **reduce** health care costs.

The Ad Hoc Committee appointed a prevention subcommittee, the "Health Provider Prevention Advisory Subcommittee," which provided the impetus behind the prevention approach. The Subcommittee's preliminary recommendations, submitted in May 1984, advanced a concept that was not generally accepted at the time--that of a long-term approach to reducing health care costs. They acknowledged the need to address immediate problems with short-term cost-containment efforts, but encouraged concurrent efforts to seek more permanent solutions through prevention. Knowing the Senate's interest in improving Michigan's economic climate, they shaped a prevention strategy that established a link between risk reduction and economic growth in Michigan. They purposely selected the terminology "risk reduction" because it connoted a positive, concrete action.

The Subcommittee addressed six risk factors: smoking, drinking, **nonuse** of seat belts, high blood pressure, lack of exercise, and poor nutrition/overweight. To these risk factors they applied the concept of "Population Attributable Risk" (PAR), which shows the percentage of disease that could be eliminated if the health risk was not present in the population.⁷ Using information from the Michigan Risk Prevalence Survey and research showing the magnitude of the relationship between the health risk and the disease or condition, they quantified the total number of deaths in Michigan attributable to each health risk. Using the 1990 health objectives for the nation, they estimated the number of Michigan lives that could be saved through a reduction in the above risk factors. Then they related Michigan health insurance costs to the specific risk factors responsible for them. Against this background, they framed the following recommendations to reduce the risk factors:

- Create a trust fund to provide a self-supporting base for health promotion/risk reduction programs
- Establish a State institute to coordinate and ensure the delivery of health promotion/risk reduction services
- Identify and support local responsibility for the coordination of health promotion/risk reduction programs

⁷ The Population Attributable Risk (PAR) calculation was used effectively throughout the Michigan effort. See the Appendix for the formula and an example of its application.

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- Maintain and expand support for the comprehensive school health education program and special prenatal **care** program
- Encourage and assist in **the** development of **worksite** health promotion **programs**
- Work toward changing insurance premiums so that rates reflect risk factors
- Emphasize **support** for prevention programs. State government health expenditures should progressively reflect increased support for prevention relative to treatment.

The Subcommittee's report was endorsed by the Ad Hoc Medical and Health Advisory committee on September 11, 1984 and was officially adopted by **the** Senate Special Committee on Health **Care** Cost Containment on November 15, 1984. It was approved by one vote, which was secured when a persistent staff member encouraged the last minute attendance of the Senator providing the swing vote. Senator Cropsey instructed the committee to formulate legislation based upon the recommendations.

II. VIM Legislation: Senate Bills 4, 5, and 622

Senate Bill 4, the program authorization bill, and Senate Bill 5, the funding bill (a cigarette tax), were introduced on January 9, 1985. Senate Bill 622, an additional funding bill, was introduced on January 15, 1986. It attempted to tax cigars and smokeless tobacco products when it appeared **that** the cigarette tax would be unsuccessful.

Senate Bill 4 contained five major components:

- The creation of a VIM Trust Fund in the Department of Treasury
- The formation of an 1&member Health Promotion and Risk Reduction Commission composed of nine agency directors and nine public members--three appointed by the Governor, three appointed by **the** Senate Majority Leader, and three appointed by the Speaker of the House
- The development and operation of risk reduction programs through community health agencies
- The appointment of a local steering committee of up to 11 members for each participating community health agency
- The establishment of a Center for Health Promotion and Risk Reduction within the Michigan Department of Public Health.

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Under this legislation, the major authority rested in the Commission, which would be charged with establishing priorities for the statewide distribution of funds to community health agencies.

The legislation attempted to solidify community support by generating strong local involvement. Ninety percent of the resources would be distributed through the community health agencies. These agencies (either local health departments or, if they declined the designation, another agency within their service area) would solicit proposals for risk reduction programs **from** local public and private sector organizations. They would also serve as information and referral clearinghouses, and would collect and analyze data to assess both risk factors and programs in their communities. Local steering committees would review proposals and make funding recommendations for risk reduction programs to the Commission.

The Center for Health Promotion would advise the Commission on the funding recommendations submitted by the community health agencies. It would also collect and analyze risk factor data, identify strategies for expanding health promotion initiatives, sponsor research and demonstration projects, sponsor a media campaign, and serve as an information and referral clearinghouse.

The legislation included language to ensure that VIM funds were to be used to promote the recommended programs and were not intended to supplant any funds **already** in place for health promotion and risk reduction.

On the premise that many preventable diseases are due to smoking, Senate Bill 5, the VIM funding bill, recommended that the \$10 per pack State cigarette excise tax be directed to the VIM Trust Fund. This tax has been levied previously, but not earmarked for a specific **program**. Revenue estimates ranged from \$100 million to \$110 million annually. Revenues were to continue until the trust fund **reached** \$150 million, at which time the program would be self-sufficient. Senate Bill 622 provided additional revenue to VIM by leveling an excise tax on cigars, noncigarette smoking tobacco, and smokeless tobacco, which had previously been untaxed. Revenue **from** this tax would provide an additional \$14 million. Thus, projected total revenue for the VIM Trust Fund ranged from \$114 million to \$124 million.

On January 10, 1985 Senator Cropsey introduced the bills to the public through a major press conference, at which apples were distributed to all attendees. Present at the press conference were the Chairman of the Senate Committee on Public Health, the Chairman of the Senate Appropriations Subcommittee on Public Health, and the Chief Medical Officer of the State Health Department. **More** than 100 **representatives** of various groups supporting the legislation also attended. The press release that was distributed hailed the legislation as a major Republican effort. Senator Cropsey **was** quoted: "Republicans have devised the most comprehensive and positive way to combat the rising cost of health care yet." This partisan expression was a surprise and a minor setback.

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III. The VIM Legislative Challenge

With the creation of the legislation, the debate on health promotion moved from a programmatic to a political level. Key staff leadership, from the Senate's Program and Policy Office and the Office of Health and Medical Affairs, joined forces to address the myriad problems of gaining political support for a new concept that had no short-term, visible political impact.

They had a difficult time securing co-sponsors for the bill. They met a lot of skepticism and a perception, prevalent at the time, that health promotion results in longer life, thus increasing the financial drain by the elderly on the workforce. There were also some innuendos that health promotion was simply a "pork barrel" program for the Health Department. They met resistance from the Democrats, who viewed health as a traditionally Democratic issue that had been usurped by the Republicans. They faced the customary political objection to earmarking funds--a loss of flexibility in the budgeting process. And they began to hear from the special interest groups who wanted to know what was in it for them.

In addition, the legislation itself was receiving some criticism. Senate Bill 4 required that 90 percent of the available funds be disbursed through the community health agencies, under the direction of the commission. With three appointing authorities (the Governor, the Senate Majority Leader, and the Speaker of the House), the Commission had no clearly defined accountability. In addition, the Health Department would be responsible for running the Center for Health Promotion and directing 48 local health departments to conduct programs, but it would have no authority as to how these programs would be run.

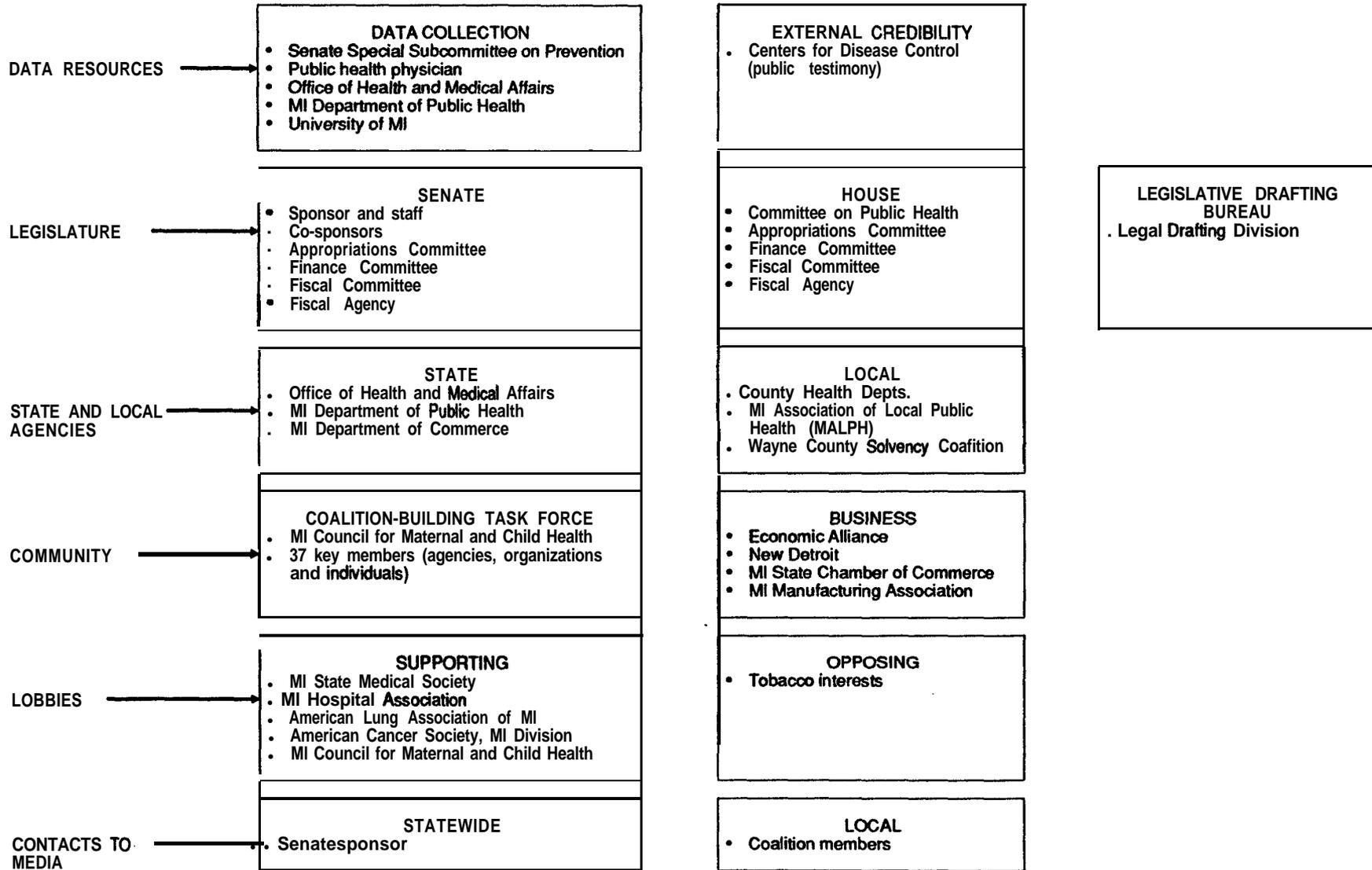
Clearly, staff leaders needed to devise and launch a forceful and sophisticated strategy if they were to have any chance of passing this legislation.

IV. The Process of Building Support

The process of gaining approval for legislation is a slow one; momentum must be built and maintained on several levels. Recognizing this requirement, staff leaders simultaneously sought to educate the legislature directly, build grass roots support to influence the legislature indirectly, and generate administration support for VIM. The coalition-building process began even before the legislation was completely written. Early involvement of legislative staff, community organizations, lobbyists, and State agency personnel was crucial to the effectiveness of the effort. "Countless hours and endless meetings" is the phrase that those involved use repeatedly to describe the process. Exhibit II-1 shows the key players in the support process throughout both the first and second legislative efforts.

EXHIBIT II-1

OBTAINING RESOURCES FOR PREVENTION IN MICHIGAN: KEY PLAYERS



Chapter II. Development of the Initial Prevention Legislation

A. Educating the Legislature

The initial thrust was designed to convince the legislature of the credibility of the prevention approach. Within a month of the press conference that introduced the VIM legislation, two public hearings were held. Speakers **were** almost uniformly positive about the legislation; however, two reservations were expressed. One concerned the wisdom of “earmarking” funds for a special program; the other questioned whether the State could afford to undertake a program of this magnitude.

Critical testimony was provided by Marshall **Kreuter**, Ph.D., Director, Division of Health Education, Centers for Disease Control. Dr. Kreuter testified that Senate Bill 4 was grounded in a solid scientific base as evidenced by the work of universities, the Carter Center, the Centers for Disease Control, and the American Public Health Association. He called VIM an “imaginative and responsible plan ... that will serve as an exemplary model the world over.” Dr. Kreuter’s testimony validated the data produced by Michigan proponents of the risk reduction legislation. It influenced doubting Senators and gave staff a needed credibility boost. This testimony was a critical turning point for the acceptance of the legislation as a serious approach to cost containment rather than as a health group special interest effort.

During the same time period, key staff leaders arranged to offer free health risk appraisals” to members of the legislature. This was a calculated effort to invest legislators in prevention on a personal basis. The Mid-Michigan District Health Department provided the staff, the Senate donated a room, and the University of Michigan contributed computer support. Printouts were distributed to legislators who participated. The impact of this initiative was enormous. It personally invested the legislator in the issue; it illustrated by example that health promotion was much more than health education; and it reversed the views of many legislators—including one who, although initially opposed, would become the champion of subsequent health promotion legislation.

Throughout all of these efforts, House and Senate staff, fiscal agency staff, and staff of key legislators were continually involved so that any emerging problems could be addressed before VIM reached the floor. A special effort was made to invite the staff of opposing legislators to attend meetings so that the reasons for their opposition could be aired and addressed.

B. Building Grass Roots Support

A legislative “hot button” during the eighties has been the issue of infant mortality. Michigan was experiencing high rates of infant mortality, and Senator Cropsey was especially interested in expanding prenatal care. In exchange for his support of the

* A health risk appraisal is a questionnaire, based on medical history, family history, and lifestyle behaviors, that **assesses** an individual’s level of risk for illness and injury. It provides information on target behaviors that can reduce identified risks.

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funding bills, which he introduced despite his usual opposition to tax increases, he included in the authorization bill a program to provide prenatal care services for women who were not eligible for other publicly supported programs and who were not able to pay for such care. Senator **Cropsey's** position paved the way to an entry point for coalition building--the Michigan Council for Maternal and Child Health.

The Council, when approached by staff leadership, was little more than a year old. It was a coalition of three ambulatory and three institutional providers funded to lobby full time on a generic basis; that is, not for its individual members, but to ensure the constituents of its members access to 'the health care system and adequate prenatal **care**. The Council's board of directors voted to commit 9 months and 80 percent of their resources to the VIM lobbying effort. They supported the legislation, but they also believed that their involvement would develop new networks to further their own mission.

A coalition task force was established, under the cochairmanship of the executive director of the Michigan Council for Maternal and Child Health and the chairman of the Senate Prevention Subcommittee.

The task force reviewed the legislation and identified three major areas in which support was needed: the private sector, business, and the health community. Subcommittees were formed to address each of these areas. Under a University of Michigan program, a graduate student was "**borrowed**" to serve as staff to the subcommittees and ensure prompt followup.

The subcommittees were charged with educating the public. A major strategy of the educational approach was to identify concerns and opposition from the field. Surveys were prepared and disseminated and responses were returned to the task force. At its meetings, the task force attempted to respond to the concerns. They invited Senate and House fiscal analysts and, especially, key opposition leaders to task force meetings to participate in resolving the problems. They published newsletters to answer the most frequently asked questions.

A media component was included in the lobbying effort. Groups and individuals were asked to feed informational articles to their local media. The articles did not take a position; they simply provided information on prevention. Through their clipping services, legislators learned the extent of local interest in the VIM legislation.

One of the major problems facing the **task** force was securing the support of the business community. The three major organizations representing this community were the Economic Alliance, New Detroit, and the Michigan State Chamber of Commerce.

The Economic Alliance is a consortium of the major business and labor groups whose agenda includes health care cost containment -interests. The "big three" automobile manufacturers are among its members. The Alliance had conducted enough research to appreciate the need for a long-term health promotion strategy. It

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was in their interest to have the cost of health promotion programs shared by **the** State; otherwise they would have to bear the burden themselves. Thus, **they** were supportive of the legislation.

The mission of New Detroit, a coalition of business and community organizations formed in the late sixties, concerned the future of Detroit. They had a health component in their agenda that meshed with the intent of **VIM**; therefore, they too were supportive.

The Michigan State Chamber of Commerce is a conservative organization normally opposed to all new taxes; on this basis they opposed the VIM legislation. Through its field efforts, VIM leadership learned that some local Chambers of Commerce were involved in prevention efforts and were supportive of the VIM legislation. By challenging the State Chamber of Commerce on the lack of consensus among its members, VIM leadership effectively neutralized any official opposition from them.

One of the key accomplishments of the VIM coalition building effort was that it made few concessions to achieve its goals. Early in the effort, the Michigan Hospital Association, responding to the new need for diversification by hospitals, insisted that hospitals be eligible to apply for local prevention grants. This concession was made in exchange for their support.

Other groups, such as the American Lung Association of Michigan, supported VIM largely because its funding mechanism meshed with their agendas. Because evidence indicates that taxing tobacco products discourages use, the tax alone was a health promotion incentive deserving Lung Association support. Since respiratory issues and smoking were not driving the legislation itself, the Lung Association found it difficult to involve its volunteers. As do many organizations who join a coalition, the Lung Association sublimated its individual identity to lend generic support to the effort.

Exhibit II-2 lists the members of the coalition-building task force. As the legislative process moved forward, additional groups lent their support to VIM. "In my 10 years around the State Capitol, I have not seen a legislative package endorsed by the variety of organizations that have endorsed this one," stated one observer.

On May 14, 1985, the Senate Committee on Public and Mental Health reported the authorization bill out of committee with recommendation for passage. The funding bill remained in the Senate Finance Committee, but it was tie-barrred to the authorization bill. (Tie-barring is a process that requires passage of both bills.) Since prospects for passage of the funding bill **were** dim, it appeared that the authorization bill would die without action.

EXHIBIT II-2

VIM Coalition-Building Task Force

Chairpersons: Paul Shaheen
William **Thar**, M.D., M.P.H.

American Health Services
American Lung Association of Michigan
American Red Cross, Southeast MI Chapter
Blue Cross/Blue Shield of Michigan
Detroit Department of Health
The Economic Alliance
Health Analysts, P.C.
House Democratic Staff
House Fiscal Agency
Ingham County Health Department
Lutheran Social Services of Michigan
Mental Health Association in Michigan
Michigan Association of Counties
Michigan Association of Local Public Health
Michigan Coalition for Safety Belt Use
Michigan Council for Maternal and Child Health
Michigan Department of Mental Health
Michigan Department of Public Health
Michigan Health Officers Association
Michigan Hospital Association
Michigan Manufacturers Association
Michigan Nurses Association
Michigan Public Health Association
Michigan Primary Care Association
Michigan Rural Health Partnership
Michigan State Chamber of Commerce
Michigan State Medical Society
New Detroit, Inc.
Office of the Governor, Executive Policy Section
Office and Health & Medical Affairs, Dept. of Mgmt. & Budget
Office of Highway Safety Planning
Office of Services to the Aging
Office of Substance Abuse Services
Staff of Sen. Vernon Ehlers
Staff of Sen. Bill Sederburg
Staff of Rep. Debbie Stabenow
Staff of Rep. Alma Stallworth

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C. Generating Administration Support

In a separate but concurrent effort, the Michigan Department of Public Health was undergoing reorganization. Spurred by the report of the Senate Prevention Subcommittee, the reorganization included the establishment of a Center for Health Promotion. The proposal establishing the Center, submitted in January 1985, closely resembled the recommendations embodied in Senate Bill 4.

At this point, the Administration was not supporting Senate Bills 4 and 5. The Governor was interested in using cigarette tax revenue to increase school aid, which had been significantly cut during the recession. As the Senate legislative process moved forward, it became clear that the only way to secure Senate approval of the authorization bill was by breaking the tie-bar to the funding bill. This action led to Administration support as well as the support of additional Senators. On June 6, 1985 Senate Bill 4 was passed by the Senate.

Bringing the authorization bill to the Senate floor for a vote, in spite of knowing that it would not be funded, served an important purpose. Once Senators are on record as having voted for a piece of legislation, they are more likely to support a second attempt to pass it. The overwhelming Senate vote of **32-4** verified support of prevention. It was considered a victory for the future and positive reinforcement for interest groups.

V. The Fate of VIM

The House of Representatives supported the concept of **VIM**; however, the strategy that enabled its passage in the Republican-controlled Senate caused its demise in the Democratic-controlled House. The VIM legislation was sent to the House without a funding source. A climate of severe fiscal austerity existed in Michigan as a result of the recent recession. New taxes were anathema. The Democratic House believed they would open themselves to Republican accusations of excessive spending if they passed this legislation without a Senate-proposed funding source. They therefore let the VIM legislation die in committee rather than risk a negative vote.

Meanwhile, the Department of Public Health completed its reorganization and formed the Center for Health Promotion. The Center established a State-Federal appropriations base by program transfers and began to secure additional funding. The State Office of Health and Medical Affairs (**OHMA**), located in the Department of Management and Budget, began to work with the Center to develop and pilot test **worksite** wellness programs. The joint activities undertaken by the Center and **OHMA** fostered a link between their respective staffs and helped build a **firm** scientific base for prevention.

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VI. The Lessons of VIM

Although the legislation died at the end of the 1985-86 legislative session, it would be incorrect to call VIM a failure. It is a political reality that few major initiatives succeed on the first attempt. Public health policy efforts, particularly, are not readily accepted. Efforts to introduce fluoride, require immunization, and institute seat belt legislation are classic examples of areas that required changes in thinking over time. The leaders of VIM had realistic expectations, and turned their attention to analyzing the strengths and weaknesses of VIM. The **VIM** effort:

- Convinced the legislature that health promotion and disease prevention were important cost-containment strategies
- Fostered awareness of the link between health and economics and applied it specifically to Michigan
- Introduced the concept of a long-term strategy for cost containment through prevention
- Provided the impetus for Health Department reorganization to include a Center for Health Promotion. This commitment of State funds enabled Michigan to access Federal dollars for which it otherwise would have been ineligible.
- Created a strong coalition whose support would be available for subsequent efforts
- Led to collaborative efforts between the Office of Health and Medical Affairs and the Michigan Department of Public Health
- Created the base for a new effort by recording an official positive vote in the Senate in favor of prevention legislation.

VIM also provided some valuable lessons for future application:

- The leader of the initiative was a Senator who was influenced to label it as a Republican effort. This error limited ownership by other members of the Senate and made it difficult to secure support and visibility. Health is a bipartisan issue.
- The legislation itself had some weaknesses:

Roles and responsibilities of those assigned to implementation were not clearly **defined**. This lack of clarity led to some discord among human services agencies, each of which was trying to define its own role.

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The structure of the legislation was cumbersome. There was a lack of realization that the dispersal of funds to **48** different local health departments would be viewed as an administrative nightmare with an excessive overhead **cost**.

Authority rested with the commission; yet, with **three** different appointment sources, little accountability was possible.

- The proposed program budget was nearly as large as the State general fund **commit-**ment to all public health programs.' Proposing a budget of **this** magnitude engendered skepticism about the "pork barrel" nature of the initiative.

Chapter III

Activities Between Legislative Efforts

Chapter III. Activities Between Legislative Efforts

I. Continued Prevention Efforts

During the hiatus between the two attempts to secure prevention legislation, the Office of Health and Medical Affairs, Michigan Department of Management and Budget, and the Center for Health Promotion, Michigan Department of Public Health, continued activities to maintain the public visibility of prevention, particularly **worksite** wellness, and to generate new support. The Center for Health Promotion piloted tested six Health Education Lifestyle Programs--community interventions focusing on risk reduction. They also held five regional planning conferences that brought together health promotion advocates, corporate benefit managers, and national leaders. These conferences, facilitated through regional Chambers of Commerce, stimulated discussion of participation in Health Department **worksite wellness** programs. They published a **Worksite** Health Promotion Resource Guide; they solicited the support of unions, particularly the United Auto Workers; and, finally, they conducted a **worksite** wellness pilot program in Jackson County that served as a template for future programs **to be** conducted under the Michigan Health Initiative.

Rapidly escalating health care costs during the mid-1980s heightened interest in the potential economic savings of a prevention approach. Early in 1987, **OHMA** and **CHP** joined forces to make a valid case for the economic benefits of health promotion. With the assistance of William **Thar**, M.D., M.P.H., who had previously chaired the Senate Prevention Subcommittee, they produced a collaborative report, **Health Promotion Can Produce Economic Savings**. The foreword of the report states:

In joining efforts to prepare this publication, our respective agencies brought forward a perspective that was united in support of a goal of this administration. That is, improving the economic climate for doing business in Michigan. Michigan employers currently pay more for employee health plans than they do for the combined expenses of unemployment insurance, workers' compensation, and the single business tax. It, therefore, seems clear that if we are serious about reducing business costs, then the issue of health care is of strategic importance. In this context, it is also important that strategies affecting health care, both short and long **term**, be analyzed as to their purported cost-benefit and cost-effectiveness.

This report went much further than the **report** of the Senate Prevention Advisory Subcommittee. **OHMA** and **CHP** estimated the total cost (not just the health insurance costs) related to health risk factors by developing a computer model that projected the impact of a set of risk factor interventions on Michigan's working age population (ages **20-64**) over their working lifetime. They then estimated the return on dollars invested in the interventions to assess the cost/benefit of prevention.

Chapter III. Activities Between Legislative Efforts

The results of the model showed clearly that risk factor intervention in seat belt use, smoking, drinking, and the combined intervention of hypertension, weight/nutrition, and exercise, all returned significant dividends for their investments as illustrated by the following table:

Return on Dollar Investments in Selected
Health Promotion Interventions
(Results from a prospective computer study)*

<u>Intervention Program</u>	<u>Return on Dollar</u>
Seat Belts	\$105.07
Smoking	15.26
Heavy Drinking	2.68
Drinking/Driving	1.30
Binge Drinking	1.30
Combined Hypertension, Weight/Nutrition, and Exercise	2.07

*Discounted at 4%

The implications of these conclusions were that for economic reasons alone, prevention efforts can be cost beneficial. The report provided an important basis for decisionmaking that went beyond the intrinsic value of improving health status. Published in October 1987, the report, which had the blessing of the Administration, set the stage for a renewed effort.

II. Steps Leading to the Michigan Health Initiative

Certain key circumstances had changed during the 2 years since the demise of VIM. The Senate's Program Specialist for Public and Mental Health joined the staff of Senator William Sederburg, a Republican who chaired the Senate Committee on Health Policy.

Senator Sederburg had opposed the VIM legislation because he supported use of the cigarette excise tax to fund education programs. He had, however, been impressed by the VIM health risk appraisal and the benefits of disease prevention programs.

During the spring of 1987, the two major champions of VIM, Senator Sederburg's new health policy specialist and a consultant from the **Office** of Health and Medical Affairs, Department of Management and Budget, participated in a fishing trip with representatives of two groups that were powerhouses of the State health movement--the Michigan State Medical Society and the Michigan Hospital Association. This "calculated investment in

Chapter III. Activities Between Legislative Efforts

camaraderie” yielded four **Lake Michigan** salmon and an agreement to proceed with a second attempt at prevention legislation under the sponsorship of Senator Sederburg.

The fishing trip was followed later in the summer by a second meeting at Senator Sederburg’s home, at which the group discussed the lessons of VIM and organized a new approach.

The first step was to change the name to disassociate the new initiative from the failure of the previous one. The next step was to redraft the legislation to address the weaknesses of VIM. The third step was, as Senator Sederburg put it, to “inventory your opportunities.”

The political climate in Michigan had changed since the VIM effort. The effects of the recession were still being felt, opposition to taxes remained high, and health care costs continued to escalate. New studies reinforced the cost containment efficacy of prevention, and even the most skeptical critics--the business community--began to embrace the concept. Furthermore, AIDS had entered the health scene. Throughout the country, the AIDS panic was at its height, and such extreme measures as quarantine were being considered. In 1985, the Governor created an expert committee on AIDS; in 1987 the House of Representatives created a special subcommittee on AIDS and a Task Force on AIDS to focus on data collection and policy development. Senator Sederburg directed his staff to include AIDS in the new legislation--to be known as the Michigan Health Initiative (MHI).

Chapter IV

The Second Attempt: Success

Chapter IV. The Second Attempt: Success

I. MHI Legislation: Senate Bills 544, 545, and 546

The purpose of the Michigan Health Initiative was to prevent and control the leading preventable diseases in Michigan. It focused generically on risk reduction programs for such conditions as heart disease, cancer, stroke, accidents, and AIDS. In its original form, Senate Bill 544 was a ten-point plan:

1. Designate the Center for Health Promotion, within the Michigan Department of Public Health, as the administrative and funding distribution core for **MHI** projects. Provide fiscal support through funds earmarked for **MHI**, as opposed to revenues from the General Fund.
2. Appoint an 11-member Risk Reduction and AIDS Policy Commission. The Commission will be appointed by the Governor with the advice and consent of the Senate. Members will not represent any one disease entity; rather, they will be responsible for recommending comprehensive approaches to prevention.
3. Establish an AIDS and risk reduction clearinghouse to evaluate health risks, coordinate research, and ensure safe and pure biologic products, including the blood supply. Conduct a public service media campaign that targets risk reduction and reinforces preventive education.
4. Provide free AIDS testing, including **pre/post** test counseling.
5. Coordinate with the Federal government to make an AIDS Education Module available to every Michigan household. Make grants available to Michigan educational facilities to educate Michigan students about AIDS.
6. Make training accessible to every “at risk” health worker in the State on precautionary techniques against the transmission of HIV virus. Encourage health care facilities to develop policies to protect employees.
7. Establish a local referral and care network for AIDS patients.
8. Fund **worksite** risk reduction programs through grants to any employer or employee organization in the State. Place special emphasis on smoking, hypertension, nutrition/weight/fitness, substance use/abuse, and safety (seat belt use).
9. Legislate and implement six smoke free initiatives: Youth Tobacco Act, Day Care Center Smoke Free Bill, Health Facility Smoke Free Bill, School Smoke Free Bill, elimination of billboard advertising for smokeless tobacco, strengthening of amendments to the “Clean Indoor Air Act.”
10. Establish an AIDS treatment trust fund.

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The major difference between VIM and **MHI** was the inclusion of AIDS in the **MHI** legislation. Approximately half of **MHI activities** related to AIDS. However, the legislation was skillfully constructed to interweave AIDS with risk reduction, making it impossible to preclude passage of either area without totally rewriting the legislation. Exhibit IV-1 shows the construction of the **MHI** legislation.

Administrative responsibility for **MHI** was assigned to the Health Department rather than to a commission as called for in VIM. The Commission's role in **MHI** was advisory to the Health Department. The Governor was the sole appointing authority; therefore the accountability of the **MHI** Commission was more clearly defined than that of the VIM Commission.

Under VIM, **worksite** wellness resources were distributed through health care providers. In an unusually innovative step, **MHI** assigned **worksite** wellness grants directly to business and industry, who in turn could choose among approved providers to conduct their risk reduction programs. This measure improved **MHI's** credibility in the business community.

The sources of revenue for **MHI** were a proposed 6 cent increase in the cigarette excise tax (Senate Bill 545) and a new tax on smokeless tobacco products, bulk tobacco, and cigars--which had never been taxed in Michigan. **MI-II** would receive 2 cents of the cigarette tax (\$24 million per year) as well as all revenue from the tax on other tobacco products (\$14.4 million per year). Another 4 cents of the cigarette tax would fund the AIDS Treatment Trust Fund (\$48 million per year). This trust fund was developed deliberately to draw all revenue to **MHI** and entice those competing for AIDS funds into a large coalition. The funding would total \$86.4 million per year.

On September 17, 1987, **MHI** was introduced to the public at a press conference held by Senator Sederburg with the Michigan State Medical Society, the Michigan Hospital Association, and the Coalition on Smoking or Health. Representative Robert Emerson, the Democratic chairman of the House Subcommittee on Public Health Appropriations, attended the press conference as the probable sponsor of corresponding House legislation. His attendance at the press conference publicly promoted **MHI** as a bipartisan, bi-house effort.

Senator Sederburg distributed a report explaining the legislation. He characterized the plan as complicated and expensive. "So is AIDS. So are cancer and other preventable diseases," he added. "We have seen a wide variety of scattered approaches to AIDS and health care cost containment suggested, but it's crucial we create a focused, centralized program that uses resources efficiently." The bills were introduced in the Senate on November 10.

II. The **MHI Legislative Process**

By the fall of 1987, the legislature was generally convinced of the value of prevention as a cost containment tool. They were aware of continuing support for the concept by the business and community coalition organized during the VIM initiative. They were also

EXHIBIT IV-1

Outline of Michigan Health Initiative Legislation

Original 10 Point Plan and 8 Point Plan as Enacted

Plan Component	Subject Area	
1. Administrative Core/Funding Distribution (Center for Health Promotion)	Risk Reduction*	AIDS
2. Policy Commission	Risk Reduction	AIDS
3. Clearinghouse and Public Service Media	Risk Reduction	AIDS
4. AIDS Testing and Counseling		AIDS
5. AIDS and Risk Reduction Education Modules	Risk Reduction	AIDS
6. AIDS Provider Protection and Confidentiality Rules		AIDS (Confidentiality statutes deleted)
7. AIDS Local Referral and Care Network		AIDS
8. Worksite Risk Reduction	Risk Reduction	AIDS
9. Smoke-Free Legislation	Deleted	
10. AIDS Treatment Trust Fund	Deleted	

* Risk reduction. refers to prevention programs other than AIDS (e.g., smoking cessation; hypertension control; nutrition and weight loss; heart disease, cancer, and injury prevention; etc.)

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aware that the Administration endorsed a prevention approach as a means of luring new business to Michigan. Nearly every legislator was eager to make a concrete response to the AIDS problem and its long-term financial needs.

Earmarking of funds was still an issue in Michigan. In 1954, Michigan earmarked 67 percent of its General Fund dollars; by 1984 that amount had decreased to 39 percent. Legislators who supported earmarking argued that it guaranteed a minimum level of program **expenditures**, contributed to financial stability, and ensured continuity for specific projects. They believed that earmarking funds for AIDS would be both reassuring to the public and commensurate with the magnitude of the problem and its long-term financial needs.

Senator Sederburg understood the current political milieu. The process used to move MHI through the legislature relied heavily on his political skill, credibility, and bipartisan connections.

A. The Senate

The MHI program authorization bill, Senate Bill 544, was assigned to Senator Sederburg's committee--the Senate Health Policy Committee. This committee included three doctorate level members--a physician, a nuclear physicist, and Sederburg himself, whose Ph.D. is in Political Science/Public Administration. It was recognized as the most highly educated State committee in the United States. Senator Sederburg's health policy specialist made a special computer presentation to this committee. It recapped the history of VIM and the proposed MHI. This presentation was the first of many private showings to legislators to familiarize them with the merits of MHI. It was visual; it was intimate; and it did not require extensive reading. Response indicated that it was an impressive medium for conveying the message.

Approval by the Senate Health Policy Committee gave additional credibility to MHI. Senate Bill 544 reached the Senate floor on December 3, 1987. Several attempts were made to add floor amendments to the bill, particularly in the area of AIDS regulations. Senator Sederburg was successful in resisting these amendments, thereby preserving the purity of the prevention approach. Senate Bill 544, with only technical amendments, passed the Senate by a vote of 33-0.

The two funding bills, Senate Bills 545 and 546, were assigned to the Senate Finance Committee. Tobacco products had become a coveted source of revenue in Michigan. A strong tobacco lobby applied continual pressure to the Finance Committee to resist the imposition of additional excise taxes on cigarettes as well as new taxes on cigars and smokeless tobacco products. Senate Bills 545 and 546 remained in committee. Senator Sederburg, however, was in an advantageous position. As sponsor of the **first** tobacco legislation submitted to the current session, protocol required that anyone competing for assignment of these taxes negotiate with him. His position was further enhanced since he was a member of the Senate Appropriations Committee.

B. The House

While the bills were proceeding through the Senate, Senator Sederburg's health policy specialist began to negotiate with House leaders. **MHI** was assigned to the House Committee on Public Health. Its chairman, Representative Michael Bennane (**D**), had Certificate of Need legislation that he wanted to move through Senator Sederburg's committee. The two legislators agreed to introduce both bills to their respective committees and let the committee debate proceed on the merits of the legislation.

Senator Sederburg continued to solicit the support of Representative Robert Emerson. Representative Emerson believed in the **MHI** concept, but offered his support only if the package included a Senate-proposed funding mechanism. Although the initial legislation would not move through Representative Emerson's committee, his support was crucial. If the legislation passed, the line item appropriation would appear annually in the health appropriations bill, and his committee could endorse or reject it. Furthermore, Representative Emerson was in a position to help neutralize the House Finance Committee, which was under the same pressure from the tobacco lobbies as the Senate Finance Committee.

C. The Conflict and the Compromise

The Wayne County Solvency Coalition was **MHI's** major competitor for cigarette tax revenue. The coalition represented Michigan's most populous county that includes the city of Detroit. Wayne County consumes approximately 60 percent of Michigan's health care costs. Health care for the indigent was creating a massive financial drain that was threatening to bankrupt Wayne County. Included in the Wayne County deficit was a \$127.7 million debt to the State. The State was required to have a balanced budget and could not write off this debt--so' there was every incentive to resolve Wayne County's fiscal crisis.

Both the Wayne County Solvency Coalition and **MHI** were having difficulty securing an adequate number of Senate votes for their respective efforts to co-opt the cigarette tax. The Wayne County advocates approached Senator Sederburg to suggest joining forces. An agreement was reached to submit a coalition bill that would give Wayne County 4 cents and **MHI** 2 cents of the cigarette excise tax.

This compromise failed to address the interests of legislators from more rural areas served by local public health departments. The health officers of these departments perceived a limited role for themselves within **MHI**--the mandated counseling to accompany AIDS testing. At the time, only about a half dozen local health departments were involved in **worksite** wellness, and funds were not available to increase this involvement, The Michigan Association for Local Public Health (MALPH) had lobbied Senators representing rural areas to secure a larger role for local public health departments.

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Without the votes of these legislators, the funding bill still would be unable to pass the Senate. Senator Sederburg's office contacted **MALPH** to offer a compromise. He asked **MALPH's** participation in writing the language that would include them more fully in the legislation. **MALPH** recognized that a prompt response' was critical. A compromise was reached and Senator Sederburg agreed that 1 cent of the 2 cents designated for **MHI** would be distributed at the State level and 1 cent would go to local public health departments on a per capita basis to be used for implementation of prevention programs. This compromise reduced the impact of **MHI** by cutting its State funding substantially; however, it was the only way to secure adequate votes for passage from Senators representing rural areas.

The proposed 6-cent increase in the cigarette tax was unacceptable to the Senate Finance Committee, which refused to report the bills to the Senate floor. Meanwhile, the MI-II bill was already on the House floor--still without a funding mechanism. Representative Emerson advised Senator Sederburg that a House bill that levied a tax on computer software had reached the Senate floor; the funds on this bill were not earmarked because of a previous loophole that viewed computer software as a service rather than as a product. Senator Sederburg spoke to the sponsor of this bill, who agreed to earmark the computer software tax for **MHI**. The software tax had the potential to raise millions of dollars for **MHI**. The State treasurer wanted a ceiling on the amount earmarked for **MHI** and Senator Sederburg wanted a floor. After 3 hours of debate, during a late evening session outside the Senate chambers, Senator Sederburg's health policy specialist secured a \$12 million ceiling and a \$9 million floor.

MHI was now funded, and Senator Sederburg renegotiated the distribution of the cigarette excise tax in a continuing effort to move this legislation out of committee. Senator Sederburg and the Wayne County Coalition agreed to reduce the cigarette tax from 6 cents a pack to 4 cents a pack. This reduction was based on the theory that a **4-cent** tax would be more palatable to the cigarette manufacturers. (Machine sales of cigarettes would require the deposit of a nickel, and the excess cent would accrue to the cigarette companies.) Under the proposed **4-cent** tax, Wayne County would receive 3 cents and local health departments would receive 1 cent to be used for preventive health services. At this point, no action had been taken on the second revenue source--the tax on cigars and smokeless tobacco products. The MI-II leadership hoped that the reduction in the cigarette tax coupled with lack of action on the new tax on smokeless tobacco products would convince the tobacco lobbies to accept the proposed compromise.

It was now late in December of 1987, and an "eleventh hour" situation existed if the bills were to pass before the legislature's year-end adjournment. The pressure for resolution in the minimal time remaining for- decision, debate, and language changes was emotionally draining on **everyone involved**.

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Most of the pressure was to resolve the Wayne County situation. The only way to secure the **required** votes to do so was to combine MI-II, Wayne County, and local health department issues into one package. Still, the funding bills remained in committee. Senator Sederburg had secured the support of the Senate Majority Leader, who wanted to pass this legislation, not only to relieve the Wayne County debt, but because it had the potential to attract new business to Michigan. With his assistance, a motion from the Senate floor forced the Senate Finance Committee to discharge the compromise funding bill without committee action. The version that reached the Senate floor proposed a 1-cent increase in the cigarette excise tax. In an almost auction-like atmosphere, the Senate raised the tax to 4 cents a pack, and passed the cigarette excise tax and the computer software tax as a funding package. The package then moved to the House, where the cigarette excise tax was applied to the House version of the Wayne County relief bill, called the "Health and Safety Fund Act." Upon passage by both Houses, the Governor signed the package into law on December 28, 1987.

III. The Final Package

In its **final** version, MHI became an "eight-point program." The first eight components, shown on Exhibit IV-1, **remained** in the bill. The smoke-free initiatives were deleted from Senate Bill 544 and introduced subsequently by Senator Sederburg as separate legislation. These six anti-tobacco bills passed the Michigan legislature in 1988 to complete the total MHI project. The AIDS Treatment Trust Fund was deleted when the total available resources were reduced. This deletion was anticipated when the legislation was drafted. The Trust Fund was inserted as a separate category to prevent the total unbundling of other AIDS initiatives from the MHI effort. Other than these changes, the legislation passed as written.

The final funding bills were the Sales Tax on Software amendment to the General Sales Tax (House Bill 4608) and the Health and Safety Fund Act (House Bill 5168). The computer software tax amendment provided that a minimum of \$9 million and a maximum of \$12 million annually be deposited to the Michigan Health Initiative Fund. The Health and Safety Fund Act provided for direct funding to counties from resources generated by an increase in the cigarette tax. Initial funding (\$16 million annually) would go to Wayne County for debt repayment to the State. After debt repayment, 1 cent of the cigarette tax would pay for indigent health care provided by Michigan hospitals. The remaining \$17 million would be distributed to Michigan's other 82 counties on a per capita basis. This money could be used to provide property tax relief; however, if not used for property tax relief, \$6 million would be used for county jails, juvenile facilities, and court operations, and \$11 million would be used for local implementation of prevention programs. Local health departments were required to apply a portion of these funds to pre- and **post**-counseling services offered in conjunction with the free AIDS testing program.

These two legislative packages were passed with mutual support and cooperation, in spite of having different sponsors. None of the counties elected to use the funds for property tax relief because the amounts returned to individual taxpayers would have been negligible.

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Therefore, the legislation provided a minimum annual allotment of \$20.2 million to public health prevention efforts through both State and local health departments. The MHI vehicle bill and the funding package to support it represented a landmark policy shift in Michigan toward preventive health care.

In a **followup** step **rarely** seen in political circles, Senator Sederburg issued a report titled *Michigan's Health Initiative As Enacted*. The report informed interested parties of the final outcome of MHI legislation, but beyond that, its publication was a message to everyone involved that they were valued contributors.

Exhibit IV-2 is a visual representation of the key events of the entire legislative effort. A brief chronology of these key events can be found in the Appendix.

EXHIBIT IV-2

OBTAINING RESOURCES FOR PREVENTION IN MICHIGAN: A CHRONOLOGY

	1983	1984	1985	1986	1987	1988
JAN	Tax increase causes recall election resulting in shift from Democratic to Republican control of MI Senate.		VIM legislation is introduced. Health Department reorganizes and forms Center for Health Promotion. Large coalition promotes legislation at state and local levels.	Legislation to tax smokeless tobacco products is introduced but dies in Senate Finance Committee.	House appoints two committees to develop AIDS policies.	Wayne County solvency package begins implementation.
FEB						
MAR						
APR						
MAY	Senate Resolution 113 creates special committee to study alternative approaches to health care cost containment.	Prevention subcommittee of Senate special committee submits recommendation to approach cost containment through prevention.			Key VIM leadership meet to discuss strategy for new legislative attempt.	
JUN			program authorization bill passes Senate. Funding bills die in Senate Finance Committee. House refuses to pass authorization bill without funding bill.	OHMA and CHP continue efforts to maintain the visibility of prevention through conferences, publications and pilot tests		
JUL						
AUG						
SEP		Efforts begin to develop a broad-based coalition to support proposed prevention legislation.				
OCT			OHMA and CHP develop and pilot test worksite wellness programs for school employees.		OHMA and CHP issue report, Health Promotion Can Produce Economic Savings. Report is endorsed by the Administration.	
NOV		Senate Special Committee on Health Care Cost Containment accepts recommendations of prevention subcommittee and publishes report, Health Care Cost Containment: A Preventive Strategy.	Governor appoints expert committee on AIDS.		MHI legislation is introduced. "Eleventh hour" funding negotiations are conducted.	
DEC					MHI package is signed into law by Governor.	

Chapter V

Lessons Learned from the Michigan Experience

Chapter V. Lessons Learned from the Michigan Experience

The Michigan experience offers several lessons to anyone seeking revenue for health promotion through a State or local legislative process.

1. **Know your State, its current economic climate, and its political biases.** Explore your State's attitude toward such issues as taxation, earmarking of funds, use of general funds, self-supporting mechanisms, and special interests. The Michigan Legislature, for example, was generally opposed to earmarking funds for specific programs. They relaxed that opposition when they understood that the earmarking was not in perpetuity--the original VIM legislation was designed to become self-supporting in ten years. Identify powerful lobbies and explore ways to work with them. Don't be discouraged if the picture is bleak. What could be worse than the situation faced by Michigan--economic recession, eroded tax base, escalating health care costs, anti-tax sentiment, wariness about earmarking funds? Yet they turned a negative situation into a winner by positioning disease prevention and health promotion as a means to address these problems.
2. **Identify committed, influential leadership.** Of all the elements that contributed to the success of Michigan's effort, this one was by far the most important. Leadership is needed on several levels.

The **first** requirement is for dedicated leaders who will continuously and persistently coordinate the entire effort from start to finish. Throughout the entire four years of the Michigan effort, continuous leadership was provided by two persons:

- A consultant **from** the Office of Health and Medical Affairs intervened with various state agencies, worked with the Health Department and other agencies to pilot test programs, and developed the MI-II budget.
- A Senate health policy consultant negotiated with legislators, tapped Senate resources for reports and publicity, and coordinated the drafting of the legislation.

That one of these leaders was from a State agency and the other from the Senate was no accident. Their joint leadership enlarged the circle of contacts for the initiative and enabled development of the numerous diverse relationships on which success depended. Together these two leaders were the negotiators and marketers for the initiative. They did everything from arranging fishing **trips** to ensuring that Senators attended meetings requiring their votes.

Both of these leaders were health professionals with knowledge of the prevention field as well as the legislative process. It is important either to identify qualified health professionals who are serving as legislative staff or to get an appropriate candidate into a political staff position.

Chapter V. Lessons Learned from the Michigan Experience

Several considerations impact **the** selection of a legislative sponsor. The sponsor must be personally invested in the effort and must represent the party in power in the body (House or Senate) in which the legislation will originate. The sponsor should serve on enough powerful committees, including the Appropriations Committee, to generate bipartisan support and to turn unexpected events to his or her advantage. The sponsor should be highly respected by colleagues, be able to debate his or her position convincingly, and be able to secure co-sponsors. Senator Sederburg, because of his graduate degree, his academic background, and his interest in education, was credible to other legislators as the sponsor of this legislation.

It is also important that the legislative sponsor have appropriate and available staff. After Senator Sederburg agreed to sponsor the MHI legislative, the Senate staff person who had led **the** VIM effort moved to Senator Sederburg's staff to provide continuity.

Once key leadership is identified, other leaders can be selected as needed. Leaders are most effective when they have a vested interest in the process. For example, the Michigan coalition task force was co-chaired by the executive director of the Michigan Council for Maternal and Child Health. While he was interested in the prevention legislation, he was also interested in the opportunity to develop new networks that would further his organization's own mission. The meshing of these two goals resulted in dedicated leadership on the part of the coalition co-chairman.

3. **Back your initiative with credible data.** It is critical to be clear about the message you want your data to convey **before you** begin **the** data collection process. Leaders of MHI knew that health care cost containment was the salient health issue for Michigan legislators. They built their data presentation around the theme "health promotion can produce economic savings." They obtained data to illuminate that theme and refrained from including extraneous or unnecessary data.

They based the data on State conducted surveys (Michigan Risk Prevalence Survey) rather than on data extrapolated from national surveys. Data derived from their own constituencies had **greater** appeal to State legislators than national data. They enhanced **the** credibility of their data by developing it under the direction of a Michigan public health physician.

4. **Use the data wisely.** Data was used most effectively in the MI-II initiative. It was presented on several levels to ensure reaching the scientific community, legislators, and potential supporters of the legislation.
 - First, a complete report was prepared and distributed (**Health Promotion Can Produce Economic Savings, see Appendix: References**). The report provided background, on health promotion and risk factor reduction, explained Population Attributable Risk (PAR), delineated the economic relationship between risk factors and disease, and presented data on selected 'risk factors. An appendix to the report described the methodology. This full report reinforced the credibility of the data collection effort.

Chapter V. Lessons Learned from the Michigan Experience

- The report **also** enabled scientists from outside of Michigan to support the data. According to Michigan policymakers, the public hearing testimony of Marshall Kreuter, Ph.D., Centers for Disease Control, validated the data for many legislators.
- MHI leaders were aware that most legislators would not read the full report. They prepared a one-page summary which was printed on the back cover of the full report. The summary showed “return on dollar investments in selected health promotion interventions.”
- MHI leaders also prepared a slide presentation, which was especially useful in coalition-building efforts.
- Finally, in a creative approach, they reinforced the data painlessly with **one-on-one** computer graphics presentations in the offices of influential legislators.

5. **Draft the legislation carefully.** At the request of your bill’s sponsor, you should be able to work with the Legislative Drafting Bureau to develop the legislative language. The final product must be legally viable and constitutional, and it must not conflict **with** other legislation. Opinions vary widely regarding legislative language. Generally worded legislation is easier to pass but more widely open to interpretation. Detailed, specific legislation is more difficult to pass, but more binding. The Legislative Drafting Bureau can help you determine what is best in your particular situation.

When defining roles and responsibilities, consider not only the programmatic impact of these assignments, but also the political impact. The VIM legislation, for example, created some problems with Health Department support when the authority for delivering services was given to the Commission rather than to the Department.

Include involved groups in the process of developing the legislation to ensure that both their interests and yours are addressed. When Senator Sederburg realized that he needed the votes of rural legislators supporting local health departments in order to pass MHI, he invited the Michigan Association of Local Public Health (**MALPH**) to assist in preparing the legislative language covering the role of local health departments.

6. **Tie into a “hot button” issue, if possible.** During the development of the MI-II initiative, AIDS was a major issue in the legislature. Several AIDS committees were functioning, but, as yet, no legislation had been introduced. Including AIDS in the risk reduction legislation garnered previously uncommitted votes.

Remember that legislative language can affect the ability to change the legislation. The MHI legislation was skillfully constructed to interweave risk reduction and AIDS activities. Removing either risk reduction or AIDS from the legislation would have been impossible without totally rewriting it, an unlikely event.

7. **Recognize that health is a bipartisan issue.** Seek to spread ownership of the legislation among as many legislators of both parties as possible. The sponsor of your legislation should be able to attract numerous co-sponsors. He or she should **also** develop support in the opposite house. Senator Sederburg, a Republican, solicited and won the support of Representative Emerson, a Democrat.
8. **Develop a structure to organize broad-based grass roots support.** Involve as many interests as possible. Coalitions both legitimize and support an effort. As one interviewee stated, "If you cannot work with a coalition, do not attempt a legislative initiative." Be aware, however, that groups give up their individual identities when they join a coalition. They need to receive something in return. It is not to your advantage to "give away the store"; however, be sensitive to their needs while protecting your own interests. The American Lung Association of Michigan worked with the coalition task force to support the prevention initiative. They did so primarily because of their belief that taxing cigarettes reduces consumption. The Lung Association now finds that it cannot get television air time for its anti-smoking public service announcements because the Michigan Health Initiative is paying for air time for its anti-smoking spots. Perhaps a cooperative approach to paid air time would have served the interests of both parties.
9. **Identify powerful lobbies and explore ways to work with them.** For example, MHI worked closely with the Michigan Hospital Association, whose interest was aroused by the inclusion of hospitals as **worksites** wellness providers. This inclusion opened the door to expanded sources of hospital income and generated active Hospital Association support for MI-II.

In a sense, MI-II even worked with the tobacco lobbies. A 4 cent tax was palatable to cigarette manufacturers because machine sales of cigarettes would require the deposit of a nickel, and the excess cent would accrue to the cigarette companies. In backing away from levying a new tax on smokeless tobacco products, MI-II further pacified the tobacco lobbies.

10. **Budget carefully.** Assume that whatever budget you submit will be cut during the legislative process. Accordingly, submit a high, but realistic budget. VIM's budget was nearly as large as the State general fund commitment to all public health programs. Proposing a budget of this magnitude engendered skepticism about the "pork barrel" nature of the effort.
11. **Market your initiative.** The concept of entering the political arena may raise a few eyebrows in State government. The concept of marketing has been raising **government** eyebrows for a long time. However, marketing is a necessary component of a successful effort. Michigan used many marketing approaches. They conducted free health risk appraisals for legislators to invest them personally in the issue, they distributed apples at press conferences, and they planned **fishing** trips for key opinion leaders. They even brought their own lobbying efforts out of the "smoke-filled conference room" and into the world of technology by developing a computer

Chapter V. Lessons Learned from the Michigan Experience

graphics presentation illustrating the MHI effort and the data supporting it. This presentation was used to educate legislators and other key leadership, briefly and painlessly. The new technology captured their attention and they learned in spite of their busy schedules.

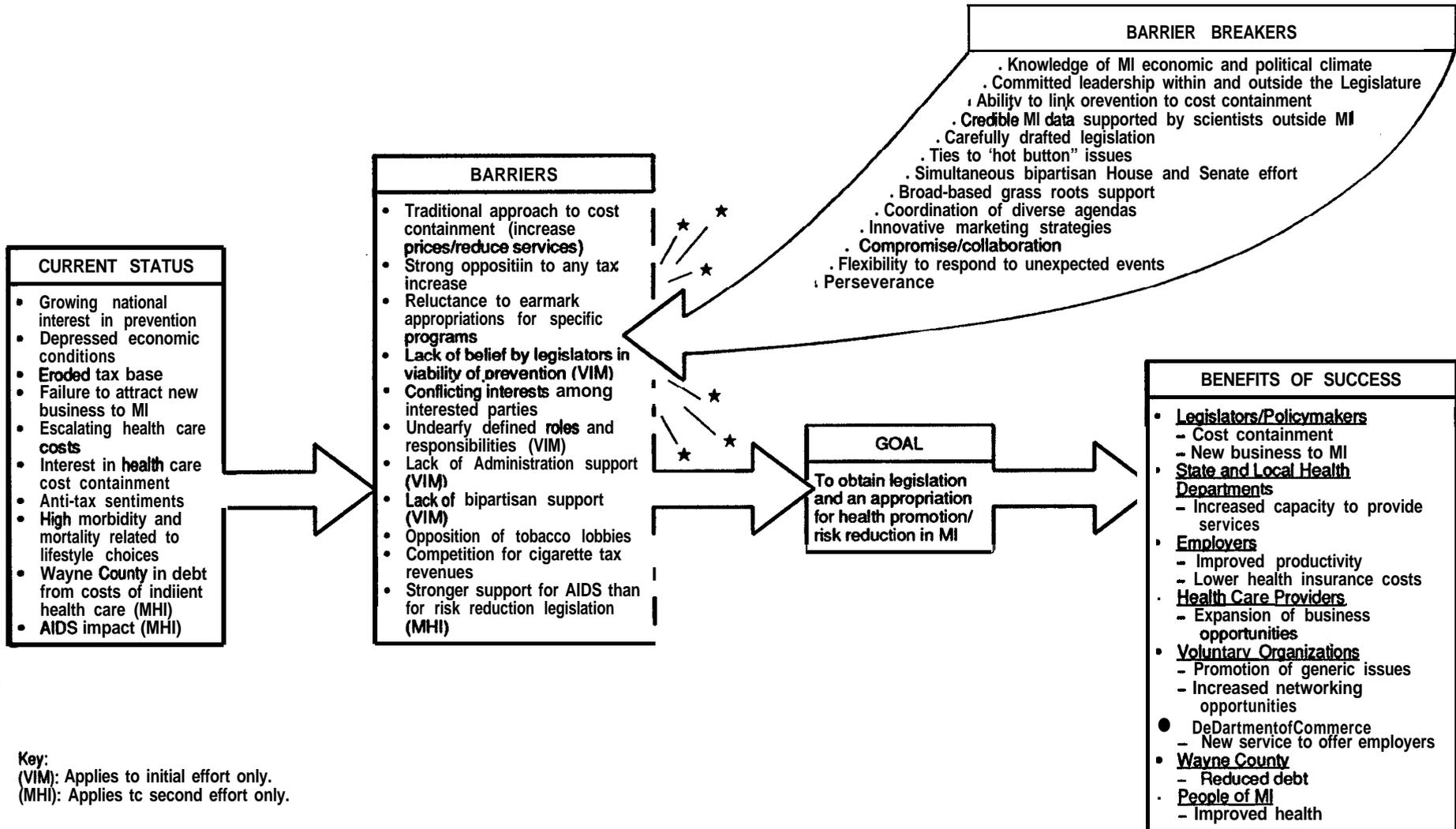
12. **Don't expect success the first time around.** It rarely happens. However, don't minimize the value of your initial effort in paving the way for ultimate success. VIM educated legislators about prevention, personally invested them in it through **the** health risk appraisal, fostered awareness of the link between health promotion and cost containment, developed grass roots support, and generally set the stage for **MHI**.
13. **Don't be greedy.** Take what you can get. Compromise and collaboration are the operative methods of politics. MHI compromised with the Wayne County Solvency Coalition and with local health departments. Had they not been willing to make that compromise, they would have ended up with nothing. The cardinal rule of politics is--nobody wins unless everybody wins.

The need to compromise does not end when the legislation is passed. In the next chapter, the **failure** of the effort to keep MI-II funds from supplanting funds from other programs is discussed. In a period of budget austerity and program cuts, it is unrealistic **to** expect that the wealth will not be shared broadly. However, it is important to provide adequate safeguards and oversight to distinguish between broad interpretation of the legislation and misuse of funds.

Exhibit V-1 is a force field analysis that graphically summarizes Michigan's approach to the recommendations of this chapter.

EXHIBIT V-1

OBTAINING RESOURCES FOR PREVENTION IN MICHIGAN
 Vitality in Michigan (VIM): Initial Effort (1983-1985)
 Michigan Health Initiative (MHI): Second Effort (1986-1988)



Key:
 (VIM): Applies to initial effort only.
 (MHI): Applies to second effort only.

Chapter VI

Implementation of the Michigan Health Initiative

Chapter VI. Implementation of the Michigan Health Initiative

With the passage of MHI, the Michigan Department of Public Health became the beneficiary of a relatively stable source of funding ranging from \$9 million to \$12 million per year. **OHMA** worked with the Senate Fiscal Agency to break the lump sum into line items.

An additional \$11 million went directly to local health departments. It was earmarked for local preventive health efforts, including **pre-** and post-counseling for AIDS tests. Each local health department has autonomy over its share of the funds, and each department is expending them according to its needs.

The remainder of this chapter is devoted to the expenditure of the **MHI** funds administered through the Michigan Department of Public Health. Exhibit VI-1 shows the allocation of funding for the first 2 years of the program.

I. Major Program Components

A. Risk Reduction and AIDS Policy Commission

The MHI legislation created an advisory commission on risk reduction and AIDS. Members of the Commission are appointed by the Governor with the advice and consent of the Senate. Some saw the creation of the Commission as politically necessary to the passage of MI-II because it would balance the power placed in the Department of Public Health.

The Commission's eleven members have broad backgrounds in prevention and health policy development. The legislation specifies that Commission members may not represent any single health interest or disease entity. An amended clause in the legislation permits the Commission to appoint subcommittees with special issue membership.

Commission members represent State and local government, business and industry, labor, health care providers, the legal community, religious organizations, and the education community. To the extent possible, members also represent the demographic and geographic composition of Michigan.

The Commission makes annual reports to the Governor and to the Legislature and makes recommendations for allocation of MHI funding. While the subtleties of the Commission's role are still evolving, a positive and cooperative working relationship between the Commission and the Department of Public Health has been established.

EXHIBIT VI-1

MHI IMPLEMENTATION
**(MHI RESTRICTED FUND IS SET
 BY STATUTE TO BE \$9-12 MILLION)**

Program Component	As Intended	FY 89	FY 90	FY 91
MHI Administration	-0-	\$0.400 M	\$0.400 M	
Media Campaign & Clearinghouse	\$2.100 M	\$2.024 M	\$2.029 M	
AIDS Education	\$1.500 M	\$1.500 M	\$1.672 M	
AIDS Prevention/Testing	\$0.700 M	\$0.927 M	\$0.517 M	
Worksite Risk Reduction Grants and Projects	\$4.500 M	\$2.856 M	\$2.666 M	
Office of Minority Health**	-0-	\$0.750 M	\$0.900 M	
Vaccine Trials**	-0-	-0-	\$0.165 M	
Project Choices**	-0-	-0-	\$0.250 M	
Provider Education	\$0.700 M	\$0.386 M	\$0.387 M	
Local Referral Network Grants	\$2.500 M	\$1.157 M	\$0.815 M	
Health Promotion Projects***		\$1.250 M	\$0.840 M	
Totals	\$12.000 M	\$11.250 M	\$10.640 M	\$9.000 M

** Programs not specifically authorized to be funded under the Michigan Health Initiative Legislation

*** Programs that were previously funded under general fund support

B. Worksite Wellness Program

Worksite wellness received a significant appropriation under MHI. It embraced many concepts that had been central to the health promotion initiative proposed in the VIM legislation. Current Health Department guidelines targeted **worksite** wellness, specifically, but not exclusively, to small and medium-sized employers--those with fewer than 500 employees. The goal was to help employers lower health care costs by reducing employees' risks of preventable disease and injury, focusing on such controllable risk factors as smoking, lack of exercise, substance abuse, high blood pressure, high cholesterol, diabetes, obesity, and failure to use seat belts. During the first year (1988-89), 807 individual worksites were funded.

Several unique aspects distinguished the **worksite** wellness program:

- **Direct Grants to Employers.** Funding for health promotion programs was made directly to employers through grants ranging from \$500 to \$3,000. Employers applied for these funds, identifying the kind of health promotion services desired and the provider selected **from** a list approved by the Department of Public Health.

By giving funds directly to employers and allowing them to fashion health promotion activities specific to their employees' needs, the **worksite** wellness program earned the support of the business community. The program was seen as a clear method to help businesses reduce health care costs, increase productivity, and become more competitive.

- **Regional Worksite Wellness Technical Assistance Centers.** Although funding for **worksite** wellness programs went directly to employers, the Center for Health Promotion had overall responsibility for implementing the program and ensuring a consistent level of quality throughout the State. The structure selected to achieve that mandate was involvement of up to 10 experienced local health departments to serve as regional Technical Assistance Centers, providing coordination and technical expertise to **worksite** wellness programs.

The Center for Health Promotion devised an innovative plan to determine which local health departments would be designated as regional centers. With the cooperation of the Michigan Association of Local Public Health (MALPH), CHP surveyed all 48 local health departments in the State, asking them which health department in their region should become the center. This process of self-selection produced a strong consensus about which local health departments were best qualified to serve as regional centers. With minimal disagreement over the choices, eight centers were selected: seven were local health departments and one was a Detroit-area consortium of seven health departments. All local **health departments must affiliate with one of these centers to ensure** access to the **worksite** wellness program by employers throughout the State.

Chapter VI. Implementation of the Michigan Health Initiative

The Technical Assistance Centers organize collaborative efforts among local health departments in their regions, approve providers of **worksite** wellness programs using statewide standards, review and approve grant applications from employers, select and fund local agencies to conduct community health promotion activities related to **worksite** health, and train all providers involved in delivering **worksite** wellness programs. Local health officers sit on center **advisory** boards, and a statewide regional center network fosters communication among staff throughout the State.

- **The Department of Public Health/Department of Commerce Partnership.** Another unique feature of the **worksite** wellness program bolstered ties to the business community and strengthened the relationship between two State agencies--the Department of Public Health and the Department of Commerce. During the MHI legislative process, a staff person in the Department of Commerce recognized the potential for reduction of health care costs through the **worksite** wellness program. Further, she recognized the opportunity the program presented to the Department of Commerce, specifically through the mechanism of Community Growth Alliances (**CGAs**), a statewide network of local groups that provide consultation to small and medium-sized businesses in an effort to strengthen economic growth. By helping market the **worksite** wellness program to employers, the **CGAs** could enhance their usefulness to the business community. There was a clear benefit to the Department of Public Health, too. Without a tradition of relating to businesses in a proactive way, public health might have had a difficult time marketing the **worksite** wellness programs. The established network of **CGAs** provided an ease of access to the business community that was a clear asset to public health.

After some negotiation between the two departments, an agreement was forged. The **CGAs** work closely with the regional Technical Assistance Centers to market the **worksite** wellness concept and, through their representation on the center advisory councils, to guide policy.

C. Merging AIDS and Risk Reduction Activities

A high level of anxiety about AIDS helped win passage of **MHI**. About one-half the **\$11,250,000** allocated to MHI in the first year supported the State AIDS program, a substantial portion of which bolstered activities in testing and counseling, education, and development of referral and care networks.

D. Clearinghouse and Media Campaign

The **MHI** legislation mandated an information clearinghouse and a media campaign to focus public attention on both AIDS and risk reduction. After exploring the "single roof" concept for AIDS and risk reduction, CHP determined that two separate clearinghouses would operate more efficiently. During the previous 3 years, the **CHP**

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had been disseminating AIDS materials and operating an AIDS information hotline--two functions of a clearinghouse--so initial planning focused on the risk reduction clearinghouse.

The funds earmarked for the media campaign were split evenly between risk reduction and AIDS. A decision was made to focus on one subject per year in each area. The first year's campaign targeted (1) smoking, specifically in preteens and women, and (2) behavior related to AIDS transmission, specifically by intravenous drug users and their sex partners, urban adults, and adolescents, particularly school dropouts. Future risk reduction media campaigns will focus on such areas as violence and teen pregnancy.

CHP contracted with a highly respected Michigan advertising agency to develop the first year campaigns. They included television and radio spots, newspaper ads, and outdoor and transit posters. In an approach that is highly unusual in public service advertising, CHP paid for air time to extend the reach and impact of the campaign. Unfortunately, the American Lung Association of Michigan is a recipient of some negative fallout of CHP's paid advertising campaign. They **are** finding it very difficult to secure air time for their own public service announcements.

E. Other Health Promotion Projects

Drafters of the MHI legislation were careful to introduce non-supplant language into the bills. Section 5911 of Senate Bill 544 clearly states, "The (MHI) Fund is in addition to, and is not intended as a replacement for, any other money appropriated to the Department." Despite this language, certain public health areas did suffer budget cuts after MHI passage. As a result, some of the MHI funds were shifted to provide continued support to those areas. A general category of "health promotion programs" supports programs that will vary each year, depending on need. In the **first** year of MHI implementation, **\$1,250,000** was allocated to such programs as cancer prevention and control, a behavioral risk factor surveillance system, health promotion conferences, a risk assessment tool to aid in prevention of osteoporosis, and grants for applied research in health promotion.

II. Perspectives on Implementation

A. Benefits

Much of the success in the process of passing the MHI legislation is attributable to the fact that "everybody got something." Similarly, the success in implementing such a complex, multi-faceted programs appears to be that virtually all players derived some benefit from MHI.

Success in implementation was not guaranteed. In fact, the broad manner in which much of the MHI mandate was framed created a potential for conflict. There was

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built-in tension between the Department of Public Health and local health districts (as represented by MALPH) over the allocation and control of **worksite** wellness funds. There was potential for conflict between the Departments of Public Health and Commerce, between the Commission and the Center for Health Promotion, and between voluntary agencies and State health programs. It took creativity to develop and implement a cohesive program that supported the public health of the State, and, at the same time, responded to the interests of various constituencies.

As **MHI** was implemented, the following groups benefited:

- **Business community.** The **worksite** wellness programs were a way for employers to demonstrate concern for employees, offer a tangible benefit, and, over the long term, produce cost savings in the areas of health insurance, disability payments, and absenteeism--without incurring expenses.
- **Health care providers.** **MHI** represented a stable funding source for health promotion, thus **guaranteeing** an expansion of business opportunities for organizations that provide such services, including hospitals and **HMOs**. Further, the publicity and activity associated with **MHI** raised awareness about the value of health promotion generally, and, in that way, indirectly helped market the concept for such providers.
- **Voluntary agencies.** Although funds for prevention under **MHI** did not directly benefit voluntary health agencies that had formed the original coalition to support VIM, some "halo effect" occurred in the sense that generic issues were addressed. For example, VIM and **MHI** legislation paved the way for subsequent smoking restriction legislation, a major goal of such voluntary organizations as the American Lung Association of Michigan.
- **Local health departments.** Many benefits **from** MI-II accrued to local health departments, despite the fact that they did not get **worksite** wellness funds directly. Specific advantages included:

Increased capacity, funds, and influence for the local health departments designated as regional centers

- Increased capacity for health departments that wanted to strengthen their potential as providers of health promotion services

Greater visibility in the community, especially the business community, as providers of services, rather than solely as regulators and enforcers

A better relationship with the State through the regional center network and through various training and meeting opportunities sponsored by **CHP's Worksite** Wellness Unit

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A foundation on which to expand health promotion efforts beyond the **worksite** to the broader community

An embryonic network, forged through various **worksite** wellness activities, that can be the foundation for future lobbying efforts.

- **Department of Public Health.** MHI gave the Department greater autonomy in decisionmaking than they would have had under VIM. With a stable trust fund to support important activities, the Department had increased fiscal power and flexibility in funding allocations. More resources meant an expansion of health promotion programmatic offerings. In a wider sense, MHI gave the Department greater visibility as an influential department in the State; it also raised awareness within the State legislature of the Department's work. And, not least, MI-II helped public health build important links to other key players: local health departments, the private sector (both businesses and providers), other State agencies, and voluntary organizations.
- **Department of Commerce.** The Community Growth Alliances benefitted from having a new service--the **worksite** wellness program--to offer employers in their areas. Health promotion at the workplace was a practical response to concerns about containing the costs of health care.
- **Wayne County.** The package **legislation--MHI** and the Health and Safety Fund--enabled Wayne County to reduce its debt to the State and reorganize services for the medically indigent in a way that gave the county control over costs and services.
- **The people of Michigan.** The Michigan Health Initiative, with its infusion of dollars for health promotion and risk reduction, supports efforts to improve the quality of life for people in **Michigan** and, at the same time, holds great promise to reduce the spiraling costs of health care.

B. Caveats and Concerns

Experience in battles for resource allocation confirms that accomplishing the legislation is not the end of the struggle. Constant vigilance is required to ensure that the original intent of the legislation is carried out and maintained over time. Since implementation of MHI, concerns have surfaced over possible redirection of funds that were allocated specifically for health promotion.

Despite the non-supplant language of the **MHI** legislation, there has been erosion of funds for earmarked programs. Exhibit **VI-1** on page 34 shows the distribution of funds for specific program components as intended by the legislation and as actually allocated in fiscal years '89 and '90. For example, new funding in FY '90 went to vaccine trials, a program not designated in the MHI legislation. For the same period, funding for **worksite** risk reduction grants and projects was set at almost half of the

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amount originally intended. One could argue that vaccine trials are an important part of public health prevention efforts; nonetheless, they were not specified under MHI. In a time of budgetary cutbacks for many worthy health and social programs, it is difficult to withstand pressures to shift intended funds to support other programs that have, been cut.

In the overall context of legislation that specifies both a ceiling and a floor for funds--in the case of Michigan, \$12 million and \$9 million--it is particularly important to try to hold the line. Whereas legislatures may begin by supporting the ceiling figure, it is realistic to expect that other funding pressures will reduce the support to the floor level in subsequent years. In Michigan, **\$11,250,000** was awarded in FY '89 and \$9 million is projected for FY '91. The lesson here is that prudence demands retention of funding for intended programs since the total amount available is likely to be diminished eventually.

The problem of shifting funds also relates to the larger question of accountability: who is monitoring the way funds are allocated once legislation has passed? In the case of Michigan, the AIDS and Risk Reduction Policy Commission has an advisory role but not strong oversight powers. Thus, the Michigan Department of Public Health has a large degree of flexibility about how the MHI monies are allocated each year. Similarly, the local health departments have significant latitude in deciding how to spend their "prevention" dollars generated under the Health and Safety Fund Act. However, both the shape of the Commission and the discretion allowed local health departments were part of the compromise necessary to win passage of MHI.

Public health advocates who expend significant efforts to develop and pass prevention/health promotion legislation need to continue their vigilance to maintain the gains they win. At the same time, they should be realistic about the price of compromise and recognize that faithfulness to the original intent of the legislation is a goal to pursue, not an absolute certainty.

Appendix

Population Attributable Risk

Several statistical methods have been developed to measure the degree of association in epidemiologic studies. **One** such measure is Population Attributable Risk (PAR). PAR is the maximum proportion of a disease in the population that can be attributed to a specific factor or characteristic. Conversely, it can be expressed as the **proportional** decrease in the incidence of a disease if the entire population were no longer exposed to the suspected factor. The formula for PAR is:

$$PAR = \frac{b(r - 1)}{b(r - 1) + 1} \times 100\%$$

where r = the relative risk and b = the proportion of the total population classified as having the characteristic. The relative risk (r) can be obtained with the following **formula**:

$$r = \frac{\text{Incidence rate of disease in exposed group}}{\text{Incidence rate of disease in non-exposed group}}$$

The relationship between the risk factor "smoking" and the disease lung cancer illustrates application of the PAR. The Michigan Department of Public Health Prevalence Survey (1983) indicated that 32.4 percent of Michigan adults smoke. Epidemiological studies have estimated that smokers have a 10 times greater risk of getting lung cancer than nonsmokers. By substituting these figures into the formula above, the PAR is created for smoking and lung cancer. When the formula is applied to each disease for which smoking is a risk factor, it is possible to identify the overall mortality related to the risk factor. In Michigan, the cumulative effect of smoking is estimated to have resulted in 12,147 premature deaths in 1983, or, conversely, the number of deaths that could have been prevented if the risk factor (smoking) **were** eliminated.

To examine the costs and benefits of risk factor intervention, the Michigan analysts developed a computer model. The model was based on Michigan's working age population (20-64 years). The computer model projected the savings for each MHI dollar invested **in** risk reduction. The model incorporated a variety of considerations, including the PAR, cost estimates of various **risk** reduction programs undertaken in the program area, 1983 Michigan DRG costs, and lost income based on estimated average annual income. It discounted future dollars to estimate present value dollars.

The application of the PAR to the computer model captured the salient issue for Michigan's legislators--the potential reduction of escalating health care costs,

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Michigan Health Initiative Chronology

- May 1983 Michigan Senate creates special committee to study health care cost containment. Focus is on reducing services and cost of care.
- May 1984 The prevention subcommittee of the Senate special committee submits preliminary recommendations for long-term cost containment strategies, focusing for the first time on prevention.
- Nov. 15, 1984 Senate Special Committee on Health Care Cost Containment accepts recommendations of prevention subcommittee, presented in report entitled *Health Care Cost Containment: A Preventive Approach*.
- Jan. 1985 Legislation is introduced to implement the recommendations of the prevention subcommittee. The legislation is called *Vitality in Michigan (VIM)*. The program authorization bill (SB 4) proposes a prevention trust fund, a commission to administer it, a Center for Health Promotion, State and local health promotion programs, and stimulation of insurance incentives. The funding bill (SB 5) proposes a funding mechanism based on taxing cigarettes.
- Late 1984--Mid 1985 A strong coalition is developed and works to support SB 4 and SB 5.
- June 1985 Support develops for vehicle bill, but tremendous opposition to funding bills exists. Passage looks dim. Tie-bar is broken between vehicle and funding bills, and vehicle bill (SB 4) passes Senate. Funding bills (SB 5 and SB 622) die in committee.
- House of Representatives refuses to pass vehicle bill without funding bill.
- 1985 CHP is formed within the Michigan Department of Public Health as part of its reorganization. This separate, but related, initiative begins to attract attention and federal funding in the prevention arena.
- The Office of Health and Medical Affairs (**OHMA**), within the Department of Management and Budget, and CHP develop and pilot test **worksite** wellness programs for school employees.
- Governor appoints expert committee on AIDS.

- Jan. 1986 SB 622, an additional VIM funding bill, based on taxing smokeless tobacco products, is introduced.
- 1987 House of Representatives appoints a special subcommittee on AIDS and a task force on AIDS to collect data and develop policy..
- Summer 1987 Key staff leadership involved in the VIM effort meet to assess the chances of a new legislative attempt and to discuss strategy.
- October 1987 OHMA and CHP issue report, **Health Promotion Can Produce Economic Savings**. Report cites health promotion as a method of reducing health care costs to employers as a means of attracting new business to Michigan.
- Nov. 10, 1987 New legislation, the **Michigan Health Initiative (MHI)** is introduced in the Senate. SB 544 proposes a 10-point plan combining AIDS and health promotion. The plan, housed in CHP, includes a prevention trust fund, a commission, an AIDS and Risk Reduction Clearinghouse, a public service media campaign, free AIDS testing, education, and counseling, and work-site risk reduction programs. SB 545 and SB **546** propose funding based on cigarette and other tobacco taxes.
- Dec. 3, 1987 MI-II vehicle bill (SB 544) passes Senate. Funding bills are opposed and held in Finance Committee. MHI does not have enough votes to pass the funding bills.
- Dec. 1987 Coalition seeking support for payment of Wayne County's major debt is competing for cigarette tax funding, but lacks the votes to obtain it. Wayne County coalition suggests compromise funding bill between Wayne County and MHI.
- Negotiations dilute MI-II's share of the funding, but provide prevention dollars directly to local health departments.
- A computer software tax is proposed to fund the State portion of MI-II.
- Dec. 21, 1987 Agreement is reached on the combined package. It is passed by both the Senate and the House.
- Dec. 28, 1987 The package is signed into law by the Governor.
- July 1988 The Michigan Health Initiative is implemented. A minimum of \$20.2 million annually is provided for prevention efforts through State and local health departments.

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